WELLS FARGO INSURANCE

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Legislative update

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Additional accommodations to contraceptive mandate proposed

On February 6, 2013, the Department of Health and Human Services, Department of Labor, and Department of the Treasury (collectively, the "Departments") proposed amendments to the Affordable Care Act rules previously issued in 2011 that require non-grandfathered group health plans to provide coverage without cost sharing of certain preventive health services, including all Food and Drug Administration approved contraception for women.

The expansion of the definition of preventive care services to include contraception, which is effective for the first plan year beginning on or after August 1, 2012, has been highly controversial. In response, the Departments provided an exemption from the requirement for certain religious employers, and subsequently also provided a one-year enforcement safe harbor for certain non-profit religious organizations (such as hospitals and institutions of higher learning) that object to covering contraceptives and do not otherwise satisfy the religious employer exemption.

In this latest set of accommodations, the Departments have relaxed the definition of religious employer that qualifies for the religious employer exemption, by eliminating the requirements that employers be an organization for which the inculcation of religious values is its purpose and that primarily employ and serve persons who share its religious tenets. A "religious employer" then must be simply a nonprofit organization described in Internal Revenue Code (IRC) section 6033(a)(1) and 6033(a)(3)(A)(i) or (iii). These IRC sections refer to churches, their integrated auxiliaries, and conventions or associations of churches as well as the exclusively religious activities of any religious order. With this expansion of the definition, many religious entities that serve the needs of persons outside of the entities' own faith and employs individuals who do not necessarily share the entities' religious tenets will be able to meet the proposed revised definition of religious employer.

In addition, the Departments have now proposed additional relief for group health plans established or maintained by certain eligible organizations, and student health insurance coverage arranged by eligible organizations that are religious institutions of higher education. For purposes of this relief, an eligible organization is an organization that:

- Opposes providing coverage for some or all of the contraceptive services otherwise required under the ACA based on religious objections
- Is organized and operates as a nonprofit entity
- Holds itself to be a religious organization
- Self-certifies that it satisfies the above criteria

Note that the definition does not extend to for-profit secular employers.

The additional relief permits eligible organizations to avoid covering contraceptive care under their own group health plans where the insurer (for fully-insured plans) or third-party administrator (for self-funded plans) arranges for individual policies covering contraceptive care. For fully-insured plans, the insurer will be required to offer contraceptive coverage at no charge without cost sharing to plan participants and beneficiaries through individual health insurance policies, separate from the group policy through which all other coverage would be provided. For self-funded plans, the third-party administrator would be required to arrange with an insurer to offer contraceptive coverage at no charge without cost sharing to plan participants and beneficiaries through individual health insurance policies. The cost of this coverage would be funded by providing to the insurer an adjustment in the user fees that otherwise would be charged by federally-facilitated public health insurance exchanges in which the insurer (or an affiliate) participates in an amount that would offset a reasonable charge incurred by, and passed through to, the third-party administrator to offer this contraceptive coverage. The Departments believe that this relief would enable an eligible organization to have no role in contracting, arranging, paying, or referring this separately provided contraceptive coverage.

Note that employers have until April 8, 2013, to comment on these proposed rules, and some have already voiced their concern that this latest round of accommodations still does not go far enough to satisfy their religious concerns. Wells Fargo Insurance is closely monitoring this evolving issue and will provide information in future Legislative Updates as it becomes available.

HHS issues final health insurance market reform rules

In 2014, according to the Patient Protection and Affordable Care Act (ACA), health insurance issuers will be prohibited from denying coverage because of a pre-existing condition and from charging individuals and small employers higher premiums based on health status or gender. In addition, health insurance issuers will no longer be able to segment enrollees into separate rating pools that result in charging high-risk individuals more than low-risk individuals. On February 27, 2013, the Department of Health and Human Services (HHS) published final rules on these health insurance market reforms (final rule). The final market reform rules specifically provide that health insurance issuers may vary the insurance premium for coverage in the individual and small group markets only based on family size, geographic rating region, age within a ratio of 3:1, and tobacco use within a ratio of 1.5:1. The final rule further requires insurance issuers to offer coverage to and accept every employer or individual who applies for coverage in the group (large and small) and individual market, to renew or continue in force coverage in the group (large and small) and individual market, and codifies the requirement that issuers maintain a single risk pool for the individual market and a single risk pool for the small group market unless a state decides to merge

those markets. Specific developments in these areas are discussed below. Note that states have some flexibility in implementing these market reforms.

