WELLS FARGO INSURANCE

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# Legislative update

**In this issue**

- IRS re-affirms that affordability under ACA is based on single coverage
- HHS issues proposed rules coordinating Medicaid, children's health insurance programs, and Exchanges processes including verification of employer-sponsored health coverage
- Delinquent Filer Voluntary Compliance Program – DOL releases notice and FAQ
- HHS issues final HIPAA privacy and security regulations

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## IRS re-affirms that affordability under ACA is based on single coverage

On February 1, 2013, the Internal Revenue Service (IRS) published final regulations on the health insurance premium tax credit under the Patient Protection and Affordable Care Act (ACA), which re-affirm its position that the concept of affordability for coverage under an employer's group health plan is based on single coverage, not two-party or family coverage, even if the employee is covering a spouse or children under the plan.

The final regulations include an example of an employee who contributes $5,300 (or 11.3% of household income) for two-party coverage under the employer's group health plan (the employee cost for single is $3,450, or 7.356% of household income). Even though the employee has elected two-party coverage (which requires an employee contribution that exceeds 9.5% of household income), the coverage is deemed to be affordable under the ACA, because employee contributions for single coverage do not exceed 9.5% of household income.

For further information about health insurance premium tax credits under the ACA, refer to the article in our June 2012 Legislative Update.

## HHS issues proposed rules coordinating Medicaid, Children's Health Insurance Program, and Exchanges processes, including verification of employer-sponsored health coverage

On January 22, 2013, the U.S. Department of Health and Human Services (HHS) published proposed regulations coordinating the application, enrollment, and appeal processes for Exchange-based health insurance affordability programs, including verification of access to affordable employer-sponsored coverage, Medicaid eligibility, and the Children's Health Insurance Program (CHIP). All of these programs will be coordinated and utilize combined applications and eligibility notices by January 1, 2015. Under this streamlined process, if an Exchange receives an application and determines that the individual is eligible for Medicaid, the Exchange would issue a single combined notice approving Medicaid eligibility and denying eligibility for Exchange-based affordability programs.

The regulations are extensive and discuss Medicaid and CHIP eligibility at length. The summary below, however, focuses on the process that Exchanges will use to verify whether individuals who apply for Exchange-based subsidies are eligible for employer-sponsored health coverage that meets the affordability threshold (the employee is not required to pay more than 9.5% of household income for employee-only coverage) and minimum value standards (60% minimum actuarial value). This is significant because applicants who are eligible for affordable coverage with a 60% minimum actuarial value are not eligible for Exchange-based subsidies. Any full-time employee that is eligible for and receives subsidized Exchange-based coverage because his or her employer plan is not affordable or does not provide value will trigger a penalty for the employer.

Initially, employers should expect to be involved in the Exchange's process for verifying eligibility for affordability programs. Verification is only required when an applicant's attestation is not consistent with other information or if there is missing information. In such cases, the Exchange must seek verification for a statistically significant random sample of applicants. The Exchange will notify the applicant that it will be seeking information from his or her employer, and employers will receive a notice from the Exchange seeking to verify the employee's eligibility for Exchange-based affordability programs. If, however, the Exchange does not receive a response from the employer within 90 days, the Exchange will determine the individual's eligibility for the affordability programs based on the employee's attestation regarding the employer's coverage.

Notably, under the prior final Medicaid eligibility rule, the Secretary of HHS is charged with establishing an electronic service (federal data service hub) through which Exchanges can access data necessary to confirm eligibility for affordability programs. HHS is currently exploring ways to electronically confirm eligibility for qualifying employer-sponsored coverage in real time. The required employer reporting that would provide the data needed for such a process does not begin until 2015. Until such real time electronic verifications are possible, employers should respond in a timely manner to any verification requests.

In addition to these verification procedures, the proposed regulations also discuss use of a "voluntary pre-employment template" to assist Exchange applicants in gathering and presenting information about their access to coverage through an employer-sponsored plan. This would be a one-page document that could be downloaded from the HHS website or from an Exchange website that an employer would complete regarding the available benefit offerings and provide to HHS or to employees. HHS noted that it intends to release the template in the near future.

Separate from the verification process, employers will also receive a notice of potential tax liability from the Exchange when its employees purchase subsidized Exchange-based coverage. Employers will have a separate opportunity to appeal any determination that the employer does not provide affordable coverage or coverage that meets the required minimum value. There will be an Exchange appeals entity that will conduct a de novo review of the determination regarding the employer's offerings. An appeals entity must consider an appeal request received within 90 days of receiving a determination that the employer plan is unaffordable for an employee or does not provide

value. However, this process remains separate from the IRS's process for assessing tax penalties. This appeal is the employer's final opportunity to correct information the Exchange received from an individual in an application, as not all applicant attestations are verified. HHS stated its intent to work closely with the IRS to educate and develop appropriate notices to correct information housed with the Exchange and address penalties levied separately by the IRS. Comments on coordinating these parallel processes are requested.

