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Work Session III: Health Care Reform-Regulation Rollout for 2014

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HEALTH CARE REFORM: PREPARING FOR 2014 AND 2015

I. MUNICIPAL EMPLOYER ISSUES UNDER THE ACA

This Work Session will explore a select few of the challenging issues facing municipal employers who are preparing to comply with the new coverage rules that are applicable under the Patient Protection and Affordable Care Act, Public Law No. 111-148 (124 Stat. 119 (2010)), and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152, (124 Stat. 1029 (2010)), as amended by the Medicare and Medicaid Extenders Act of 2010, Public Law 111-309 (124 Stat. 3285 (2010)), the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Public Law 112-9 (125 Stat. 28 (2011)), the Department of Defense and Full-Year Continuing Appropriations Act, 2011, Public Law 112-10 (125 Stat. 38, (2011)), and the 3% Withholding Repeal and Job Creation Act, Public Law 112-56 (125 Stat. 711 (2011))(collectively, the Affordable Care Act ("ACA")). Municipal employers must, along with other employers across the United States, prepare to comply with many new requirements under the ACA's employer shared responsibility provisions. Given the complexity of this topic and the need to cover a number of issues in this session, we will focus our portion of the materials on only a few specific issues related to the implementation of the ACA that may be of particular concern to municipal employers.

A. Delay of Employer-Shared Responsibility Provisions Until 2015

The employer-shared responsibility rules under the ACA , more commonly referred to as "pay or play", were scheduled to go into effect on January 1, 2014. These provisions are implemented through Section 4980H of the Internal Revenue Code of 1986, as amended from time to time (the "Code"). On July 2, 2013, the Treasury Department announced the delay of two key components of pay or play: (1) the need to offer coverage in 2014 to full-time employees or pay substantial penalties and (2) health care information reporting requirements under Code sections 6055 and 6056.[1] While this means that the penalty taxes will not apply and, therefore, the need to offer coverage under the proposed rules of Code section 4980H will not apply until 2015, there is substantial value in continuing to plan for implementation, as is discussed in more detail below.

B. What is Not Delayed?

The delay announced by the Treasury Department does not affect many other additional requirements under the ACA. Municipal employers, as well as other

[1] Announcement posted in Treasury Notes by Mark J. Mazur, July 2, 2013, on U.S. Department of Treasury website.

employers, insurers, sponsors of self-insured plans, and certain other entities that provide health insurance coverage, must continue to comply with all health care reform requirements as they become effective. The following chart summarizes upcoming requirements under the ACA.

ACA Requirement	Effective Date
Patient-Centered Outcomes Research Institute (PCORI) Fee	**Due date – July 31, 2013** First year fee of $1 per covered life for the first plan or policy year ending on or after October 1, 2012 is due by July 31, 2013. The fee increases to $2 per covered life for policy or plan years ending after September 30, 2013.
Exchange Notice Requirement – employers must provide a notice to employees regarding the availability of health insurance exchanges and premium assistance tax credits. ***Note:*** The Department of Labor's model notice for employers that offer a health plan to employees requires the employer to disclose whether the plan provides minimum value and is intended to be affordable. Accordingly, despite the delay in reporting requirements under Code sections 6055 and 6056, it appears that employers will still need to make a determination as to whether their health insurance coverage provides minimum value and is intended to be affordable in order to satisfy the exchange notice requirement. However, employers should watch for additional changes from the Treasury Department regarding the exchange notice requirements because this would be consistent with the delay in the pay or play penalties.	**Due Date – Before October 1, 2013**. Must be provided to current employees by October 1, 2013; and to new employees hired after October 1, 2013 within 14 days of the employee's start date.
Summary of Benefits and Coverage ("SBC") – employer must provide SBC at the beginning of every open enrollment period and upon request	**Due date – 2013 open enrollment**

