# City of Maryville

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# HEALTH & WELFARE INSURANCE BROKER PROVIDING BENEFIT CONSULTANT SERVICES PROPOSAL

*Presented: August 21, 2014*

BENEFITS | COMPENSATION | RETIREMENT | RISK MANAGEMENT

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# Introduction

### Cost increases. Marketplace uncertainties. Regulatory pressures.

These challenges loom large in Human Resources' ongoing quest to balance a happy workforce with a healthy bottom line. The good news is that even though challenges are everywhere, so are solutions.

Consider some of the latest findings from Arthur J. Gallagher & Co.'s national 2013 Benefits Strategy and Benchmarking Survey:

- High deductible health plans continue to gain acceptance as a way to temper rising healthcare costs, and are now offered by over 34% of organizations – second only to PPOs;
- Employers are adopting benefits technology at a faster rate – 87% provide a portal, and the number of organizations that adopt mobile benefits applications is expected to triple in the near future;
- Prescription coverage is one of the main drivers of increased healthcare costs and copayments – part of about 95% of plans – are the dominant cost-sharing mechanism;
- Voluntary benefits continue to increase in popularity and provide value to employers in all U.S. industries, offering the flexibility to meet individual employee needs at a minimal expense to the organization.

What are the right choices for you and your organization? Before you can manage the complexities of today's benefits marketplace, you need to decode them and learn what they mean for you.

Gallagher can help you make sense of your benefit options. With more than 2,500 benefit services employees and over 170 office locations worldwide, City of Maryville has access to a local team backed by a network of global resources. Industry practitioners and compliance professionals add the specialized insight needed to help you resolve the financial, legal and corporate culture issues that affect your employee benefit decisions.

Because data drives decisions at Gallagher, our analysts, actuaries and clinicians also put the power of predictive models, health risk assessment tools, industry benchmarks and data from over 1,200 client companies to work for you. The results give you a true understanding of factors that may be affecting the costs and performance of your benefits program.

In total, you'll have a partner who works closely with you to break through business barriers and develop long-term benefit strategies and innovative solutions that support growth while minimizing risk. We are confident that once you review this proposal you will agree that Gallagher is fully qualified to exceed your expectations.

We look forward to serving as your expert, advocate and guide in creating a total compensation and benefits program that positions City of Maryville as an employer of choice in the Public Sector industry. Together, we'll bring the right talent to your door and keep them engaged once they're hired.

## Scope of Services

*The scope of services to be provided by the selected firm includes, but is not limited to the following:*

- *Evaluate the total health care benefit package and provide recommendations for options to meet the needs of employees and the City's financial objectives.*

  The ability to deliver comprehensively structured employee benefits solutions to clients is Gallagher's signature in the marketplace. Often, those clients also cite their experience of that delivery – the way we do business together.

  At Gallagher, we want to know what makes your organization unlike anyone else's. Your account team listens intently to learn about your business, and delves deeply into all the details that matter when balancing employee satisfaction with your bottom line. This single-minded focus on excellence – characterized by innovation and creativity – is the driving force behind every Gallagher customized employee benefits program.

- *Identify, solicit, and present final recommendation for selection of vendors for city's benefit plans. Included should be recommendations for plan design alternatives with cost projections.*

  Putting together all of the pieces of the employee benefits program puzzle, from innovative plan design to solutions for addressing complex regulations, requires an experienced partner with the expertise to identify, implement and strategically manage the entire spectrum of options. Specifically, you need programs that allow you to recruit, retain and reward your best employees, while lessening your HR department burden and carefully managing your employee benefits costs.

  Gallagher will prepare recommendations for your program, constantly monitoring their fit with your needs and company culture and making adjustments if required.

- *Ensure competitive market placement of health insurance and benefits packages with multiple vendors when necessary.*

  When it comes to representing City of Maryville to carriers, Gallagher has the experience, the relationships and the independence you need. We know the markets and we know their specific strengths. As a result, we can objectively evaluate carriers that offer the right products for your individual needs. Gallagher maintains complete independence to remain objective in providing the most qualified carriers, vendors, networks and risk arrangements for each unique negotiation.

- *Assist with the continual development and refinement of a long-term benefits strategy.*

  Your Gallagher team combines experience in developing and delivering innovative benefits strategies, compelling employee communications, time-saving administrative support and knowledgeable compliance and legislative services. Using Gallagher's benefits delivery process, we make sure every facet of your program aligns with your employee benefits strategy. With Gallagher as your partner, you can be certain that your needs will be fully served now and well into the future.

