THE WAGNER LAW GROUP

A PROFESSIONAL CORPORATION

Health Care Reform and Welfare Benefits Update

ERISA, Employee Benefits and Executive Compensation Law

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With health care reform enacted on Tuesday, we wanted to bring you updates on the Act as soon as possible. The Wagner Law Group is prepared to help you determine the proper course for navigating the minefields of the new Health Care Reform Act. Please let me know if you have any questions.

Best regards,
Marcia Wagner

Health Care Reform Enacted

President Obama signed the Patient Protection and Affordable Care Act (the "Reform Act") into law on March 23, 2010. The Reform Act was then amended by the Health Care and Education Affordability Reconciliation Act, which revised some of the Reform Act's provisions and delayed certain effective dates.

This massive law, which is designed to provide access to health insurance coverage for most Americans, will impose new responsibilities on employers, individuals and insurers, as well as government programs such as Medicare and Medicaid.

Employers of all sizes will find themselves subjected to new rules, regulations and penalties. Many, if not all, employers may be required to make substantial changes to their group health plan design and communications. In addition, while most of the provisions of the Reform Act, as amended, will not be effective until 2014, employers should take immediate steps to reassess their plans with respect to those provisions that are to become effective in a short period of time. Employers should also begin to assess their plans to prepare for plan design and administrative changes that will be required in the future.

Reform Act Provisions

The major provisions of the Reform Act, as amended, that affect employers either directly or indirectly through their employees or through insurance mandates are as follows:

Employee Contribution Safe Harbor
Employment Law Matter
Proposed Regulations -- American with Disabilities Act
Family and Medical Leave Act Expanded
Mass Data Security Law Takes Effect
Cost of Living Adjustments

Webinar on Health Care Reform Act

We are contemplating offering a webinar for our clients and friends about the Health Care Reform Act. If you would like to receive an invitation please click here.

Marcia Wagner
Managing Director

The Wagner Law Group
A Professional Corporation

Specializing in ERISA, Employee Benefits and Executive Compensation Law

Marcia will be speaking for **John Hancock** and **Deutsche Bank** News from Washington: Effects on You and Your Clients." (May 4th, 5th and 6th)

Al Lurie will be moderating a Health

Mandatory Coverage

Effective in 2014, most US residents will be required to have "qualified" health coverage. Generally, the penalty for each individual who does not have this coverage will be the greater of $95 or 1% of income in 2014 and will increase to the greater of $695 or 2.5% of income in 2016. The qualified health coverage must contain an "essential health benefits" package and insure at least 60% of the actuarial value of covered services, with annual out-of-pocket limits equal to those that currently apply to high deductible health care plans associated with Health Savings Accounts. (For 2010, this would be $5,950 for an individual and $11,900 for a family.) Furthermore, employer-sponsored plans in the small group market may not impose deductibles that exceed $2,000 for individuals and $4,000 for families.

Essential health benefits include: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative services and devices; laboratory services; preventative and wellness services; chronic disease management; pediatric services; and other services as defined by the Department of Health and Human Services ("HHS").

Employer Group Health Plans

The Reform Act makes significant changes which will affect the design and administration of employers' group health plans, whether they are insured or self-funded. Among the most significant provisions:

- Employers with more than 50 employees who do not offer minimum essential health coverage and have at least one employee who receives a federal premium tax credit because of coverage through an "Exchange" (see below) will be assessed a fee of $2,000 per full time employee, with an exception from the penalty for the first 30 employees.
- If the employer's group health plan requires contributions in excess of 9.8% of income for any employee, the employer will be assessed a penalty of $3,000 for each full time employee who receives a premium tax credit, with an exception from the penalty for the first 30 employees.
- Employers with more than 50 employees may not have a group health plan waiting period of more than 90 days.
- Employers with more than 200 employees must automatically enroll their employees in the employer-sponsored group health plan. Employees must be given the opportunity to opt out of coverage.
- Group health plans must provide for preventative care without cost sharing requirements.
- Dependent coverage must be offered for unmarried children until age 26. The rule is effective six months after enactment for former dependents who are not offered employer-provided coverages.
- Lifetime and annual limits on coverage would be prohibited, as would pre-existing condition exclusions on children. Certain annual limits and pre-existing condition restrictions for adults are permitted until 2014.
- A group health plan must have "effective" internal and external appeals processes for coverage determinations and claims.
- Insured group health plans will be subject to nondiscrimination rules similar to those currently in effect for self funded plans.
- Employers must offer a voucher to an employee to help pay for coverage through an Exchange, if the employee's income is less than 400% of the federal poverty level, and the

Reform Symposium on employer related issues sponsored by **John Marshall Law School** in Chicago. (April 29th)

Alex Olsen Joins Firm as Associate

The Wagner Law Group is expanding and we have added another associate to our growing group of outstanding ERISA, employee benefit and executive compensation attorneys. Alex Olsen will be helping our clients with submissions to the IRS and DOL for various correction programs, 5500 filings, summary annual reports, termination and administration of orphaned plans, and welfare and cafeteria plan documents.

