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HR News Alert

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Brown & Brown of Garden City, Inc.

October 2013 Issue

High Deductible Health Plans May Cover Preventive Services With No Deductible

Under Health Care Reform, non-grandfathered group health plans are required to cover certain preventive health services with no cost-sharing. New IRS guidance clarifies that a health plan **will still qualify** as a high deductible health plan (HDHP) even though it provides such preventive services without a deductible.

An HDHP is a health plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses. Generally, an HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied. However, the law provides an exception for certain preventive care.

Among other requirements, an individual must be covered under an HDHP to be eligible for a health savings account (HSA). Seventeen percent (17%) of employers that provide health benefits offer an HSA-qualified HDHP, according to the 2013 Employer Health Benefits Survey conducted by the Kaiser Family Foundation and Health Research & Educational Trust.

You can read more about HSAs in our section on Health Savings Accounts.

In this Issue

New Guidance on Health Care Reform Rules for HRAs & Other Arrangements

A new set of Q&As provides additional guidance regarding how the prohibition on annual dollar limits and the requirement to cover preventive services under Health Care Reform apply to health reimbursement arrangements (HRAs) and certain other employer healthcare arrangements. The following are key highlights that may be of interest to employers:

- A group health plan, including an HRA and an employer payment plan, **cannot be integrated with individual market coverage**.
    - An HRA or employer payment plan used to purchase coverage on the individual market will therefore **fail to comply** with the annual dollar limit prohibition and the preventive services requirements.
- An HRA that is **integrated with a group health plan** will generally comply with the annual dollar limit and preventive services requirements if the group health plan with which the HRA is integrated

complies with those requirements.
    - An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it qualifies under either of two integration methods described in the Q&As.
- A health flexible spending arrangement (FSA) that does not qualify as excepted benefits is not integrated with a group health plan, and thus will fail to meet the preventive services requirement.
    - Effective retroactively as of September 13, 2013, a health FSA that is not offered through a cafeteria plan (a plan which meets specific requirements to allow employees to receive certain benefits on a pre-tax basis) is subject to the annual dollar limit prohibition and will fail to comply with this requirement.
- Effective for taxable years beginning after December 31, 2013, an employer is prohibited from providing a qualified health plan offered through a Health Insurance Exchange as a benefit under the employer's cafeteria plan.

The agency guidance applies for **plan years beginning on or after January 1, 2014**, with certain exceptions, but may be applied for prior periods. Visit our section on HSAs, FSAs, & Other Tax-Favored Plans for more information on these types of arrangements.

SHOP Online Enrollment Delayed Until November

Online enrollment for small employers to purchase employee health coverage through the federally-facilitated SHOP Marketplace (Small Business Health Options Program) **will not be available until November**. Small employers will be able to start the application process and get an overview of available plans and premiums beginning October 1, 2013.

For 2014, the federally-facilitated SHOP Marketplace is open to employers with **50 or fewer full-time equivalent employees**. According to the U.S. Department of Health and Human Services, all functions for SHOP will be available in November and if employers and employees enroll by December 15, 2013, coverage will begin January 1, 2014.

Reminder: Exchange Notice Requirements After October 1st
All employers covered by the Fair Labor Standards Act are required to provide employees with a notice regarding the Health Insurance Exchange (Marketplace), regardless of whether they offer a health plan.

Following the distribution of notices to current employees (required no later than October 1, 2013), employers must provide the notice to each **new employee** at the time of hiring, within 14 days of an employee's start date. Although the U.S. Department of Labor announced that there is no fine or penalty under the law for failing to comply, the law still requires that employers provide the notice.

Our Summary by Year provides information on other upcoming changes under Health Care Reform.

Planning for Workplace Emergencies

A workplace emergency is an unforeseen situation that threatens your employees, customers, or the public; disrupts or shuts down your operations; or causes physical or environmental damage. Having an emergency action plan is key to preventing a disorganized evacuation or emergency response that could result in confusion, injury, and property damage.

Developing an Emergency Action Plan
Almost every business is required to have an emergency action plan. An emergency action plan covers designated actions employers and employees must take to ensure employee safety.