- *Advise of new developments, products, and trends within the employee benefit field on a national and local government level.*

  Keeping City of Maryville well informed is a top priority at Gallagher. We publish a series of newsletters and bulletins, in addition to regular seminars and webinars, to keep you up-to-date on benefit issues. Samples of these newsletters and bulletins can be found in the Exhibit Section.

- *Act as a liaison with insurance companies and managed care organizations, including the preparation, analysis, and presentation of claims and utilization information on a periodic basis.*

  Because data drives decisions at Gallagher and the advice we give to you, we have an in-house team of analysts, actuaries and clinicians to provide you with consulting and proprietary data warehousing. They use predictive models, health risk assessment tools, industry benchmarks and data from over 1,200 Gallagher client companies to give you a true understanding of the underlying issues that may be affecting the costs and performance of your benefits program.

- *Assist in the planning, staffing and execution of potential annual open enrollments and annual benefit fairs as well as disbursement, production and distribution of periodic information materials.*

  Two of your best opportunities to communicate how much you care about your employees' well-being coincide with two of the biggest jobs for your benefits administrative staff. Open enrollment and new hire orientation are key touchpoints for influencing the employee experience, so they call for a carefully considered strategic approach. Designing programs specifically for your workforce and culture will return the greatest value on the time, effort and financials you invest in these priorities.

  We can help you plan and carry out the most effective approaches to open enrollment and new hire orientation based on City of Maryville's unique communication style.

- *Act as a consumer advocate for employees as specific claim or administrative discrepancies arise.*

  Your Gallagher team will help City of Maryville design and implement an employee benefits program, and then manage the administration from the top down for the most effective outcome. Dedicated staff will oversee your program at a high level. We'll also step in on your behalf to ensure productive vendor and carrier interactions that both prevent and resolve issues.

  Your best interests will be well represented in all interactions with carriers and vendors, including negotiations and ongoing service. As your advocate and partner, Gallagher will help you resolve individual claim problems and get prompt answers to your questions about billing and plan provision interpretation. These issues will be handled directly with the service provider.

# Broker/Consultant Qualifications

*Please provide an overview of services and qualifications of your firm, including the following:*

- *Provide firm history and areas of expertise, particularly the employee benefits and consulting staff that will be directly serving the City of Maryville. Include how long the benefits consultant assigned to this account has been licensed.*

## Company History

Arthur J. Gallagher & Co. opened its doors for business in 1927 and is still "growing strong" because of a practiced ability to help clients think ahead. Founded by its namesake who was previously the leading producer for Chicago's largest insurance brokerage, Gallagher is now one of the world's largest insurance brokerage and risk management services firms. At year-end 2013 we had more than 16,000 employees, an increase of more than 19% from year-end 2012. We have operations in 25 countries, and extend our client-service capabilities to more than 140 countries through a global network of correspondent brokers and consultants.

Since 1961, we've been helping clients overcome business barriers and create new opportunities to cost-effectively attract, retain and productively engage the best performers in their field. Gallagher started trading on the NYSE under the symbol AJG in 1984.

Gallagher has maintained its steady growth through new business development and acquisitions. In recent years we acquired dozens of independent employee benefits consulting firms and allied service providers. This strategy continually adds some of the brightest minds in the employee benefits business to our talent pool, and serves clients through an expanding local office presence as well as our national and multinational practice and service groups.

As an industry-leading provider of employee benefits brokerage, consulting and administrative services with a strong growth record, we are well positioned to develop and administer programs that support a marketplace advantage for your organization.

## Company Culture and Philosophy

The ideals, principles and values embodied by the founder whose name still appears on our door are part of our corporate DNA. Gallagher's approach to business, cultivated through three generations of family leadership, has always centered on creating relationship value as true partners to our clients.

Gallagher's interactions with you will be straightforward and candid. By earning the trust of our clients, we've sustained a reputation for ethics and a commitment to transparency that continue to contribute to our growth. In fact, Gallagher was the first insurance broker named to the Ethisphere® Institute's annual list of the World's Most Ethical Companies in 2012 – and was again recognized in 2013 and 2014.

The high standards of conduct we've set for our external professional relationships are the same rules we follow internally. *The Gallagher Way*, a one-page document that outlines our 25 shared values, was

written in 1984 but is just as culturally relevant today. It speaks to the value of relationships and several tenets set guidelines for ethical behavior.