Alex was previously employed by the IRS as a Lead Tax Examiner. He also worked as a legal intern with the New England Patriots.

Description

The Wagner Law Group, A Professional Corporation, is a nationally recognized ERISA, employee benefits, executive compensation and

required employee contribution for the group health plan is between 8% and 9.8% of the employee's income. The value of the voucher must equal the contribution the employer would have made to the group health plan on behalf of the employee.

- The permitted employee incentive for wellness programs is increased from 20% to 30%.

In addition to the design changes, employers will have certain notification requirements. Among these, employers will have to include the cost of group health care coverage on the employees' W-2 Forms. Employers (or their insurers) must also provide an information return stating the number of months during which an individual was covered by the employers' plan.

Also, an employer must notify employees about the Exchange and inform them they may be eligible for premium assistance and cost sharing reduction if the employer's contribution to the plan is less than 60% of the total cost of coverage and that if the employee chooses coverage through the Exchange, the employee may lose the employer's coverage contribution.

Finally, group health plans will have to comply with HHS standards for the provision of information about benefits and coverage. HHS will provide these standards within 24 months of enactment.

Premium Assistance and Premium Tax Credit

Employers with fewer than 25 employees who have average wages of less than $50,000 will be given a tax credit, starting this year, of up to 35% of the employers' contribution towards health care coverage, if the employer contributes at least 50% of the total premium.

Employees (and other individuals) who are not eligible for essential health benefits will receive advanceable and refundable premium tax credits if their incomes are between 100% and 400% of the federal poverty level. An employee who is offered coverage by his employer will be eligible for the premium tax credit if the employer's group health plan does not pay at least 60% of covered benefit costs or the employee contribution would be more than 9.8% of the employee's income.

In addition, the Reform Act provides federal cost sharing subsidies to employees and other eligible individuals with incomes below 200% of federal poverty level.

Exchanges

The Reform Act creates "American Health Benefit Exchanges" and "Small Business Health Option Program" (SHOP) Exchanges that will allow individuals and small businesses of up to 100 employees to purchase qualified health coverage. States may opt to have regional exchanges. The Exchanges are to be operational in 2014.

Four health care coverage benefit categories (Bronze, Silver, Gold and Platinum) will be offered by the Exchanges plus a less expensive "Catastrophic Plan" for those under age 31. Other than the Catastrophic Plan, the least expensive Bronze Plan would provide "essential health benefits" and cover 60% of essential benefit costs.

Out-of-pocket limits would be reduced for individuals with incomes below 400% of the federal poverty level.

The Reform Act also creates a Consumer Operated and Oriented Plan (CO-OP) program to help create non-profit member run health insurance organizations.

employment practice.

Established in 1996, The Wagner Law Group has 15 attorneys engaged exclusively in employee benefits law. The firm is among the largest ERISA boutiques in the country. Our practice is national in scope, with clients in more than 30 states and several foreign countries.

Services We Provide for Our Clients

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Flexible Spending Accounts, Health Reimbursement Accounts and Health Spending Accounts

Under the Reform Act, salary reduction contribution amounts will be limited to $2,500 for health care Flexible Spending Accounts ("FSAs") in 2013. The Reform Act eliminates coverage for non-prescription, over-the-counter medications from FSAs and Health Reimbursement Accounts ("HRAs") and makes reimbursements for these items taxable for Health Spending Accounts ("HSAs") in 2011.

Employers that offer health care coverage through an Exchange can allow employees to purchase insurance with pre-tax contributions through their Section 125 plan.

The excise tax on reimbursements from HSAs for nonqualified medical expenses will increase from 10% to 20% in 2011.

Insurance Market

In addition to the coverage and design requirements listed in the Employer Group Health Plans section (see above), insurers will be required to provide guaranteed issue (i.e., insurance companies cannot bar applicants based on health status) and guaranteed renewability in the group and individual markets. A national high-risk pool would be created to provide health insurance coverage to individuals with pre-existing conditions until the Exchanges are established.

Insurers' rating variations can only be based on family structure, community rating area, actuarial value of benefits, age (limited to a 3 to 1 ratio) and smoking.

HHS will work with the states to review "unreasonable" rate increases, which must be justified to HHS and the state insurance department.