## Delinquent Filer Voluntary Compliance Program — DOL releases notice and FAQ

In January 2013, the U.S. Department of Labor (DOL) released a notice and frequently asked questions (FAQ) about its Delinquent Filer Voluntary Compliance Program (DFVC), which enables plan administrators to file overdue annual reports on Form 5500 and pay a reduced penalty. According to the DOL, the notice and FAQ are intended to provide a comprehensive update and restatement of the DFVC Program that incorporates changes made to the program since 2002.

Group health and welfare benefit plans subject to federal ERISA law (that is, all plans other than those maintained by government agencies, by certain religious organizations, or outside the U.S.) are generally required to file an annual report on Form 5500 if the plan has 100 or more covered employees on the first day of the plan year. The due date for filing Form 5500 is the last day of the seventh month after the plan year ends (for example, by July 31 following the end of a calendar year plan), subject to a 2-1/2 month extension if Form 5558 is filed by the original due date for filing Form 5500.

The DOL has authority under federal ERISA law to assess a penalty of up to $1,100 per day against a plan administrator that fails or refuses to file a timely annual report. The DOL has adopted the following enforcement policy relating to the assessment of penalties for delinquent Forms 5500:

- If Form 5500 is filed late, the DOL may assess the plan administrator a penalty of $50 per day, with no limit.
- If Form 5500 is not filed at all, the DOL may assess the plan administrator a penalty of $300 per day, up to $30,000 per year, until the filing takes place.

These penalties are measured from the original due date for filing Form 5500, without regard to any extension of time for filing. The DOL has the discretion to waive all or part of the penalty if the plan administrator can show that there was reasonable cause for failure to file a complete and timely annual report, or there is reasonable cause that the penalty (as calculated) should not be assessed. Note that if the plan administrator takes advantage of the DFVC Program, then it waives the right to the "reasonable cause" exception from the DOL's assessment of penalties for a delinquent filing of Form 5500.

Under the DFVC Program, the DOL penalty is reduced to $10 per day for each day that Form 5500 is filed late (measured from the original due date, without regard to any extension of time for filing), not to exceed $2,000. If more than one Form 5500 is being filed late under the DFVC Program, the maximum penalty amount is $2,000 for each Form 5500, not to exceed $4,000 per plan. The penalty cap applies to all filings that are being made at the same time. For example, the plan administrator would pay a penalty of $4,000 under the DFVC Program if it files delinquent Forms 5500 for plan years 2006, 2007, and 2008, provided that all of the delinquent Forms 5500 relate to the same plan and are being filed at the same time.

The penalty under the DFVC Program must be paid by the plan administrator from its own assets, and not from the assets of the group health and welfare benefit plan. For example, if the plan is funded through a trust, the penalty cannot be paid from the trust.

To take advantage of the DFVC Program, the plan administrator must follow two steps.

1. File a complete Form 5500, including attachments (such as Schedule A for each insurance policy), for each delinquent filing that is being made under the DFVC Program. Be sure to check the box labeled "DFVC program" located on line D in Part I on Form 5500. The filing must be made via the EFAST2 electronic filing system; paper filings are not accepted. For more information about EFAST2, refer to our February 2010 and March 2010 Legislative Updates.
2. Use the online calculator to compute the correct penalty amount http://www.askebsa.dol.gov/dfvcepay/calculator. The plan administrator has the choice of paying this penalty amount electronically (by following the instructions on the website) or by mailing a check, payable to "Department of Labor," to DFVC Program, P.O. Box 71361, Philadelphia, PA 19176-1361. If the penalty is paid by check, the check must be accompanied by a paper copy of the electronically completed and filed Forms 5500 (without any schedules) that are included in the DFVC Program filing. Because the DFVC Program does not have a physical address, the check and paper copies of the delinquent Form 5500 cannot be submitted using a private delivery service.

Important: Filers submitting delinquent Forms 5500 electronically under the DFVC Program must include information for all filings in the same online transaction in order for the penalty cap to apply. Also, all paper submissions to the DFVC Program must be included in the same envelope or package (along with the penalty check) to ensure that those filings count toward the per-plan capped penalty amount. Otherwise, each separate filing of delinquent Forms 5500 under the DFVC Program is subject to a separate penalty cap.

The DFVC Program applies to every delinquent Form 5500 with a plan year beginning on or after January 1, 1988; late filings prior to that date are not subject to penalty. The EFAST2 electronic filing system includes electronic versions of Form 5500 for only the past three years. If a delinquent Form 5500 is being filed under the DFVC Program for one of the past three years, filers should use the correct year's version of Form 5500. If the delinquent filing relates to a plan year that is more than three years in the past, filers should use the current year's version of Form 5500, and indicate the correct dates for the first day and last day of the plan year.