Today's complex marketplace requires a trusted partner who is committed to making a genuine difference in the health and welfare of both your valued employees and your bottom line. Gallagher combines innovative solutions, thoughtful advice and honest business practices to minimize risk and help fuel *your* growth.

## Mission and Values

Gallagher's mission is to:

- Build the best benefit services practice with brokers and consultants who understand the value of building relationships and trust, and creating experiences and results that inspire our clients' confidence;
- Provide superior, cost-effective benefit products and services that meet the ever-changing needs of employers, while striving for the highest professional excellence in the delivery of those solutions;
- Measurably help organizations manage and grow their businesses through our benefit services expertise and counsel.

Gallagher will accomplish this mission with the kind of leadership that maintains our philosophy and continues to strengthen our company culture. We will honor the moral and ethical standards that are inherent to building trust in all relationships, and clients' confidence in our ability to create and maintain a Gallagher team that is the very best at what we do.

## The Gallagher Way

*The Gallagher Way* is a one-page document, written by our former Chairman and CEO Robert E. Gallagher, which defines the Gallagher culture. It describes the principles, behaviors and beliefs that have produced great work – and great working relationships – at Gallagher since the company was founded. These 25 shared values guide business conduct for each of us as individuals, and all of us as a team. A copy of *The Gallagher Way* can be found in the Exhibit Section.

## Your Client Team

Putting together all of the pieces of the employee benefits program puzzle, from innovative plan design to solutions for addressing complex regulations, requires an experienced partner with the expertise to identify, implement and strategically manage the entire spectrum of options. Specifically, you need programs that allow you to recruit, retain and reward your best employees, while lessening your HR department burden and carefully managing your employee benefits costs.

Gallagher is in the business of removing barriers to practical insights and productive actions that can help employers develop and maintain a competitive employee benefits strategy. We are a caring partner and committed expert in the Public Sector industry.

Your Gallagher team combines experience in developing and delivering innovative benefits strategies, compelling employee communications, time-saving administrative support and knowledgeable compliance and legislative services. Using Gallagher's benefits delivery process, we make sure every facet of your program aligns with your employee benefits strategy. With Gallagher as your partner, you can be certain that your needs will be fully served now and well into the future.

## How We Work

It is critical that Gallagher gets to know City of Maryville through and through. We take the time to ask the right questions so that you can consider the right recommendations.

Your account team will explore how you have delivered your employee benefits in the past and will listen to understand your current and future goals. By fully addressing City of Maryville's challenges, benefit objectives and business goals, your consultants gain the insights they need to help you act strategically in the present to support your long-term success. This rigor allows us to apply the full benefit of our industry experience, including the Public Sector industry, to your situation.

Gallagher will then prepare recommendations for your program, constantly monitoring their fit with your needs and company culture and making adjustments if required. We will implement our mutually developed plan, completing outlined activities and meeting targeted objectives to optimize your total experience and outcomes.

Thorough project management leaves nothing to chance. So your Gallagher team will develop a calendar with specific actions and deadlines for your program's implementation, and constantly monitor and report on key milestones throughout the year. Meetings with City of Maryville will be run efficiently and effectively with tight agendas and expected outcomes. You can rely on our prompt follow-up after each meeting to recap key activities, identify next steps and assign accountabilities and timeframes for all work.

Communications are very important to a successful partnership. Your advisors are good listeners. Gallagher makes it a priority to understand how you prefer to work and communicate.

Making the transition as smooth and easy as possible for City of Maryville is our first priority. We value and will act on your feedback, and we'll also ask you to formally rate your experience by completing a report card.

## Your Gallagher Team

Your Gallagher team will be your local resource that puts the strength of our entire 2,500-person global benefits team to work for City of Maryville's employee benefits program. Areas of expertise include:

- Public Sector industry experience
- Experience with all types of benefit programs
- Strategic planning and consulting
- Carrier underwriting and negotiation
- Relationship management and executive presentations

- Employee communication programs for Public Sector organizations
- Compliance and regulatory support
- Human Resource department systems and processes
- Market research and statistical reporting
- Third party administration and ancillary services
- Wellness programs

## Senior Benefit Consultant

Your Gallagher team is led by Senior Benefit Consultant Mike Keller. Mike has years of experience and in-depth knowledge of employee benefits and industry trends. He excels in structuring plans, conducting program analysis and meeting client objectives. Mike is also responsible for the team and is charged with ensuring resources are available at all times to meet your needs.