Open Enrollment for Health Insurance Exchanges – begins for individuals and small employers	**Starts – October 1, 2013**
Health Insurance Exchange Coverage – begins for individuals and small employers; premium tax assistance credits available to qualifying individuals	**Starts – January 1, 2014 for employees who seek coverage under the Exchange**
Group health plan and insurer mandates (all plans): • elimination of annual limits on essential health benefits (restricted limits previously applied) • elimination of waiting periods in excess of 90 days • elimination of pre-existing condition exclusions (previously prohibited under age 19)	**Starts – Plan years beginning on or after January 1, 2014** See the discussion below regarding limitations on health reimbursement accounts.
Group health plan and insurer mandates (non-grandfathered plans): • comprehensive health insurance coverage (*i.e.,* essential health benefits) (see discussion below regarding health reimbursement accounts) • cost sharing limitations • coverage for certain costs associated with approved clinical trials • guaranteed availability and renewability of coverage • prohibition of discriminatory health insurance premium rates • prohibition of discrimination based on health status • prohibition on discrimination against health care providers	**Starts – Plan years beginning on or after January 1, 2014**
Shared Responsibility for Individuals – requires individuals to obtain minimum essential health coverage or pay a personal	**Starts – January 1, 2014**

income tax penalty (*i.e.*, the greater of $95/adult or 1% of taxable income in 2014)	
Reporting of Health Insurance Coverage	**Delayed to 2016 (for health plan coverage provided on or after January 1, 2015)**
Shared Responsibility for Employers	**Delayed to 2015** Depending on selected measurement period, employer may want to start collecting data in fall 2013; penalties delayed until 2015 based on 2014 data[2]
Annual Fee on Health Insurance Providers	**Beginning in 2014** This fee is not a direct employer issue, but could affect the cost of insurance coverage

Special Issues with HRAs. Municipal employers who offer health reimbursement account ("HRA") plans should be careful to review whether the annual limit restrictions adversely impact their HRA plan. HRAs are generally account-based benefits that provide a maximum dollar amount for reimbursements for a particular coverage period. This means that HRAs by their nature impose annual and lifetime limits on the dollar value of their benefits.

Whether an HRA will be considered permissible under ACA's annual dollar-limit rules will depend on whether the HRA is an "integrated" HRA or a "stand-alone" HRA. The preamble to regulations jointly-issued by the DOL, IRS and HHS indicates that integrated HRAs do not violate the annual dollar-limit rules:

> "When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711 [the prohibition of annual and lifetime dollar limits], the fact that benefits under the HRA by

[2] In addition to the administrative delay by Treasury, employers should watch for the outcome in a pending case in which Liberty University brought a challenge that the employer mandate under Pay or Play was beyond Congress' powers under the Commerce Clause of the Constitution, which is proceeding in the Fourth Circuit (*Liberty University v. Lew*, Circuit docket 10-2347).

itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements."[3]

The agencies subsequently confirmed this position in the introduction to FAQs pertaining to HRAs they issued on January 24, 2013.[4] The introduction also states that an HRA is not considered integrated with primary health coverage offered by the employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by employer-provided primary group health plan coverage that meets the requirements of PHS Act section 2711. This FAQ makes it clear that the employee receiving the HRA must actually be enrolled in that coverage.

An HRA is not an integrated HRA, however, if it is paired with individual market coverage or with an employer plan that provides coverage through individual policies.[5] This means that employers and plan sponsors will not be able to offer a stand-alone HRA for employees to purchase individual coverage.

Violating these rules could expose an employer to excise taxes under the Internal Revenue Code (equal to $100 per day for the noncompliance period for each individual to whom the failure under the ACA relates).[6] Therefore, "standalone" HRAs will generally no longer be permissible on and after January 1, 2014, unless otherwise exempted from the annual limit requirements under the ACA (*e.g.*, retiree-only HRA plans). The guidance provides limited transitional relief that allows unused amounts credited to HRAs prior to January 1, 2013, to be used after December 31, 2013 for reimbursing medical expenses under the terms of the HRA.[7] Amounts credited during 2013 under the terms of an HRA in effect on January 1, 2013, may also be used after December 31, 2013.[8] New contributions to the HRA after December 31, 2013, however, would have to cease to avoid violating the ACA.

It is possible that further federal agency guidance on these HRA issues will be issued before the end of 2013.