States may allow the creation of "health care choice compacts" to permit purchase of individual insurance across state lines.

Medicare and Medicaid

The Reform Act reduces certain Medicare payments and establishes an Independent Payment Advisory Board to make recommendations to further reduce the growth of Medicare payments. Medicare Advantage payments will be restructured to be based, in part, on the local market and on performance bonuses.

The Medicare Part D prescription drug "donut hole" will be eliminated. Currently, Medicare stops paying after an individual has spent $2,830 on prescription drugs and does not resume payments until out-of-pocket spending reaches $4,550. Coverage will be gradually provided for amounts within the gap until the donut hole is completely eliminated in 2020.

Medicaid will be expanded to cover everyone under age 65 who have incomes up to 133% of the federal poverty level.

Funding

In addition to taxes imposed on the insurance industry:

- A 40% excise tax is imposed on "Cadillac" health insurance coverage (i.e., a tax on most health plan coverage to the extent the value of the coverage exceeds $10,200 for individuals

and $27,500 for family coverage, as indexed by the Consumer Price Index. The excise tax would be effective in 2018.

- The Medicare portion of FICA tax is increased 0.9% in 2013 to 2.35% for taxpayers with joint filings over $250,000 and individual filers with income over $200,000.
- A 3.8% surtax is imposed in 2013 on net investment income (subject to limits) for taxpayers with joint filings over $250,000, or $200,000 in the case of those filing individual returns.
- The Reform Act reduces Medicare Part D premium subsidies in 2011 for joint filers with incomes over $170,000 and individual filers with incomes over $85,000.
- Federal subsidies are paid to employers who maintain retiree drug coverage after the implementation of Medicare Part D. The Reform Act eliminates the deduction for expenses attributable to the Medicare Part D subsidy.
- The Reform Act increases the threshold on personal deductions for unreimbursed medical expenses from 7.5% to 10% of adjusted gross income beginning in 2013.
- A 10% excise tax is imposed on indoor tanning services.

Employers Must Take Action Now

Although many of the provisions of the Reform Act will not take effect for several years, employers should be aware of the provisions that will take effect within the next few months. These provisions may require changes in plan design or amendments to insurance contracts to ensure compliance with the new law. These changes will affect both insured and self-funded group health plans and may require immediate action on the part of the employer.

These provisions would include:

- the requirement that dependent children who are not eligible for other employer-provided coverage be permitted to remain on their parents' plan until the age of 26;
- the elimination of certain annual and lifetime limits on benefits;
- the prohibition of pre-existing condition exclusions for children;
- the requirement that plans cover preventative services and immunizations without cost-sharing;
- the requirement that plans have effective internal and external appeals processes;
- the elimination of tax-exempt reimbursements of over-the-counter medications in FSAs, HRAs and HSAs; and
- the 35% tax credit for contributions by employers with fewer than 25 employees.

In addition to these statutory changes, all employers must keep abreast of any initial guidance from the federal government agencies that will be enforcing these laws, and should take steps to determine their future obligations and potential liabilities under the new laws. For example:

- How will the law, particularly the definition by HHS of an essential benefit package, affect employers who sponsor HSAs? Will an exception be made for these types of plans or will the definition force employers to abandon their HSAs/high deducible plans?
- Will any employee be responsible for a group health plan contribution that exceeds 9.8% of his income, thereby exposing the employer to the $3,000 penalty?
- For employers who provide retiree health care benefits, should coverages be adjusted due to the taxation of the Medicare Part D subsidy and the changes to Medicare reimbursement?
- For employers with "Cadillac" plans, should the coverage provisions of the plan be

adjusted to prevent the taxation of group health care coverage?

- With the increase in wellness incentives, should employers consider wellness programs as an integral part of their health program?

Welfare and Fringe Benefits

Cobra Subsidy Update

1. Subsidy Extended

A provision in the Department of Defense Appropriations Act of 2010 extended the 65% COBRA subsidy for involuntarily terminated employees for an additional six months (creating a maximum subsidy period of 15 months) and extended the subsidy eligibility period for an additional two months, until February 28, 2010. The Appropriations Act also requires employers to provide an additional notice to anyone who is eligible for the subsidy on or after October 31, 2009. The notice must inform these individuals of the extension of the COBRA subsidy, as well as the extended eligibility period. The notice's due date for current qualified beneficiaries was February 17, 2010.

A notice must also be given to qualified beneficiaries who dropped their COBRA coverage when they reached the end of their original 9-month subsidy. These individuals must be notified of their right to make retroactive, subsidized premium payments by February 17, 2010 (or, if later, within 30 days of receiving the notice). Qualified beneficiaries who make these late payments will receive coverage retroactive to their original subsidy expiration date.