## Benefit Consultants

Sally McHugh and Kylie Hurtig will implement City of Maryville's strategic timeline and coordinate other Team Members to provide additional expertise in specific areas. Sally and Kylie each have over ten years experience in providing services to clients according to their needs.

## Account Manager

Shelly Wilson will manage all aspects of City of Maryville's program and will be your daily contact whenever you need help. She is an expert in administering benefit plans, including employee communications, analysis and reporting, carrier negotiations and problem solving.

## Account Coordinator

As an Account Coordinator with GBS, Ofelia Mayorga will be responsible for day to day assistance with City of Maryville's claim issues and routine administrative functions related to your employee benefit plans. Internally, Ofelia helps the team with preparation of deliverables used for marketing and presentations, maintaining complete and accurate client files.

## Wellness Consultant

Amanda Schuster's primary focus as Wellness Consultant will be to assist and support City of Maryville with wellness initiatives by acting as a wellness resource and liaison. Amanda will help to design, implement, and evaluate City of Maryville's wellness programs.

## Specialized Support

Complementing your local Gallagher team are our corporate and regional industry experts who provide specialized client support. They monitor and communicate on legislative and compliance issues, provide actuarial support and analysis, and audit plan performance, systems and tools. Their integrated efforts help you manage your benefit plans and costs based on the latest trends, research and carrier information.

Together, these Gallagher professionals will provide City of Maryville an unsurpassed client experience and the most competitive employee benefits plan possible.

Attached in the Exhibit Section are bios of your Gallagher Team.

- *Please provide references including direct contact information for three similar clients.*

City of Atchison, Kansas
Trey Cocking, City Manager
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City of Paola, Kansas
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City of Valley Center, Kansas
Kristine Polian, City Clerk
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Valley Center, KS 67147
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316-755-7310

- *Provide a detailed list of "value added" services your organization provides to its clients such as Wellness Programs, facilitation of employee meetings, benefits guides and newsletters. Please specify if any additional fees are associated.*

The ability to deliver comprehensively structured compensation and employee benefits solutions to clients is Gallagher's signature in the marketplace. Often, those clients also cite their experience of that delivery – the way we do business together.

Services include program design and delivery, administration, and ongoing analysis and evaluation that keep your programs calibrated with your expectations. Our areas of expertise are Health & Welfare, Healthcare Analytics, Human Resources & Compensation, Institutional Investment & Fiduciary Advisors, Multinational Benefits & Human Resources, Retirement Plan and Voluntary Benefits.

At Gallagher, we want to know what makes your organization unlike anyone else's. Your account team listens intently to learn about your business, and delves deeply into all the details that matter when balancing employee satisfaction with your bottom line. This single-minded focus on excellence – characterized by innovation and creativity – is the driving force behind every Gallagher customized employee benefits program.

Support comes from every direction. Besides your core Gallagher team, you'll have access to the specialized knowledge that innovative custom solutions require. Our professionals have years of employee benefits services experience, including specialized expertise in Municipalities, and thoroughly understand the complex financial, legal and culture issues that weigh on your benefits decisions. Gallagher has 28 dedicated compliance professionals averaging more than a decade of benefits compliance experience, and 19 of them are licensed attorneys.

Gallagher acts on your best interests in the near term, helping you break through business barriers to develop long-term strategies that support growth, reduce risk and strengthen your organization.

## Health & Welfare Consulting

What's your strategy for making sure your organization is as healthy, sustainable and competitive as it can be in this historic era of change? One of the best competitive moves you can make is to invest in the health and welfare of your organization, your employee culture and your workforce.

Gallagher's Health & Welfare Consulting team can help City of Maryville manage change and simplify workforce planning with a strategic, innovative approach to benefits and compensation rewards. We will partner with you to design, implement and manage a cost-effective benefits program plan that's structured to reduce costs, improve workforce productivity, educate employees, mitigate risk and help you attract, develop and engage top talent.

Holistically designed solutions create a big-picture benefits program that is fairly priced, competitive within your industry and region, and aligned with City of Maryville's operational goals and budget. Your reward will be healthier employees, more efficient processes and workflows, improved recruiting and retention and more effective compliance strategies.