Family size. The final rule requires issuers to develop premiums for family coverage by totaling the rate of each covered family member. The rates of no more than the three oldest family members under age 21 would be taken into account in computing the family premium. There would be no cap on the number of family members age 21 and older whose per-member rates would be added into the family premium. Also, rating based on specified family tiers, and other family rating practices that fail to apply the age and tobacco use factors proportionately to individual family members are impermissible.

Geographic location. Rating areas are determined by states subject to approval by HHS. Under the final rule rating areas are presumed adequate if there is one rating area for the entire state, there are no more than seven rating areas based on counties, all ZIP codes in the area share the same first three digits, or the area is based on metropolitan statistical areas or non-metropolitan statistical areas. States may also use other actuarially justified geographic divisions, or a number of rating areas greater than seven, with approval from HHS.

Age. Age rating by a health insurance issuer for non-grandfathered health insurance coverage in the individual or small group market may not vary rates by more than 3:1 ratio for adults under the ACA. HHS has defined adults as individuals age 21 and older for purposes of this rule, including those who may be eligible for Medicare based on age. For individuals under age 21, HHS proposed that rates must be actuarially justified based on a standard population determined at the time of policy issuance and renewal.

Tobacco use. Any tobacco rating under the ACA may not vary rates by more than a ratio of 1.5:1. The final rule would require a health insurance issuer in the small group market to offer a tobacco user the opportunity to avoid paying the full amount of the tobacco rating factor if he or she participates in a health contingent tobacco cessation wellness program. If an enrollee failed to disclose tobacco use, an issuer may not rescind the coverage on this basis. The final rule provides that tobacco use is not a material fact for which an issuer may rescind coverage; they must instead pursue the remedy of recouping the tobacco premium surcharge that should have been paid since the beginning of the plan or policy year.

Guaranteed availability of coverage. Guaranteed availability rules require a health insurance issuer in the individual or group market (large or small) to offer any individual or employer in the state coverage under all of the issuer's products that are approved for sale in that market and to accept any individual or employer that applies.

This requirement raised adverse selection concerns with respect to the small group market. There is no exception to guaranteed availability based on a failure to meet contribution or participation requirements. However, an issuer can limit enrollment to open and special enrollment periods. HHS has chosen to define "open enrollment periods" in the final rule to include an annual enrollment period, for a small employer that fails to meet contribution or minimum participation requirements as the period beginning November 15 and extending through December 15 of each year. Otherwise, the group market will have "continuous" open enrollment. HHS found that this approach addresses concerns about adverse selection. HHS did not extend this rule to the large group market, reasoning that large employers generally do not present the same adverse selection risk as small employers.

This development is welcomed by small employers who have historically battled low employee participation in their group health plans or have struggled to meet the carrier contribution requirements, resulting in the cancellation of the small employer policy. Under the new rules, the small employer who has lost its small group medical plan for failure to meet carrier participation or contribution requirements will now be allowed to enroll in the small group market (including the Small Business Health Options Program, or SHOP) during the annual enrollment period of November 15 through December 15.

Guaranteed renewability of coverage. Guaranteed renewability provisions, subject to some exceptions, require insurance issuers in the group or individual market to renew or continue in force the coverage at the option of the plan sponsor or individual. Exceptions to this rule include nonpayment of premiums; fraud; violation of minimum employer participation or contribution rules, as permitted under applicable state law; termination of a particular type of product or all coverage in a market; enrollees' movement outside the service area of a network plan; and, for coverage provided through a bona fide association, an employer's loss of association membership. How contribution or participation requirements will be applied for renewing groups as opposed to new groups that cannot be subject to such requirements is yet to be resolved.

These final rules are available in full at http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf. We will continue to monitor market reform developments. Contact your Wells Fargo Insurance representative for more information.