The Temporary Extension Act later extended the COBRA subsidy eligibility period until March 31, 2010, and also provides that certain employees who previously lost their group health insurance coverage due to a reduction in hours, and who were later involuntarily terminated, are now eligible for the subsidy. The subsidy will be made available to employees who lost their coverage between September 1, 2008 and March 31, 2010 due to a reduction in work hours and whose employment was then involuntarily terminated on or after March 2, 2010 (the date of enactment).

DOL has released revised model notices to participants which include:

- an updated general notice for qualified beneficiaries who have not yet received an election notice;
- an alternative notice for coverage under state continuation coverage laws (e.g., employees whose employer have fewer than 20 employees and are therefore not subject to COBRA);
- a premium assistance extension notice for individuals who were receiving COBRA subsidies as of October 31, 2009, including terminated employees (and their families) who have received the original 9-month subsidiary and who either: did not make any further COBRA payments; or who paid the full COBRA premium after the initial expiration of their subsidy. This notice must also be sent to employees who were terminated on or after October 31, 2009, but who were not provided with a notice that included the information required under the COBRA subsidy extension law; and
- a model COBRA Continuation Coverage New Election Period Notice for individuals who lose coverage due to a reduction in hours and later have an involuntary termination of employment after March 1, 2010.

The notices are available at http://www.dol.gov/ebsa/COBRAmodelnotice.html.

Those qualified beneficiaries who continued their COBRA coverage by paying the full COBRA premium upon the expiration of their original nine-month COBRA subsidy, will be entitled to a credit, or a reimbursement, of their excess COBRA premium payments.

2. IRS Guidance

In related news, IRS has released additional questions and answers on the COBRA subsidy. In its release, IRS assures employers that, for purposes of the employer payroll tax credit, it will not challenge any reasonable determination on whether an employee's termination was involuntary, and therefore eligible for the COBRA subsidy.

The new guidance also clarifies that involuntary terminations include an employer's failure to renew an employment contract. Also, employees hired for a limited period of time, such as temporary and seasonal employees, will be eligible for the COBRA subsidy when their employment is terminated, if they had been covered under the employer's group health plan prior to termination. Similarly, if a member of a military reserve unit or the National Guard is called to active duty, it will be considered an involuntary termination.

In addition, IRS has issued a Q&A on its website pertaining to when an employer can recover the 65% COBRA subsidy, if the qualified beneficiary's 35% premium payment is received in January of 2010 for coverage in December of 2009.

Employers use Form 941 "Employer's Quarterly Federal Tax Return" to recover COBRA subsidies from the federal government. IRS says that an employer may claim the payroll tax credit for the premium subsidy for the quarter in 2010 in which it receives the qualified beneficiary's portion of the premium payment, or in a later quarter, but may not claim the credit in 2009 for 2010 payment, regardless of the fact that the premium relates to coverage during 2009.

IRS also points out that while a controlled group of corporations is generally treated as a single employer for employee benefit plan purposes, each member of the group is treated as a separate employer for payroll tax purposes. Therefore, if a group health plan covers different members of a controlled group, each employer in the group will be separately entitled to claim reimbursements, through the payroll tax credit, attributable to the COBRA subsidy on its own former employees.

3. CMS Guidance

The Centers for Medicare and Medicaid Services ("CMS") has issued forms and guidance for requesting a CMS review of an employer's denial of eligibility for health care continuation subsidies on state continuation coverage. Under ARRA, DOL is responsible for reviews of denials involving COBRA coverage, but CMS was given responsibility to review denials involving state continuation laws and continuation for government employees.

The CMS materials can be found at http://www.cms.hhs.gov/COBRAContinuationofCOV/.

DOL's materials for requesting a review of a detail of a COBRA subsidy is at

www.dol.gov/esba/COBRA/main.html.

Employers Must Report Welfare Plan Excise Taxes

Starting in 2010, employers and other persons responsible for providing or administering group health care plans will be required to report and pay certain welfare plan excise taxes. The excise taxes relate to failures to comply with certain requirements including: COBRA; HIPAA (including pre-existing conditions, creditable coverage, special enrollments and non-discrimination); the Genetic Information Nondiscrimination Act; required hospital stays under the Newborns' and Mothers' Health Protection Act; the Mental Health Parity Act; coverage of seriously ill college students under Michelle's Law; and a failure to comply with the comparable contribution rules for Health Savings Accounts ("HSAs").

Noncompliance must be reported on Form 8928 "Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code". This Form will generally be due at the same time as the employer's (or other responsible party's) regular tax returns (without extensions). However, for a failure to make comparable contributions to an HSA, the Form will be due by April 15 of the calendar year following the year in which the noncompliance occurred.