A plan is disqualified from the DFVC Program on the date that the plan administrator is notified in writing by the DOL of its failure to file a timely annual report. A DOL notice of intent to assess a penalty will always disqualify a plan from the DFVC Program. However, an IRS late-filer letter will not disqualify the plan from participating in the program.

The DFVC Program is sponsored by the DOL, which does not have jurisdiction over the Internal Revenue Service (IRS). Participation in the DFVC Program does not protect a plan administrator from penalties that may be assessed by the IRS. However, the IRS has indicated that it expects to issue separate guidance that will provide relief from filing penalties under the Internal Revenue Code for a delinquent Form 5500 relating to a group health and welfare benefit plan, if the conditions of the DFVC Program have been satisfied.

Please contact your Wells Fargo Insurance representative if there are any questions about the DFVC Program, or if there is concern about the possibility of a delinquent Form 5500.

## HHS issues final HIPAA privacy and security regulations

On January 17, 2013, the Department of Health and Human Services (HHS) released its much-anticipated final Omnibus Rule, which modifies several parts of the privacy, security, and enforcement rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA). The Omnibus Rule is effective March 26, 2013, but the compliance date for most aspects of the final rule is September 23, 2013.

Although the Omnibus Rule modifies all current sets of HIPAA regulations and adds to them, HIPAA's coverage of employee health benefits information has not been materially expanded. Employers have substantially the same compliance obligations and plan participants have substantially the same rights with respect to their protected health information (PHI). However, there are some significant changes in the new regulations, which are summarized below.

### New liability for business associates

Historically, business associates (BAs) were expected to comply with the terms of their business associate agreements (BAAs), but were not subject directly to HIPAA or any of the accompanying regulations. The Omnibus Rule adopts proposed modifications to HIPAA that make BAs directly liable under certain provisions of the HIPAA privacy and security rules and possibly subject to civil monetary penalties for HIPAA violations.

BAs are *directly liable* under the HIPAA for:

- Uses and disclosures of PHI not permitted under HIPAA
- A failure to provide breach notification to the covered entity
- A failure to provide access to a copy of electronic PHI to the covered entity, the individual, or the individual's designee (as specified in the business associate agreement)
- A failure to disclose PHI to the Secretary of Health and Human Services to investigate or determine the BA's compliance with the HIPAA Rules
- A failure to provide an accounting of disclosures
- A failure to comply with the HIPAA Security Rule

The Omnibus Rule clarifies that a BA is a person who performs functions or activities on behalf of, or certain services for, a covered entity or another BA that involve the use or disclosure of protected health information. There is an exception for a "conduit" of PHI, i.e., an entity that provides only courier or transmission services, whether in digital or hard form. The Omnibus Rule establishes that a person becomes a BA by definition, not by the act of contracting with a covered entity or otherwise. Therefore, direct liability for the BA for impermissible uses and disclosures and other provisions attaches immediately when a person creates, receives, maintains, or transmits PHI on behalf of a covered entity or BA and otherwise meets the BA definition.

It is critical that BAAs be updated to reflect new requirements and to allocate certain liabilities and responsibilities. A qualifying BAA will be deemed compliant until the earlier of the date that the agreement is renewed or modified on or after September 23, 2013, or September 22, 2014. The transition rule applies only to the language in the agreements; the parties must operate as required under the HIPAA rules in accordance with the applicable compliance dates.

Patient safety organizations, health information organizations, and subcontractors of business associates will be considered business associates and must comply with HIPAA as described above. Subcontractors are entities that perform functions for, or provide services to, a business associate, other than in the capacity as a member of the business associate's workforce. BAAs between business associates and their subcontractors must comply with the same standards as BAAs between business associates and covered entities.

## Changes to notice of privacy practices

The Omnibus Rule requires several updates to the privacy notice required under the HIPAA Privacy Rule. While the 2013 amendments do not require the privacy notice to include all situations requiring authorization, it must contain a statement indicating that most uses and disclosures of psychotherapy notes, marketing disclosures, and sale of PHI do require prior authorization, as well as the right of the individual to be notified in case of a breach of unsecured PHI. Covered entities must distribute a new privacy notice to individuals because the changes to the notice of privacy practices are deemed to be material.

## Revised definition of breach

The Omnibus Rule revised the definition of "breach" so that any impermissible use or disclosure of protected health information is presumed to be a breach unless the responsible covered entity or business associate can demonstrate that there is a low probability that the PHI has been compromised.