Final regulations on essential health benefits and minimum value calculator

On February 20, 2013, the Department of Health and Human Services (HHS) issued a final rule establishing the benefits that must be covered by individual and small group plans beginning in 2014. The rule applies to plans sold within public exchanges as well as to plans sold outside of the exchanges. Under the rule, essential health benefits (EHB) must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

EHB must be equal in scope to benefits offered by a "typical employer plan." To meet this requirement in every state, the final rule defines EHB based on a state-specific benchmark plan. States can select a benchmark plan from among several options:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market
- Any of the largest three state employee health benefit plans options by enrollment
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment
- The HMO plan with the largest insured commercial non-Medicaid enrollment in the state

Twenty-seven states and the District of Columbia have picked benchmark plans, and 23 states have not. In the remaining states that do not make a selection, HHS will select the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default base-benchmark plan. All plans subject to EHB must offer benefits substantially equal to the benefits offered by the benchmark plan.

Minimum value calculator

In conjunction with the these regulations, HHS and the Internal Revenue Service (IRS) released a minimum value calculator for large employers (those with 50 or more employees) to determine whether the percentage of the total allowed costs of benefits provided under a group health plan meets the minimum value requirement (where plan's actuarial value is at least 60%), which is one of the requirements under the Employer Shared Responsibility requirements. If the employer's plan meets the minimum value test and is affordable (that is, single coverage does not cost an employee more than 9.5% of income) a full-time employee cannot obtain subsidized exchange coverage and therefore cannot trigger employer penalties.

The calculator was released "for informal external testing" and included an explanation of the calculator methodology, which specifies that the calculator is based on a standard population and data reflecting typical self-insured employee plans.

As an alternative to the calculator, an employer may engage an actuary who is a member of the American Academy of Actuaries to determine whether the plan meets the 60% minimum value threshold. In addition, the IRS stated in previous guidance that it would release checklists that employers may use as a safe harbor for determining whether a plan meets the minimum value test, but those checklists have not yet been released.

The calculator can be found on the Centers for Medicare and Medicaid Services website under Plan Management at http://cciio.cms.gov/resources/regulations/.

Regulators release more ACA FAQs

On February 20, 2013, the Department of Labor, Treasury Department, and Department of Health and Human Services (collectively, "the Departments") issued a 12th set of frequently asked questions (FAQs) on the Patient Protection and Affordable Care Act (ACA).

The FAQs confirm that only insurance plans and issuers in the insured small group market (employers with 50 or fewer employees) are required to comply with the deductible limit described in the ACA, which is $2,000 for single coverage and $4,000 for two or more covered members. Large employers (those with 50 or more employees) and self-funded medical plans, regardless of size, are exempt from complying with the deductible limits. However, small group coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit.

The FAQs clarified that small non-grandfathered group health plans will be required to comply with the annual limitation on out-of-pocket maximums applicable to high deductible health plans (for 2013, $6,250 for single coverage, or $12,500 for two or more covered members), however, further guidance will determine its applicability to non-grandfathered large group health plans.

The FAQs also address specific preventive coverage services. The ACA requires non-grandfathered group health plans to provide benefits for preventive services with a rating of "A" or "B" given by the United States Preventive Services Task Force, for immunizations, and certain other services without any cost-sharing requirement when performed in-network. An FAQ clarifies that if a plan does not have an in-network provider who can perform the particular service, then the plan must cover the service when performed by an out-of-network provider without cost-sharing.

Last, the FAQ addressed the requirement to provide over-the-counter (OTC) items without cost sharing when prescribed by a health care provider and the scope of several other preventive care services such as polyp removal during colonoscopy, breast

cancer susceptibility testing, and well women preventive services (HIV testing, domestic violence screening, and OTC contraceptive methods).

To view the complete set of FAQs and for additional details please visit http://www.dol.gov/ebsa/healthreform/.

Small employers participating in a MEWA must begin filing Form 5500 annually

On March 1, 2013, the U.S. Department of Labor (DOL) issued final regulations which eliminate the "small employer" exemption from the annual Form 5500 filing requirement for group health plans that obtain any coverage through a multiple employer welfare arrangement (MEWA), beginning with the 2013 Form 5500 (which generally applies to plan years ending in 2013).