The excise tax for most of these violations is $100 per day for each affected employee or beneficiary. For non-comparable HSA contributions, however, the penalty is 35% of the aggregate amount contributed by the employer to the HSA, unless IRS waives some or all of the excise tax.

Not all violations are subject to an excise tax, however. For example, in most cases, an excise tax is not due if the responsible party, exercising reasonable diligence, did not know that the violation occurred, or if the violation is due to a reasonable cause and is corrected within a 30-day correction period.

Mental Health Parity Act Regulations Issued

IRS, DOL and HHS have issued interim final regulations on the Mental Health Parity Act. The Act, which amends the Internal Revenue Code, ERISA and the Public Health Service Act, does not require that mental illnesses or substance abuse be covered under a group health plan and allows the term "mental illness" to be defined under each particular plan or insurance contract. However, if mental illness (and/or substance abuse) treatments are covered by a plan, the Act requires financial parity for coverage of physical and mental illnesses, including deductibles, co-payments, coinsurance, out-of-pocket expenses and yearly and lifetime maximums. Similarly, the Act requires parity as to treatment, including the permitted frequency of visits, the total number of visits permitted, and the total days of coverage.

In general, under the regulations, parity for financial purposes is determined separately for each of six classifications: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs.

In addition, the regulations provide that under the parity of treatment rules, a plan cannot require a participant to exhaust Employee Assistance Program benefits for mental illness or substance abuse before turning to the group health plan for coverage, unless it has the same restrictions for

medical/surgical benefits.

Employers can opt out of these requirements if they can demonstrate that the new mental health parity provisions will increase health care costs by more than 2% in the first year and 1% in subsequent years. Small employers (between two and fifty employees) are automatically exempt from the Act.

The Act clarifies that mental health parity requirements are merely a floor for mental health coverage and that states can enact more extensive requirements for insurance contracts, and for self funded plans that are not covered by ERISA, as long as these state laws do not conflict with federal law.

Although the Act itself is effective for plan years beginning after October 3, 2009, the regulations are generally effective for plan years beginning on or after July 1, 2010.

Children's Health Insurance Program Notice Requirements

DOL has released a model notice employers can use to inform employees of the potential for state premium assistance subsidies for employee contributions to group health coverage.

The Children's Health Insurance Program ("CHIP") Reauthorization Act of 2009 requires employers who maintain group health plans to provide an annual notification of the opportunity for premium assistance subsidies from state Medicaid or CHIP programs. The notice must be provided to all employees who reside in states that provide such assistance, regardless of whether the employees are currently plan participants. Massachusetts is one of the states that does provide this type of assistance.

The first notice is due by the first day of the first plan year beginning after February 4, 2010 or by May 1, 2010 if this is later. (The due date would be January 1, 2011 for calendar year plans.) However, the notice need not be distributed separately and can be combined with other materials, such as annual open enrollment forms.

Employers can use the DOL model notice which is located at http://www.dol.gov/ebsa/chipmodelnotice.doc. Because the model notice lists the states that provide premium assistance, DOL has said that an employer can meet its obligation by simply providing the notice to all employees, regardless of where they live.

HIPAA Privacy and Security Rules Update

1. Breach Notices

HHS has issued additional regulations on the notification requirements when there is a breach of unsecured protected health information ("PHI") as defined under the Health Insurance Protection and Portability Act ("HIPAA").

As a part of the American Recovery and Reinvestment Act of 2009, the "Health Information Technology for Economic and Clinical Health Act", or HITECH provisions, amended HIPAA to provide that if there is a security breach due to unsecured PHI, the covered entity will have to notify each individual whose

information may have been accessed or disclosed. HHS and "prominent media outlets" must also be notified of breaches involving more than 500 residents in a particular area. If fewer than 500 individuals are involved in the breach, the covered entity would have to keep a record of the breaches and submit the list to HHS annually.

HHS has modified its definition of a breach. Previously, it had said that, with the exception of certain minor, inadvertent disclosures, a breach occurs when there is an unauthorized acquisition, access, use or disclosure of PHI, which compromises the security or privacy of such information. However, under the new regulations, a breach occurs only if there is a significant risk of harm to an individual's finances or reputation.

HHS says the notification to individuals and to HHS (when not required annually) must be made within 60 days after the breach is discovered. The breach notification rules became effective September 23, 2009. However, reports on breaches are not due until February 22, 2010, at the earliest.

HHS has created a website at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html to receive reports of security breaches involving unsecured, protected health information.