C. Controlled Group Issues for Governmental Employers

[3] 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010)

[4] *See* DOL FAQs about Affordable Care Act Implementation, Part XI, Introduction to FAQs #2-4 (January 24, 2013)

[5] DOL FAQs about Affordable Care Act Implementation, Part XI, FAQ #2.

[6] Code § 4980D

[7] DOL FAQs about Affordable Care Act Implementation, Part XI, FAQ #4.

[8] *Id.*

1. General Calculation Rules for Determining Large Employer Status

Under Code Section 4980H, "large" employers must offer adequate health coverage or may have to pay substantial penalties.[9] In general, whether a governmental employer, such as a municipality, will be considered a "large" employer for purposes of the ACA depends on whether that entity employed an average of 50 or more full-time equivalent employees in the prior year.[10] The IRS has issued guidance in the form of proposed Pension Excise Tax Regulations under Code section 4980H.[11] In determining whether or not an employer will be considered a "large" employer, the employer first determines the number of "full-time" employees of the organization. A full-time employee means an employee who is employed an average of at least 30 hours of service per week for a calendar month.[12] For this purpose, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week, so long as this method is applied on a reasonable and consistent basis.[13]

The new proposed regulations provide the manner in which the calculation is performed. The employer totals the number of full-time employees (including any seasonal workers) for each calendar month in the preceding calendar year and the total number of full-time equivalent employees (including seasonal workers) for each calendar month in the preceding calendar year, and divides that total by 12. The result is rounded to the next lowest number.[14]

Solely for determining large employer status, part-time employees also must be counted to determine the health care entity's total "full-time equivalent" employees. In performing this test, the new proposed regulations define "full-time equivalent employee" as a combination of employees, each of whom individually is not treated as full-time because he or she is not employed on average at least 30 hours of service per week, but who, in combination, are counted as the equivalent of a full-time employee solely for purposes of whether an employer is a "large employer".[15] The number of full-time equivalent employees for each calendar month for the preceding calendar year is determined by calculating the aggregate number of hours of service for employees who were not full-time (but not more than 120 hours of service for any employee) and dividing that number by 120. For this purpose fractions for each month are taken

[9] Code § 4980H(a),(b)

[10] Code § 4980H(c)(2)(A)

[11] Prop. Treas. Reg. § 54.4980H-1 though - 6 (78 Fed. Reg. 218 (Jan. 2, 2013))

[12] Prop. Treas. Reg. § 54.4980H-1(a)(18)

[13] *Id.*

[14] Prop. Treas. Reg. § 54.4980H-2(b)(1)

[15] Prop. Treas. Reg. § 54.4980H-1(a)(19)

into account.[16] The new regulations also include a number of examples of how these calculations are performed.[17]

2. Controlled Group Issues—New Reasons to Reexamine Status

(a) Controlled Group Rules Can Subject Small Entities to the ACA

"Employer" under the employer-shared responsibility rules means the common-law employer of an employee.[18] Thus, the first step for an employer is to determine the number of individuals for which it is the "employer" as defined under the ACA. Then the employer will calculate the number of those individuals who are full-time and the number of full-time equivalent employees as described above, and determine if any of the limited exceptions apply (generally dealing with seasonal workers).[19] If that total number is 50 or more then the employer is a "large employer." Under these rules, whether or not the employer is the common-law employer of the various employees is a facts and circumstances analysis. If the number is less than 50, the employer needs to review whether, based on the controlled group rules described below, it may nevertheless be considered a "large employer" for ACA purposes.

Apart from the controlled group test, there also may be complex situations related to determining the status of individuals as common law employees of various related entities. In some cases, related employers (particularly government entities) may have chosen to use combined payroll processing and reporting for cost-savings and convenience. This practice may need to be examined if smaller entities are in fact independent employers and would not individually meet the 50 employee test. As will be explained in more detail below, the status of an entity as the "employer" will be important from the standpoint of determining liability under the penalty provisions.

Solely for purposes of determining whether or not any particular entity is a "large employer," Code section 4980H(c)(2)(C) provides that any entities which are treated as a single employer for purposes of subsections (b),(c)(m) or (o) of Section 414 of the Code will be treated as a single employer for purposes of determining if an entity will be treated as a large employer.