Gallagher also strengthens City of Maryville with:

- Innovative services and solutions for private exchanges, benefit stop-loss captives, data warehousing, workforce evaluation tools and other needs;
- Communications for an informed workforce that understands the value of the benefits and compensation you provide;
- Customized strategies to control the costs of claims, liability, noncompliance and data security;
- Expert data analysis, interpretation and forecasting to improve budgeting and decision making;
- Risk management and wellness strategies that resonate with employees and foster a culture of health and wellness;
- A full range of pharmacy benefit management consulting services that help control your overall health plan costs.

Local, regional, and national professionals apply the most updated knowledge on:

- Medical plans including consumer-driven health plans, health savings accounts and health risk assessment/wellness programs;
- Life insurance and accidental death and dismemberment coverage;
- Long-term and short-term disability;
- Voluntary and worksite benefits.

The many specialized services available to City of Maryville's HR department are:

- Compliance consulting to meet your regulatory obligations, including compliance newsletters, alerts and seminars on FMLA, COBRA, HIPAA, ERISA and cafeteria plan rules;
- Benchmarking for plan competitiveness and cost-effectiveness;
- Online benefits administration;
- Custom wellness and productivity programs;
- Online communication solutions;
- Pharmacy consulting to best manage your prescription drug program;
- Retiree healthcare to help your organization cope with rising retiree health costs and the aging of our population.

At Gallagher, our teams specialize in disciplines including analytics, finance, compliance, governance, wellness, risk management and retirement. Each practice team brings industry-focused knowledge and expertise to energy, healthcare, higher education, public sector, hospitality and restaurant, private equity, religious and nonprofit and other organizations. They are uniquely qualified to assess your needs, provide guidance and help ensure that your benefits decisions align with your competitive objectives.

With the resources of a global partner and the customer focus of a dedicated team, City of Maryville can foster a culture of health and well-being and create an organization that's ready to seize opportunities, compete with confidence and thrive.

## Human Resources & Compensation

What's your strategy to put the right talent in the right positions? How does your total rewards program drive employee engagement – and how does it compare to your competitors' offerings? With Gallagher's Human Resources & Compensation Consulting team, you will have a partner who understands the important, strategic role of human resources and can customize a solution that will help City of Maryville focus on – and achieve – meaningful business outcomes.

Your Gallagher team will dig deep to help you pinpoint the root causes of problems. In-depth audits and industry surveys help you see the big picture, so you understand the business effects of human resources and how City of Maryville's HR practices compare to your industry peers. Our consultants will combine these insights with intellectual capital and years of practical experience to create unique solutions – from employee and executive compensation to benefits administration, and the design and development of policies and procedures.

Through a practice dedicated to human resources and compensation, we can provide flexible, customized solutions informed by data analysis and competitive benchmarking. The focus is on bringing our broad-based knowledge and cross-industry experience to bear on your problems and opportunities – so you can see them from all sides.

We can strengthen City of Maryville with:

- A holistic approach to customized human resources solutions that support long-range corporate strategies and goals;
- Broad-based compensation assistance including research, analysis and strategic recommendations for pay plan, incentive and sales compensation design;
- Executive compensation program design to balance base salary, incentives and perquisites;
- Support for HR teams – administration, program design and implementation of all HR activities;
- Customized salary and benefit surveys by Gallagher Surveys.

Your Gallagher consultant will guide you every step of the way through our consultative process with transparent, open dialogue. Your solution will make sense for your organization, your timetable and your budget, and will take a holistic approach that can bring meaningful change, sustainable growth and a competitive edge to City of Maryville.

## Retirement Plan Consulting

Are you offering retirement plans that help your employees while meeting your organization's objectives? As your partner who is part financial expert, part strategist, part analyst and part communicator, Gallagher can help City of Maryville satisfy your fiduciary obligations as plan sponsor and fully understand your liabilities.

The goal of retirement plans and programs should be overall financial wellness for City of Maryville and your employees. Gallagher will create a well-planned retirement strategy for your organization based on a big-picture view of the future, a deep understanding of the retirement plan environment and an informed perspective. Our consultants address all aspects of employee retirement plans, investments, legislation, compliance, cost control, reporting requirements, ethics and other factors.

City of Maryville will have access to Gallagher's national resources and the personal touch of on-the-ground teams who understand local cultures and demographics. We'll provide comprehensive plan and investment consulting solutions including 401(k), 403(b), profit sharing and defined benefit that help secure your employees' financial health. And since we're not provider-aligned, guidance will come from consultants you know, and research and market insights that are customized for City of Maryville's industry or niche. We will help you improve your plan and manage your vendor relationships.