2. HITECH Rules Become Effective

Many of the HITECH amendments to the HIPAA Security and Privacy Rules have recently become effective. However, HHS has yet to issue any guidance on what will be required for business associates under these amendments.

The HIPAA Security Rule requires administrative, physical and technical safeguards for PHI and includes training requirements to enable employees to protect electronic systems and data from unauthorized access. These safeguards previously applied only to covered entities (e.g., group health plans and insurers) but will now apply directly to business associates. In general terms, a business associate is a service provider that uses PHI to perform its services for a covered entity. Under the new rules, a business associate must (i) conduct a formal risk assessment; (ii) appoint a security officer; (iii) adopt written polices and procedures; and (iv) train its workforce on how to protect electronic PHI. Business associates must comply with both the physical and technical safeguards related to PHI, beginning February 17, 2010.

The HIPAA Privacy Rule also applies directly to business associates for the first time, effective February 17, 2010. This includes the requirement to have and comply with a business associate agreement. Previously, it was the covered entity's responsibility to identify all business associates and have valid business associate agreements in place (e.g., a business associate did not need to determine if it was a business associate). Now the business associate will have the same responsibilities, and be subject to the same penalties, as the covered entity.

HHS has not issued regulations explaining how the Privacy Rule will be applied to business associates. However, a House Committee report on HITECH says that the privacy standards will be applied to business associates "in the same manner as they apply to the providers and health plans for whom they are working." While HHS might not impose all of the Privacy Rule requirements on business associates, it is nevertheless probable that the regulators will add some substantive privacy requirements to ensure that business associates are taking affirmative steps to comply, beyond merely signing a business associate agreement.

Regulations Issued on Genetic Information Nondiscrimination Act

IRS, DOL and HHS have issued interim final rules on the Genetic Information Nondiscrimination Act of 2008 ("GINA"), as it relates to insurers and group health plans.

Under GINA, employers cannot make employment decisions such as "hiring, discharge, compensation, terms, conditions or privileges of employment" based on genetic information. In addition, health insurers and employers' group health plans cannot deny coverage or require higher premiums or contributions based on genetic information.

Therefore, genetic information cannot be used for underwriting purposes. The regulations define "underwriting" to include rules for plan eligibility and enrollment, as well as the determination of premiums and employee contribution amounts, including any discounts, penalties or other "premium differential mechanisms."

GINA also restricts the acquisition and disclosure of genetic information. However, the law does not ban the use of genetic information for life insurance, long-term care and disability policies and does not affect insurers' ability to take pre-existing conditions into account when making coverage or pricing decisions. Also, genetic information can be requested by certain health care professionals for purposes of medical treatment; by insurers and group health plans for purposes of determining whether benefit payments are medically appropriate; and for certain types of research.

The regulations say that family medical history is considered to be genetic information and, while Health Risk Assessment ("HRA") programs can request family history, an employer may not offer a reward for the completion of such information or impose a penalty for failure to do so. In fact, the regulations provide that, if a reward is given, the HRA materials must state that an employee should not include genetic information when completing the HRA forms.

HHS has also issued additional regulations which state that genetic information is protected health information and, therefore, subject to the HIPAA privacy rules.

These regulations became effective December 7, 2009. Further regulations on the employment-related aspects of GINA are expected to be issued by the EEOC.

Massachusetts Health Care Reform Regulations Modified

Under the Massachusetts Health Care Reform Act, employers with the equivalent of 11 or more full time employees that fail to make a "fair and reasonable" contribution towards the cost of group health care coverage must pay a "Fair Share Contribution" of $295 per employee. To be exempt from the payment, a smaller employer has to cover at least 25% of its full time Massachusetts employees (the participation test); or pay at least 33% of the cost of coverage for these employees (the contribution test). Employers with more than 50 employees must either pass both tests, or cover at least 75% of their full time employees who are employed at Massachusetts locations.

Under a recent modification of the Fair Share Contribution regulations, for purposes of these tests, an employer "must adopt and maintain a written Group Health Plan document, and maintain written documentation with employees about the plan and employer contributions." However, it is not clear if

this means that all employers must have ERISA-required plan documents to pass the test, or whether insurers' certificates and employee election forms would be sufficient. Also, previous court cases have ruled that state laws requiring employer communications about ERISA-covered plans interfere with the administration of these plans and are therefore preempted (made void) by ERISA.

Under another change, the modified regulations recognize "premium reimbursement arrangements" as group health plans for purposes of the participation and contribution tests. In a premium reimbursement arrangement, an employer offers to reimburse employees for at least a portion of the premium expense of individual health insurance coverage. Again, the arrangement would have to be in writing and communicated to employees, and would have to designate a specific insurance plan or plans for employee enrollment. The regulation does not say how much an employer must contribute to create a premium reimbursement arrangement.