These aggregation rules are the same rules that apply for purposes of meeting specified tax-qualified retirement plan requirements, including eligibility, vesting,

[16] Prop. Treas. Reg. § 54.4980H-2(c)(2)

[17] Prop. Treas. Reg.§ 54.4980H-2(d)

[18] Prop. Treas. Reg. § 54.4980H-1(a)(14)

[19] Prop. Treas. Reg. § 54.4980H-2(b)(2),(3)

coverage, nondiscrimination and benefit limits. Under Code section 414(b), members of the controlled group are limited to corporate entities and as determined based on the rules under Code section 1563(a) (without regard to 1563(a)(4) and (e)(3)(C)). Code section 414(c) provides for similar rules with respect to other business entities. The Internal Revenue Service ("IRS") has issued regulations that apply the same ownership principles to other non-corporate entities.[20] Generally, other than for Code section 415 purposes, parent-subsidiary relationships exist when one entity owns or controls at least 80% of one or more other entities.[21] For controlled group purposes, a brother-sister relationship exists if 5 or fewer "common owners" meet the 80% ownership test and a 50% identical ownership test.[22] Code section 414(m) applies similar rules of aggregation applicable for meeting the tax-qualified plan requirements to an affiliated service group. Similarly, for years beginning after December 31, 2008, for purposes of these rules, a tax-exempt organization must be treated as a single employer with any other tax-exempt organization if at least 80 percent of the directors or trustees of one of the organizations are also directors, trustees, agents or employees of the other organization, or may be removed and a new director or trustee appointed, by the other organization.[23] The guidance in the current regulations is essentially the same test as the one described in IRS Notice 89-23,[24] which applied to nondiscrimination testing for 403(b) plans, thus providing some guidance on controlled group application to governmental educational institutions.

Many employers are familiar with the application of the controlled group rules because these rules have applied previously for purposes of meeting the tax-qualified retirement plan rules. However, many of the requirements for which employees in a controlled group must be treated as if employed by a single employer either do not apply to governmental and church retirement plans or detailed guidance has not been issued.[25] These entities, therefore, may not be as familiar with the application of the controlled group rules. Applying these concepts to governmental entities now may have a significant impact if smaller organizations become subject to the ACA because of the application of the controlled group rules. Additionally, as described below, each organization must separately satisfy the coverage requirements or incur potentially significant penalties. Since the IRS has not yet issued guidance on determining controlled group status for governmental entities under the ACA, these entities will need to

[20] See Treas. Reg. §§1.414(c)-1 through 1.414(c)-5.

[21] Code § 1563(a)(1) and Treas. Reg. § 1.414(c)-2(b); Code § 415(h) and Treas. Reg. § 1.415(a)-1(f)(1)

[22] See Code § 1563(a)(2), as modified by Code § 1563(f)(5).

[23] Treas. Reg. §1.414(c)-5.

[24] 1989-1 CB 654 (since obsoleted by Rev. Rul. 2009-18, 2009-18 IRB

[25] See e.g. Code § 401(a)(5)(G); Code § 401(a)(26)(G); Treas. Reg. §1.414(c)-5(e)

use good faith efforts to interpret their controlled group situations.[26] Governmental entities can find some guidance in the previously issued IRS advance notice of proposed rulemaking on the definition of what is a government agency for retirement plans and on what is a government plan. [27]

(b) Compliance and Penalties Determined Separately for Each Controlled Group Member

As indicated above, if an entity is determined to be part of a controlled group, that entity will be a "large employer," and thus subject to all the requirements (and penalties) of the ACA, depending on the number of full-time employees and full-time equivalent employees in the controlled group. However, the determination of whether an employer that is a member of a controlled group is subject to a penalty (and the amount of any penalty) is made on a member-by-member basis.[28] In other words, the IRS will assess each controlled group member separately by taking into account each entity's offer of coverage (or lack thereof). Therefore, even if various entities are members of a controlled group, this will not enable those entities to treat all of the members of the controlled group as a "single employer" for purposes of assessing whether penalties might apply.