Under the "small employer" exemption, employers with fewer than 100 employees (not counting spouses and children) participating in a group health and welfare benefit plan on the first day of the plan year (for example, January 1 for a calendar-year plan) are exempt from filing Form 5500 with the DOL for that plan year. Under the new regulations, employers with fewer than 100 employees participating in the plan on the first day of the plan year must file Form 5500 for that year if any coverage under the plan is provided through a MEWA.

Employers subject to the above rules are generally required to file the full version of Form 5500, along with Schedule A for each insurance coverage offered under the plan (including through the MEWA). The regulations prohibit the employer from using the short version of Form 5500 (Form 5500-SF) if any coverage is provided through a MEWA. Form 5500 is generally due on the last day of the seventh month after the plan year ends (for example, July 31, 2014, for a plan year ending December 31, 2013); the deadline may be extended for 2-1/2 months by filing Form 5558 with the DOL by the original due date.

Please contact your local Wells Fargo Insurance representative if you have any questions.

New Form M-1 filing requirements for MEWAs

On March 1, 2013, the U.S. Department of Labor (DOL) released final regulations that substantially change the Form M-1 filing requirements that apply to Multiple Employer Welfare Arrangements (MEWAs). The new filing requirements generally apply to all filing events (described below) beginning on or after July 1, 2013, except that in the case of the 2012 Form M-1 that was due on March 1, 2013, the filing deadline has been postponed until May 1, 2013, with an extension until July 1, 2013, available.

A MEWA is an employee welfare benefit plan or other arrangement that is established or maintained for the purpose of offering or providing any health and welfare benefit to the employees of two or more separate employers. Under the rules governing MEWAs, two or more trades or business (whether or not incorporated) are deemed to be a single employer if they are members of the same controlled group or under common control. For example, if two companies are 100% owned by the same individual, a medical plan that covers employees of the two companies would not be a MEWA because the two companies are treated as a single employer for MEWA purposes; however, if two employers are otherwise unrelated, a single medical plan that covers employees of the two employers would be a MEWA.

Unless an exception applies, a MEWA is required to file Form M-1 with the DOL as follows:

- For each calendar year. The filing due date is the following March 1, except that the March 1, 2013, deadline has been postponed until May 1, 2013. This calendar-year filing is waived if Form M-1 was required to be filed for any other purpose (see below) between October 1 and December 31 of the calendar year.
- Within 30 days of knowingly operating in any additional state that was not indicated on a previous Form M-1 filing. For example, if a MEWA is operating in Arizona, and one of the employers participating in the MEWA extends MEWA coverage to employees in its new California operations, then the MEWA must file Form M-1 within 30 days of knowing that it is operating in California. Note: if a MEWA does not offer or provide medical benefits within a state during the calendar year immediately following the year in which a filing is made by the MEWA, the filing will be considered to have lapsed with respect to that state.
- At least 30 days prior to operating in any state. This requirement does not apply to MEWAs that were already in operation in the state before July 1, 2013, as shown in the previous Form M-1 filing. For example, if a MEWA is preparing to operate for the first time in Ohio on August 31, 2013, then it must file Form M-1 with the DOL at least 30 days prior to that date to report its operations in Ohio. Note: if a MEWA does not offer or provide medical benefits within a state during the calendar year immediately following the year in which a filing is made by the MEWA, the filing will be considered to have lapsed with respect to that state.
- Within 30 days of the MEWA including employees of an additional employer after merger with another MEWA.
- Within 30 days of the date the number of employees receiving medical coverage under the MEWA is at least 50% greater than the number of employees receiving medical coverage on the last day of the previous calendar year.
- Within 30 days of experiencing a "material change" as defined in the Form M-1 instructions.

If multiple filings are required under the above rules, then a single filing will satisfy these requirements as long as the filing is timely for each required filing. A 60-day extension of the filing due date may be obtained by complying with the procedure described in the Form M-1 instructions. If the filing deadline is a Saturday, Sunday, or a federal holiday, the form must be filed no later than the next business day.