EFAST2 On-Line

The Department of Labor ("DOL") has announced that its EFAST2 online filing system for the Form 5500 series is now operational. According to DOL, "the revised EFAST Web site has been updated to provide filers with a variety of tools and guidance, including the 2009 and 2010 Form 5500 and new Form 5500-SF [for most smaller plans], schedules and instructions, Frequently Asked Questions, user guides and tutorial."

Filers must submit Forms 5500 electronically for plan years beginning in 2009. Prior year delinquent or amended Forms 5500, must also be filed electronically, except that timely 2008 filings may still be submitted through the original EFAST, or on paper, until October 15, 2010.

Short plan year filers with a due date before January 1, 2010 have been granted an automatic 90-day extension from the date EFAST2 became operational. (These filers were also allowed to use the 2008 paper forms and schedules if they filed on or before December 31, 2009.)

To assist in the transition, the DOL website, http://www.efast.dol.gov/, provides information on the new electronic filing requirements, including electronic filing options, software availability, as well as publications and forms.

All electronic Forms 5500 must be signed electronically. However, before signing a Form 5500, each individual must register for electronic signature credentials. This registration must be done even if the individual has previously obtained electronic credentials under EFAST, because EFAST2 is a completely separate system from EFAST.

In order to obtain electronic signature credentials:

1. Go to the EFAST2 website at www.efast.dol.gov.
2. Click on "Register" under "Main" in the left hand column.
3. Read and accept a "Privacy Statement."
4. Complete an information profile. To receive signature credentials you must check "Filing Signer" as your user type.
5. Select a "Challenge Question" (i.e., date or place of birth) and provide appropriate answer.
6. You will then receive an e-mail from the DOL at the address listed in your information profile. Click on the link in this e-mail to continue.
7. Answer your challenge question.

8. Accept the "Signature Agreement."
9. DOL will then provide your User ID and PIN. Be sure to print the page for your records.
10. Click "Next" to create your own password. Be sure to keep the User ID, PIN and password in a secure location.

Employee Contribution Safe Harbor

DOL has created a safe harbor for the deposit of employee contributions for plans with under 100 participants.

In general, DOL regulations require employers to deposit employee contributions for a welfare plan in a trust within a maximum of 90 days after the employer receives the employee contributions or 90 days from the date on which the contributions would otherwise have been payable to the participant. DOL exempted cafeteria plan contributions and insured welfare plans (if they pay the employee contributions to the insurer within three months) from these rules. For retirement plans, the limit is 15 business days after the month in which the employer withholds or receives the employee contributions.

DOL has insisted, however, these 90-and 15-day deadlines are not safe harbors. Rather, employers must deposit employee contributions "on the earliest date on which they can reasonably be segregated from the employer's general assets." This created considerable confusion as to when these amounts had to be deposited.

The new safe harbor rule says that the deposit deadline will be met if the contributions are deposited not later than the seventh business day after the contribution is received by the employer or the seventh business day following the day on which the contribution amount would otherwise have been payable to the participant. The safe harbor also applies to plan loan repayments.

DOL says it believes the adoption of the seven-day safe harbor will give employers "a higher degree of compliance certainty" but rejected calls to apply the safe harbor to plans with 100 or more participants. It also emphasized that this safe harbor is not the only means of complying with the employee contribution deposit rule.

Employment Law Matters

Proposed Regulations on Americans with Disabilities Act

The EEOC has issued proposed regulations on the revisions to the Americans with Disabilities Act ("ADA") made by the ADA Amendments Act of 2008 ("Amendments Act").

The ADA prohibits employment discrimination against individuals with disabilities. It requires employers to make reasonable accommodations for employees who have a disability, which is defined as someone with mental or physical impairments that substantially limit a major life activity. It also protects individuals with a record of a disability and those who are regarded as disabled.

In conjunction with the Amendments Act, the proposed regulations expand the definition of a "disability" by providing that an impairment need not prevent or "significantly" restrict the performance of a major life activity. Rather, an individual has a disability if the condition "substantially limits" the ability of the individual to perform a major life activity, as compared to most people in the general population.

"Major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. The term also includes the operation of major bodily functions including, but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

The regulations also include clarifications of other aspects of the ADA. For example, they include provisions that state:

- An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability;
- An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active; and
- The determination of whether an impairment substantially limits a major life activity is be made without regard to the ameliorative effects of mitigating measures (e.g., prescription medications).

Employers should be aware that there may be instances where employees who were not previously considered disabled have now been extended protection under the ADA. Therefore, employers should, as a first line of defense, review their hiring procedures for ADA compliance and also determine whether they approach employee disabilities with an eye towards reaching a reasonable accommodation.