At a minimum, your plan should include the following elements:

- Means of reporting fires and other emergencies;
- Evacuation procedures and emergency escape route assignments;
- Procedures to be followed by employees who remain to operate critical plant operations before they evacuate;
- Procedures to account for all employees after an emergency evacuation has been completed;
- Rescue and medical duties for those employees who are to perform them; and
- Names or job titles of persons who can be contacted for further information or explanation of duties under the plan.

Your emergency action plan should be tailored to your worksite and include information about all potential sources of emergencies. Keep a copy of your emergency action plan in a convenient location where employees can get to it, or provide all employees a copy. (If you have 10 or fewer employees, you may communicate your plan orally.)

OSHA's Emergency Action Plan Expert System Can Help
You can use the online Emergency Action Plan Expert System, available from the federal Occupational Safety & Health Administration (OSHA), to help you create a simple emergency action plan for your company. According to OSHA, this basic plan will be adequate for the needs of many small and medium-sized entities, but may not be adequate for large establishments or those with more significant hazards.

Note that the OSHA Expert System only provides information based on federal OSHA Emergency Action Plan requirements. If you are covered by a state OSHA plan, you may need to contact your local state OSHA office. Our section on Planning for Workplace Emergencies includes additional information and tips for protecting your employees and business during a disaster.

Benefits for Same-Sex Spouses: Recent Agency Updates

Federal agencies continue to issue guidance applying the U.S. Supreme Court decision that invalidated part of the Defense of Marriage Act (DOMA), which denied federal benefits to legally married, same-sex couples. The latest updates include the following:

Legal Same-Sex Marriages Recognized for Purposes of Employee Benefit Plans
The terms "spouse" and "marriage" will generally be read to **include same-sex couples legally married in any state that recognizes such marriages, regardless of where they currently live** for purposes of Title I of the Employee Retirement Income Security Act (ERISA) and related agency regulations.

ERISA is a federal law that sets minimum standards for employee benefit plans in the private sector. Among other requirements, Title I includes the health coverage continuation provisions of COBRA (the Consolidated Omnibus Budget Reconciliation Act) and the portability provisions of HIPAA (the Health Insurance Portability and Accountability Act). Future guidance is expected to address the impact of the decision on specific provisions of ERISA and its regulations.

The agency guidance makes clear that the terms "spouse" and "marriage" for purposes of ERISA **do not include individuals in domestic partnerships, civil unions, or similar formal relationships recognized under state law**, regardless of whether these individuals have the same rights and responsibilities as those who are married under state law.

Guidance on Correcting Overpayments of FICA and Employment Taxes
The IRS has outlined special optional procedures for employers to correct overpayments of Federal Insurance Contributions Act (FICA) taxes and federal income tax withholding (employment taxes) for 2013 and prior years with respect to certain benefits provided to same-sex spouses.

Prior to the DOMA ruling, employers may have withheld and paid employment taxes with respect to certain benefits provided to the same-sex spouse of an employee (e.g., employer-provided health coverage and fringe benefits) because the marriage was not recognized for purposes of federal tax law, and the benefits

were not treated as excludable from gross income or wages for federal income or employment tax purposes.

For guidance on same-sex marriage laws specific to your state, visit our State Laws section, click on your state, and select "Same-Sex Relationships" from the left-hand navigation menu.

Model HIPAA Notice of Privacy Practices Now Available

New model notices are available to help health plans comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. The Privacy Rule generally requires covered entities, including health plans, to develop and distribute a notice informing individuals of the entity's privacy practices and of the individual's privacy rights with respect to his or her personal health information (PHI).

Note: Group health plans providing benefits only through one or more contracts of insurance with issuers or HMOs, and that do not create or receive PHI--other than summary health information or enrollment information--are **not required to develop this notice**.

The model notices reflect changes made by the HIPAA final omnibus rule that became effective in March. Covered entities were required to revise their notices to reflect those changes by September 23, 2013, and must redistribute the notice as provided in the final omnibus rule. You can visit our HIPAA section for more information.

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