D. Coverage Issues—Concerns Related to Categories of Employees

1. Penalties Under the ACA May Be Triggered By Percentage of Full-Time Employees Offered Coverage

The "pay" or "play" requirement, or shared responsibility provisions, under the ACA refers to the new rules that covered employers must either offer qualified health coverage to substantially all their full-time employees and dependents, which would be considered "playing", or will be assessed penalties under the tax rules for failing to offer required health coverage, which would be "paying".

To avoid penalties under the ACA, every "large employer" must offer "minimum essential coverage"[29] to at least 95% of its full-time employees, as defined above, and their dependent children under age 26[30] to avoid a $2,000 per year penalty for every full-time employee (less 30) (the "A Penalty").[31] The penalty tax is

[26] Preamble to Prop. Treas .Reg. 54.4980H; see also Prop. Treas. Reg. § 54.4980H-2(b)(4)

[27] 76 Fed. Reg. 69172 (Nov. 8, 2011)

[28] See Prop. Treas. Reg. § 54.4980H-4(d),(e) and Prop. Treas. Reg. § 54.4980H-5(d)

[29] "Minimum essential coverage" is defined under Code section 5000A(f) and regulatory guidance issued under that Code section. Prop. Treas. Reg. § 54.4980H-1(a)(23)

[30] "Dependent" as defined in the proposed regulations includes children as defined under Code section 152(f)(1), but does not include a spouse. Prop. Treas. Reg. § 54.4980H-1(a)(11)

[31] Code § 4980H(a); Prop. Treas. Reg. § 54.4980H-4

triggered when one full-time employee of the employer receives subsidized health insurance from a state health insurance exchange.

If a large employer offers minimum essential health coverage to 95% of its full-time employees and their dependents (and thereby avoids the A Penalty), but the coverage it offers is either not "affordable"[32] or of "minimum value,"[33] as defined under the ACA, then the employer must pay $3,000 per year for each full-time employee who gets subsidized health insurance from a state health insurance exchange, as long as at least one employee receives coverage through the exchange (the "B Penalty").[34] The employer will never pay more under the B Penalty than it would have paid under the A Penalty.[35]

A simple example will illustrate the potential liability exposure involved.

EXAMPLE—A PENALTY

Employer has 500 full-time employees (as determined under the ACA rules)

Employer either does not offer coverage at all, or offers coverage to 450 employees and required dependents (only 90%, not 95%)

One full-time employee receives subsidized coverage through the exchange

Penalty is due to the IRS of $2000 X (500-30) = $940,000 penalty due to IRS

EXAMPLE—B PENALTY

Employer has 500 full-time employees (as determined under the ACA rules)

Employer offers minimum essential coverage to 480 employees and required dependents (96%)

Coverage for 30 employees is not "affordable" and all receive federal subsidy through the exchange

Penalty is due to the IRS of $3000 X 30 = $90,000 penalty due to IRS

There are examples of penalty calculations provided in the proposed regulations.[36]

For employers with a large workforce, these penalties represent a significant tax liability. If the employer is attempting to avoid the penalties (or at least the A Penalty), determining whether or not 95% of the full-time employees (as defined

[32] Prop. Treas. Reg. § 54.4980H-5(e)

[33] Prop. Treas. Reg. § 54.4980H-1(a)(24)

[34] Code § 4980H(b); Prop. Treas. Reg. § 54.4980H-5

[35] Code § 4980H(b)(2)

[36] Prop. Treas. Reg. § 54.4980H-4(e) and § 54.4980H-5(e)(2)(v)

by the ACA) will be eligible for the employer's health care program will be a critical task.

The regulations also provide that the reduction for 30 employees allowed in computing Penalty A will be allocated to members of a controlled group.[37]

2. Some Categories of Employees May Require Careful Consideration

As municipal employers assess whether they are offering minimum essential coverage to at least 95% of their full-time employees and dependents (as defined under the ACA), there may be particular categories of employees that could represent a significant percentage of the workforce that should be examined carefully to avoid inadvertently failing to offer to 95% of the ACA-covered workforce.