Gallagher strengthens City of Maryville with:

- Partnership and consultation to help you mitigate risk and avoid conflicts of interest;
- A communications strategy to help employees clearly understand their retirement plan options, responsibilities and liabilities;
- A retirement program that aligns with your corporate objectives while helping employees meet their individual goals.

With our well-planned fiduciary management process and hands-on, consultative approach, Gallagher can mitigate your risk as a plan sponsor, prepare your workforce for retirement and improve confidence across City of Maryville's organization.

## Voluntary Benefits

At Gallagher, we believe that a one-size-fits-all approach to employee benefits is not in the best interest of City of Maryville or your employees. A more effective strategy for the long-term success of your organization is to offer a wide selection of voluntary benefits. Options such as life, disability and critical illness insurance often determine how employees rate their program and their employer.

Results of the Gallagher 2013 Benefits Strategy and Benchmarking Survey of nearly 1,000 U.S. organizations showed that voluntary benefits continue to increase in popularity and provide value to employers in all industries and demographics. Two of the most popular benefits among participants were accidental death and dismemberment offered by over 75% of survey participants, and a stand-alone vision plan offered by almost 70% of respondents.

Gallagher will help you craft the ideal set of voluntary options to help City of Maryville compete effectively for the right employees. Through single-source planning, record keeping and project management, we'll also support your overworked HR staff.

Your Voluntary Benefits team will start with a thorough analysis which determines the standard in your industry, what is missing from your benefits package and your long-term strategy for attracting and retaining employees. Our planning and evaluation models look three to five years out, so we can help

City of Maryville build a voluntary benefits program that provides immediate results as well as a foundation for growth.

Clear communications are important at every step with everyone from the C-suite to new hires. Our team will help City of Maryville educate your workforce about the value of their benefits and make sure they know how to enroll.

Gallagher's enrollment processes are continuously measured, tested and refined to simplify the experience for your HR staff and employees. The focus is on ensuring City of Maryville's employees can make fully informed decisions whether they are evaluating their benefits package, considering a wellness program or navigating changes in their benefits due to healthcare reform policies. Clarity through education and communications can lead to increased participation in your benefits program and greater employee satisfaction.

Voluntary benefits will provide your employees a choice of benefits that are most important to them without your incurring additional costs for your organization. Your Gallagher team will work with City of Maryville to identify and implement benefit options that increase employee job satisfaction, improve retention, boost productivity, enhance recruiting and ultimately, help differentiate your business as an employer-of-choice.

## Wellness and Productivity Strategies

Improving the health and well-being of City of Maryville's employees is good business. Sound, healthy employees are better employees who are more engaged, productive and reliable. A successful wellness program can also help your organization contain costs. Gallagher's model combines strategies and tactics for health promotion, risk identification, risk stratification, lifestyle programs, clinical programs and access to care.

Gallagher is experienced in helping our clients successfully implement wellness strategies and programs. We will use data to drive decisions, analyzing City of Maryville's medical and pharmaceutical data to identify hidden program costs. Predictive modeling provides insights into future costs. This data will be compared to an in-depth analysis of your current workforce demographics, and the results will speak to the alignment between your financial outcomes, plan design and employee composition.

Taking a look at employees' overall well-being, we integrate five elements of health including physical, emotional, financial, career and community. With your goals in mind, and a focus on executing to your plan and measuring results over time, Gallagher will:

- Assess current wellness programs and make recommendations on how to expand and improve them to create a culture of health and productivity;
- Develop multi-year health and productivity strategies and budgets to achieve measurable health and productivity gains;
- Create and implement data-driven health and productivity-based programs that support and enhance your organization's multi-year health strategy;

- Identify health and productivity programs that will be put out to bid: conduct RFPs, select wellness partners, and negotiate and outline the scope of work along with pricing;
- Assist in developing incentive programs tied to current or future health and productivity programs that will increase participation, engage employees and encourage behavioral change.

Gallagher will also manage all facets of your wellness program to make sure that all components are aligned, including vendor and community partners, so that you maintain the integrity of the program and achieve program goals.