Family and Medical Leave Act Expanded

Leave rights under the Family and Medical Leave Act ("FMLA") have been expanded once again for families of military personnel.

Last year, the FMLA was amended to allow an employee who is a spouse, child, parent or nearest blood relative of an active member of the military service to take up to 26 weeks of leave to care for the service member if he or she has a serious illness or injury that occurred during military service. This right to take leave has now been expanded to cover veterans, if the veteran undergoes treatment, recuperation or therapy for the condition at any time within five years of the date the veteran was a member of the Armed Forces. In addition, the rule now covers serious illnesses or injuries that either occurred or were "aggravated" during military service.

Last year, FMLA was also amended to allow an employee to take up to 12 weeks FMLA leave, if there is a "qualifying exigency" arising out of the fact that a spouse, child, or parent of the employee is on, or

has been called to, active military duty, as a member of the Reserves or National Guard, in support of a "contingency operation." This right to take leave has been expanded to include relatives of all servicemen on active duty who are deployed to another country or a contingency operation. Examples of qualifying exigencies include: preparing for short notice deployment; making legal or financial arrangements; arranging for child care; and post deployment activities. A contingency operation involves, or may involve, military operations or a call up to active duty during war or national emergency.

Mass Data Security Law Takes Effect

On March 1, 2010, the Massachusetts Data Security Law takes effect. Under this law, businesses that hold own, license, store or maintain "personal information" about Massachusetts residents, including information on their own employees, are required to notify affected individuals, plus the Massachusetts Attorney General and the Massachusetts Office of Consumer Affairs and Business Regulation, in the event of an unauthorized acquisition or use of personal information.

Personal information, in general terms, includes items with an individual's name plus either a Social Security number, driver's license number or financial account number (e.g., payroll automatic deposit, 401(k) account, IRA, or health FSA debit card) that would give access to a financial account of the individual. Personal information may be in electronic, written or verbal form.

Businesses that have this personal information are required to have data security policies that conform to regulatory standards, including firewall protection and encryption of the personal information. The Massachusetts regulations require employers to develop written security polices to ensure compliance with the new law and to provide training for employees. To assist in this requirement, the Office of Consumer Affairs has developed a "Comprehensive Written Information Security Program" for small employers.

Cost of Living Adjustments

	2009	2010
Maximum annual payout from a defined benefit plan at or after age 62 (plan year ending in stated calendar year)	$195,000*	$195,000*
Maximum annual contribution to an individual's defined contribution account (plan year ending in stated calendar year)	$49,000**	$49,000**
Maximum Section 401(k), 403(b) and 457(b) elective deferrals	$16,500***	$16,500***
Section 414(v)(2)(B)(i) catch-up limit for individuals aged 50 and older	$5,500***	$5,500***
Maximum amount of annual compensation that can be taken into account for determining benefits or contributions under a qualified plan (plan year beginning in stated calendar year)	$245,000	$245,000
Test to identify highly compensated employees, based on compensation in preceding year (plan year beginning in stated year determines "highly compensated" status for next plan year)	$110,000	$110,000
Wage Base For Social Security Tax	$106,800	$106,800
Wage Base For Medicare	No Limit	No Limit

Amount of compensation to be a "key" employee	$160,000	$160,000
Maximum Social Security Benefit at Social Security Normal Retirement Age	$2,323/month	$2346/month
Earnings Test - Early Retirement (Age 62) (Amounts that Can Be Earned before Benefits Are Cut)	$14,160/year	$14,160/year
PBGC maximum monthly guaranteed life annuity at age 65	$4,500/month	$4,500/month
Maximum exclusion for adoption assistance plan	$12,150	$12,170
Long term care premiums treated as medical expenses:		
• Age 40 or less	$320	$330
• Age 41-50	$600	$620
• Age 51-60	$1,190	$1,230
• Age 61-70	$3,180	$3,290
• Older than 70	$3,980	$4,110
Qualified transportation benefits:		
• Parking expenses	$230	$230
• Transit pass or commuter vehicle	$120	$230
Health savings accounts:		
• Maximum contribution-single	$3,000	$3,050
• Maximum contribution-family	$5,950	$6,150

• Maximum out of pocket expense-single	$5,800	$5,950
• Maximum out of pocket expense-family	$11,600	$11,900
• Minimum deductible for high deductible health plan-single	$1,150	$1,200
• Maximum deductible for high deductible health plan-family	$2,300	$2,400

* There are late-retirement adjustments for benefits starting after age 65.
** Plus "catch-up" contributions.
*** These are calendar year limitations.