On-Call and Per Diem. A number of municipal employers may be responsible for operations that provide health care. Since the ACA rules for determining full-time are strictly looking at hours worked, not employee classifications, if individuals in classifications such as on-call and per diem work significant amounts of time during the year, they may fall into the full-time employee definition under the ACA. Under the employment policies and bargaining agreement terms for many health care employers, these groups may not be provided benefits. While, for example, the participation requirements for tax-qualified retirement plans provide more leeway in excluding individuals from participation,[38] under the ACA, there is only a 5% allowance for excluding employees who average 30 hours a week during a month—considered full-time under the ACA. If the employer uses a significant number of on-call and per diem workers who are excluded from coverage under health care plans, this may cause a problem in meeting the ACA requirements. This could be particularly problematic if the employer were to have to consider providing health coverage, since, for example, salary rates for per diem workers are often set higher in exchange for not providing benefits.

Part-Time, Temporary and Seasonal. A number of municipal employers may also employ a number of part-time, temporary and seasonal workers who are excluded from health care coverage by job classification. Since the ACA rules for determining full-time are strictly looking at hours worked, not employee classifications, if individuals in classifications such as part-time and temporary work significant amounts of time during the year, they may fall into the full-time employee definition under the ACA. There are complex rules under the proposed regulations dealing with variable hour employees and seasonal workers.[39]

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[37] Prop. Treas. Reg. §§ 54.4980H-4(d),(e)

[38] See e.g. Code § 410(b) where the employer may cover 70% of its non-highly compensated workforce.

[39] See Prop. Treas. Reg. § § 54.4980H-1, 54.4980H-2, and 54.4980H-3

Municipal employers will need to review these rules carefully in light of their particular situations.

Employees of Contractors and Independent Contractors. Another area of concern for all employers is the determination of whether or not the employees of certain contractors or individuals under direct independent contractor arrangements providing services to the employer may be considered the "common law" employees of the employer, rather than as employees of the contractor or self-employed, for ACA purposes. The definition of "employee" under the proposed regulations is an individual who is an employee "under the common law standard."[40] It is interesting to note, however, that the definition excludes leased employees.[41] Leased employees, as defined under Code section 414(n) (2) are individuals who are not employees of the recipient of the services, provide services under an agreement between the recipient and any other person (referred to as the leasing organization), have performed services for the recipient employer on a substantially full-time basis for a period of at least one year, and those services are performed under the primary direction and control of the employer who is the recipient of the services. While it is not clear yet how this situation will be viewed by the IRS in practice, this exclusion may provide protection for at least some employees of contractors who have been working primarily on assignments for the employer recipient of services for some extended period.

In defining "employee," the regulations reference the IRS guidance on employment tax withholding (Treas. Reg. § 31.3401(c)-1(b)).[42] The IRS often examines employment situations during an employment tax audit and asserts deficiencies based on the employer's misclassification of workers as independent contractors rather than employees. Thus, employers have yet one more reason to carefully assess the employer/employee relationship with all individuals, particularly those providing services directly to the employer as independent contractors.

The preamble to the proposed regulations also indicates that the IRS anticipates including an anti-abuse rule in the final regulations to address situations where it appears that the employer may be using temporary staffing agencies or similar organizations to avoid the application of Code section 4980H.

Staffing Issues. Employers who have a substantial number of part-time employees, low-wage employees, high-turnover employees, seasonal employees and perhaps "contractors" as well, will have administrative difficulties in ensuring compliance with the new rules. Each of these types of employees can cause

[40] Prop. Treas. Reg. § 54.4980H-1(a)(13)

[41] *Id.*

[42] *Id.*

special ACA compliance issues that must be watched carefully to avoid incurring significant penalties.

E.. What Employers Need to Do to Prepare for "Pay or Play" in 2015

Employers may have multiple concerns under the ACA's new rules. In determining if they are a large employer, and then for determining which employees meet the definition of full-time so these employees and their dependents must be offered coverage in order to avoid significant penalties, employers have workforce issues that may present challenges.