The Omnibus Rule retains many requirements from the interim final breach notification rule. However, it removes the "risk of harm" standard in exchange for a more objective standard for determining whether a breach has occurred. The 2013 amendments provide that an impermissible use or disclosure of PHI is presumed to be a breach, unless it can be demonstrated that there is a low probability that PHI has been compromised based upon a four-part risk assessment that considers:

- The nature and extent of the PHI involved
- The unauthorized person who used the PHI or to whom the disclosure was made
- Whether the PHI was actually acquired or viewed
- The extent to which the risk to the PHI has been mitigated

If no exception applies and, after reviewing all of these factors, the covered entity cannot demonstrate that there is a low probability of compromise to the PHI, notification is required. The time period for notification begins when the incident is known to have occurred, not when it has been determined to be a breach. However, a covered entity is expected to make notifications after a reasonable time to investigate the circumstances surrounding the breach in order to collect and develop the information required to be included in the notice to the affected individuals.

Written notification by first class mail is the general, default rule. However, individuals who agree to receive notice by email may be notified by email. If the breach involves more than 500 persons, HHS must be notified in accordance with instructions posted on its website.

## Marketing, sales, and fundraising involving PHI

Covered entities are now obligated to obtain separate written authorization from individuals before using PHI for marketing if a third party whose products or services are marketed provides remuneration to the covered entity. Exceptions include any communication that is made:

- To provide refill reminders or information regarding a drug that is currently being prescribed, as long as any financial remuneration received by the covered entity is "reasonably related" to the cost related to the marketing
- Regarding the product or service of a third party for certain treatment or operations purposes, except where financial remuneration is involved

The sale of any PHI is prohibited unless the covered entity or business associate first obtains an authorization from the individual for the disclosure. The authorization must state that the disclosure will result in remuneration. The sale of PHI is defined broadly to mean any disclosure where the covered entity or business associate receives, directly or indirectly, any remuneration in exchange for the PHI and is not limited to financial payments as in the case of marketing provisions. Exceptions include disclosures for public health, treatment and payment purposes, and sale and merger transactions.

Covered entities and business associates may continue to use PHI for fundraising activities without the individual's authorization, including the individual's health insurance status, certain treatment and outcome information, and other demographic data. Covered entities may decide which opt-out methods to provide to individuals, as long as the chosen methods do not impose an undue burden or more than a nominal cost for the individuals.

## Rights to PHI

Consistent with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Omnibus Rule expands the rights of patients to receive electronic copies of their PHI and restrict disclosures of PHI to health plans concerning treatment for which the patient paid out of pocket in full. The covered entity may charge an individual a reasonable fee for providing copies of the PHI, subject to certain labor and supply costs.

The Omnibus Rule limits the period during which a covered entity must comply with HIPAA regarding a decedent's PHI to 50 years following the individual's date of death. In addition, covered entities may disclose the PHI of deceased individuals to family members and non-family members who were involved in the care or payment for healthcare of the decedent prior to death. However, the disclosure must be limited to PHI relevant to such care or payment and cannot be inconsistent with any prior expressed preference of the deceased individual.

## Prohibition on use of genetic information for underwriting

The Genetic Information Nondiscrimination Act (GINA) prohibits discrimination on the basis of an individual's genetic information. The Omnibus Rule prohibits health plans from using genetic information for underwriting purposes, with the exception of the underwriting of long-term care policies.

In addition, the Omnibus Rule requires a change to the privacy notice for health plans. A health plan that performs underwriting must include in its privacy notice a statement that it is prohibited from using or disclosing genetic information for underwriting purposes.

## Expanded enforcement

The Omnibus Rule implements the changes the HITECH Act made to the enforcement provisions of the HIPAA rules, including penalty amounts, which now also apply to BAs. Civil monetary penalty amounts and annual limits on penalties for identical violations will be imposed depending on the culpability and knowledge of the covered entity or BA.

- **"Did not know" penalty** — an amount not less than $100 or more than $50,000 per violation when it is established that the covered entity or BA did not know and, by exercising reasonable diligence, would not have known of a violation
- **"Reasonable cause" penalty** — an amount not less than $1,000 or more than $50,000 per violation when it is established the violation was due to reasonable cause and not willful neglect
- **"Willful neglect-corrected" penalty** — an amount not less than $10,000 or more than $50,000 per violation when it is established the violation was due to willful neglect and was corrected in a timely manner
- **"Willful neglect-not corrected" penalty** — an amount not less than $50,000 for each violation when it is established the violation was due to willful neglect and was not corrected In a timely manner

Correction of the violation within 30 days can either ease or eliminate the imposition of civil monetary penalties, depending on the circumstances of the violation. A penalty for violations of the same requirement or prohibition under any of these categories may not exceed $1.5 million in a calendar year.

HHS will launch mandatory investigations or compliance reviews where a preliminary review of the facts indicates that the alleged violation occurred due to willful neglect. Willful neglect is defined as the "conscious, intentional failure or reckless indifference to the obligation to comply with the administrative simplification provision violated."

The new regulations are available in full at http://www.ofr.gov/OFRUpload/OFRData/2013-01073_PI.pdf.