A MEWA is exempt from filing Form M-1 if any of the following requirements is met:

- The MEWA is a group health plan not subject to ERISA, such as a governmental plan, church plan, or plan maintained solely for the purpose of comply with workers' compensation laws; or the MEWA provides coverage only through group health plans that are not covered by ERISA, such as governmental plans, church plans, or plans maintained solely for the purpose of complying with workers' compensation laws; or other arrangements not covered by ERISA, such as individual market coverage.
- The MEWA provides coverage that consists solely of excepted benefits that are not subject to ERISA Part 7, such as limited scope dental or vision benefits, benefits for long-term care, coverage only for accident or disability income insurance, coverage for on-site medical clinics, coverage only for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance.
- The MEWA is licensed or authorized to operate as a health insurance issuer in every state in which it offers or provides medical coverage to employees.

The final regulations also, for the first time, contain an exemption from the Form M-1 filing requirement for group health plans that are not MEWAs except when one of the following circumstances occurs:

- The entity provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25% at any time during the plan year, applying principles similar to the principles in Internal Revenue Code section 414(c). For example, if a company establishes a joint venture in which it has a 25% interest, and it transfers some of its employees to work on the joint venture, then it may continue to cover those transferred employees under its group health plan without filing Form M-1.
- The entity provides coverage to the employees of two or more employers due to a change in control of businesses (such as a merger or acquisition) that is temporary in nature, but only if the change in control occurs for a purpose other than avoiding the Form M-1 filing requirement. "Temporary" means that the coverage does not extend beyond the end of the plan year following the plan year in which the change in control occurs. For example, if an employer has a group health plan with a calendar plan year, and it sells part of its business to a third party on December 31, 2013, then the employer can continue (as part of the change-in-control agreement) to provide coverage under its plan to former employees who went to work for the third-party buyer without filing Form M-1, as long as that coverage ends not later than December 31, 2014.
- The entity provides coverage to non-employee members of the board of directors, independent contractors, or other individuals who are not employees or former employees of the plan sponsor, provided that the number of such individuals does not exceed 1% of the total number of employees or former employees covered under the plan, determined as of the last day of the year to be reported (or determined as of the 60th day following the date the plan began operating in a manner that would otherwise require making a Form M-1 filing). Note: spouses and children are ignored for purposes of the 1% computation.

Please contact your local Wells Fargo Insurance representative if you have any questions about this issue.

Final FMLA regulations released

The U.S. Department of Labor (DOL) recently issued final regulations under the Family and Medical Leave Act (FMLA). The regulations went into effect on March 8, 2013, and adopt in final form the majority of the amendments to the FMLA introduced by the National Defense Authorization Act in 2010. The most significant developments are:

- **New definition of covered veteran.** A "covered veteran" is defined under the final regulations as a veteran discharged or released under conditions other than dishonorable five years prior to the date the employee's military caregiver leave begins.
- **New definition of a serious injury or illness for a covered veteran.** The final regulations introduce a flexible definition for serious injury or illness of a covered veteran that includes four alternatives, only one of which must be met.
- **Certification of a service member's serious injury or illness.** The final regulations provide for certification of both current service members and veterans, that provide that the certification for a service member's serious injury or illness may be obtained from any health care provider as defined in the FMLA regulations, not only those affiliated with the Department of Defense, Veterans Affairs Administration, or TRICARE networks (as was permitted under the 2009 regulations).
- **Amendments to the qualifying exigency leave:**
  - Qualifying exigency leave is extended to eligible employees who are family members of members of the Regular Armed Forces and adds the requirement for all armed forces members to be deployed to a foreign country in order to be on "covered active duty" under the FMLA.
  - The amount of time an employee may take for qualifying exigency leave related to the military member's rest and recuperation (R&R) leave is increased from five days to up to 15 days.

  - An additional qualifying exigency leave category is created for parental care leave to provide care necessitated by the covered active duty of the armed services member for the military member's parent who is incapable of self-care.

- **New calculation of leave for airline flight crews.** A unique method of calculation of leave for airline flight crew employees was created, and final regulations established that FMLA leave for intermittent or reduced schedule leave taken by airline flight crew employees must be accounted for using an increment no greater than one day.
- **New poster.** Employers subject to the FMLA must prominently display the revised FMLA poster in the workplace. The poster can be downloaded from the DOL website at www.dol.gov/whd/compliance/posters/fmlaen.pdf. The poster is available in both English and Spanish.