Every employer needs to begin preparing immediately for the January 1, 2015 operational date. To meet this date, the typical employer with a fall 2014 health care open enrollment needs to determine how to count each employee's hours of service in accordance with the complex new employer shared responsibility or "pay or play" rules under the ACA. To count hours under these complex rules, the employer will need to review its IT and payroll systems because it may take time to change these, if required. Before deciding whether to change payroll and human resource systems, the employer will need to know what to count and why, and develop its strategy for the employer shared responsibility rules. Gathering the required information, understanding the rules, applying the rules to each employer's particular situation, as well as assessing an employer's particular tax risk, will take time. In order to avoid last minute scrambling, an employer will need to work quickly to avoid penalties beginning January 1, 2015.

Act Now to Keep Annual Open Enrollment Period. To keep a fall annual open enrollment period, under the current proposed rules a municipal employer will need to begin a 12-month measuring period in the fall of 2013. Because determinations for 2015 will be based on hours worked during a prior measurement period of one to twelve months (with a subsequent up to 90-day administrative period before coverage begins), if a municipal employer wants to retain calendar year medical coverage elected during a several week open enrollment period in the fall then, under current proposed rules, the municipal employer will need to begin tracking hours for employees in the fall of 2013. The IRS is scheduled to provide final rules on pay or play but there is no indication of when the IRS may issues this guidance.

The IRS will enforce the penalties under Code section 4980H and, unfortunately, the information that the IRS will get for enforcement from the newly created state and federal health exchanges may not be accurate, at least in the beginning. The burden will be on each employer to demonstrate to the IRS that no penalties are due, or that if any are due, the correct amount is being assessed. In order to prevail with the IRS, good records are critical. Because the IRS has already indicated informally that it is planning to audit for ACA compliance, it is important not only to capture the data that is needed for compliance on January 1,

2015, but also to capture information in a way that meets the IRS audit requirements. The time to start preparing for the complicated tax rules under the ACA's new shared responsibility provisions is today.

II. MUNICIPAL EMPLOYER ISSUES REGARDING THE SUPREME COURT'S DECISION AFFECTING DOMA

On June 26, the Supreme Court in *United States v. Windsor* [43] held that section 3 of the Defense of Marriage Act was unconstitutional. No longer can the federal government distinguish in any of its laws or regulations between same sex and opposite sex marriage.

This decision has substantial and immediate practical effects for participants in and administrators of retirement and welfare benefit plans. In all cases, if benefit payments have not yet begun, plan administrators now should make appropriate good faith reasonable efforts to ensure that each same sex spouse is treated as every other spouse.

The most important unanswered questions involve transition from the current situation. It is not clear whether the decision in *Windsor* is retroactive or prospective; the Court did not address this issue. In a number of instances, it is unclear whether an employer or benefit plan administrator must (or may) take action to undo or redo existing situations where benefits are already in pay status and the participant has a same sex spouse. There are several possible solutions such as sending a notice to each person affected (such as a retiree) or just waiting and dealing with inquiries as they occur. Even though there are open issues, employees will inevitably have questions and employers may want to provide some communication in the immediate future explaining the situation, particularly where it is clear that changes have occurred in how benefits will be treated under various plans.

An additional issue raised by *Windsor* concerns the state law definition of "spouses" for plans and the taxation of benefits. How will individuals be treated who married in, e.g., California, and have moved to another state where same sex marriage is not recognized? Historically for tax purposes, where the individual resides-"domicile"- determines tax treatment. Will that be the case for benefits for same sex spouses? If the IRS interprets *Windsor* as applying to the state of domicile, then plan administrators will have to keep constant track of domicile and adjust benefits based on where people live in order to avoid potential severe tax issues.

Even though there is uncertainty, in a number of situations – particularly for California residents – the law is clear. In these cases, there seems to be no reason

[43] 133 S. Ct. 2675, 2013 LEXIS 2675 (2013).

to delay taking action. Moreover, if action is not taken quickly employers and plan administrators could be at risk for later litigation if delays caused loss to a same sex spouse. Where the rules are not clear, employers may have some leeway and might wish to delay action (and plan amendments) and wait for guidance from the IRS. It is not known when the IRS guidance will be issued, but employers are hopeful it will come prior to the time tax reporting has to be done for 2013.

Note that under *Windsor* the change applies to "spouses" as defined by state law. It does not apply to domestic partners. For Californians, the companion case to *Windsor, Hollingsworth v. Perry* [44] does not invalidate or change any of the California Family Code related to registered domestic partners. While individuals who are registered domestic partners have the same rights as spouses under California law,[45] they may not be treated as spouses under federal tax law. The IRS may issue guidance on this issue.

The chart below summarizes the major areas involving health benefit plans that are affected by *Windsor*.

PRE-DOMA RULE	NEW RULE	COMMENT
1. <u>Participation in health plans – tax status of plan</u> Under IRS rules, a person who is not a spouse or tax dependent cannot participate in a tax free health plan. If someone who is not a spouse or dependent does participate, the tax free nature of the plan is lost for every person who participates (but see item 2 below).	A same sex spouse may participate in a tax free health plan.	

[44] 133 S. Ct. 2652, 2013 LEXIS 4919 (2013).

[45] California Family Code section 297.5 provides that registered domestic partners have the same rights, protections and benefits, as well as the same responsibilities obligations, and duties as spouses, whether these rights or responsibilities derive from statutes, administrative regulations, court rules, government policies, common law, or other provisions or sources of law.

PRE-DOMA RULE	NEW RULE	COMMENT
2. <u>Participation in health plans – imputed income</u> To avoid losing the tax free status of a health plan, employers commonly impute as income to the employee the fair market value of coverage for the same sex spouse.	Income imputation is not needed for same sex spouse.	If *Windsor* is retroactive, then same sex spouses may wish to file for a tax refund because the income imputed may be incorrect – health coverage would not have been taxable. A refund may be appropriate for income tax and perhaps for FICA tax.[46] Employers should stop imputing income to the employed spouse and should stop withholding taxes for that imputed income where the benefit is clearly now non-taxable. This action should occur as soon as reasonably possible. FYI – OPM will immediately allow same sex spouses and their children to participate in federal government plans. Enrollment must be in the 60 day period after *Windsor* was decided.

[46] Same sex married couples may also consider whether they wish to file for income tax refunds that may be due because joint returns are now available to them.

PRE-DOMA RULE	NEW RULE	COMMENT
3. <u>FSAs, HRAs, HSAs</u> Same sex spouse could not receive benefits if not a tax dependent.	Reimbursement of expenses may be made for same sex spouse.	Again, it is unclear whether expenses incurred before *Windsor* was decided can be reimbursed. FYI - OPM has not made a distinction based on when expenses were incurred.
4. <u>COBRA</u> COBRA coverage is not available to same sex spouses	COBRA coverage is available to same sex spouses.	It is not clear whether plan administrators should now offer COBRA coverage to same sex spouses when the statutory period for offering coverage has already run.
5. <u>HIPAA</u> No special enrollment rights are available on marriage or when same sex spouse loses eligibility for coverage under another plan.	The same special enrollment rights must be made available to same sex spouses, as other spouses.	It is not clear whether plan administrators should now offer coverage to same sex spouses when the statutory period for offering it has already run.
6. <u>Cafeteria pans including dependent care plans</u> Mid-year election changes are not available because of changes in marital status for same sex spouses.	Mid-year election changes are available under standard rules for spouses.	It is not clear whether plan administrators should offer elections to change when the standard time has run before *Windsor*.

PRE-DOMA RULE	NEW RULE	COMMENT
7. Family and Medical Leave Act FMLA leave not required with respect to same sex spouse, including extensions of certain health care coverage rights during FMLA leave.	FMLA is now required as well as extension of health coverage.	

Municipal employers should keep careful watch for guidance from the IRS and other agencies, especially regarding retroactivity and domestic partner provisions in state law.

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To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) was not intended or written to be used, and cannot be used, for the purpose of (i) avoiding penalties under the Internal Revenue Code or (ii) promoting, marketing or recommending to another party any transaction or matter addressed herein.