- *Describe your employee communication capabilities and provide samples.*

It is imperative that City of Maryville's employees clearly understand your benefits program and the role it plays as a part of their total compensation package. Employees who have a greater understanding of their benefits program will value it more and will be more likely to stay with their organization. A strong communications program is also very important in a competitive recruiting environment.

Your communications strategy will address the cost drivers specific to your plan and adhere to City of Maryville's cultural and financial constraints. At the same time, it will provide your employees with a competitive benefits program that they highly value. This dynamic approach allows you to validate and define an effective long-term benefits strategy by aligning employer and employee needs.

In addition to employee communications strategy development, Gallagher's communications services, resources and technology solutions include:

- Open enrollment and new hire orientation materials
- Employee education programs and websites
- Employee Benefit Guides
- Total compensation and benefits statements
- Employee newsletters
- Benefits confirmation statements
- Employee communication sites
- Employee satisfaction surveys

Within Gallagher, you have the expertise and the commitment required to communicate a straightforward, compelling message about the value of City of Maryville's benefits program.

## Web-based Employee Communications

Employees don't always want to wait for a busy HR staff to respond to requests and questions about their benefits coverage. Increasingly, they expect access to benefits information at any time and from any place. Gallagher can help City of Maryville reduce the burden on your HR administrative team and respond to your employees' needs through online, 24/7 access to benefits information and resources.

Through relationships with leading technology companies, we will connect you with online communications, administrative services and tools, and enrollment solutions that can help you and your employees fulfill benefits needs more efficiently and effectively.

### Employee Benefit and Total Compensation Statements

Well-informed employees are more satisfied employees, which is why it's important for City of Maryville to make employees aware of all the employee benefits they receive.

Following your open enrollment period, Gallagher will provide a personalized annual benefits statement to each of your employees that presents the exact details of their benefits. We'll also provide total compensation statements, also known as hidden paychecks, to show the monetary value of these benefits. Improving your employees' understanding of the value of their total benefits and compensation package can help increase retention, strengthen recruiting results and position City of Maryville as an employer of choice.

- *How does your firm stay current with state and federal regulations?*

### Legislative and Corporate Compliance Support

Gallagher's compliance practice has a national canvas with a regional and local focus. Our 27 dedicated experts, 17 of whom are licensed attorneys, average more than a decade of benefits compliance experience. These experienced professionals monitor legislative initiatives, regulatory developments, court cases and industry changes, and analyze their impact on City of Maryville's employee benefit plans. These resources will assure that we apply our understanding of the latest developments to help you manage your benefits program.

Gallagher will help City of Maryville comply with state and federal laws and regulations. Our experts will evaluate the design of your benefit plans and review relevant documents such as summary plan descriptions, insurance contracts and your employee benefit communications. Gallagher will help you identify potential problem areas and conduct a year-end review using our proprietary tools and resources to make certain that your benefit plans are in compliance with COBRA, ERISA, FMLA, HIPAA, cafeteria plan rules, healthcare reform and all other relevant laws and regulations.

Keeping City of Maryville well informed is a top priority at Gallagher. We publish a series of newsletters and bulletins, in addition to regular seminars and webinars, to keep you up-to-date on benefit issues. They include:

- **Healthcare Reform Update** – a monthly publication written by our own compliance experts on the latest healthcare reform developments and their potential impact on employers
- **GBS Directions** – a monthly publication featuring general interest articles on employee benefits and human resources
- **Technical Bulletin** – detailed white papers on proposed or new legislation

Samples of these newsletters and bulletins are attached in the Exhibit Section.

It is understood and agreed that any such services provided by Gallagher shall not constitute the practice of law.

- *Describe your firms approach to provide the services specified in this RFQ. Specifically address areas of negotiating and managing health care costs, plan administration, maintaining legislative compliance, and developing a long-range benefits strategy.*

## Plan Design and Analysis

Your Gallagher team will always begin with your needs in mind. They will work with City of Maryville to fully understand your employee benefit strategies and priorities, including cost containment, employee satisfaction and engagement, industry competitiveness, your benefits philosophy and other concerns.

With experience with Municipalities, we know what's typical in your industry and can help you gain or maintain a competitive advantage. We also know that the right combination of benefits can differ within an organization, and will develop plans that meet the needs of your employees at all levels.

If you're interested in controlling costs with new concepts, ideas, and trends in health plans, we'll help you explore your options. Gallagher has designed and implemented several types of consumer-driven plans. Through our liaison with Bright Choices, one of the options we offer is Gallagher Marketplace, a private exchange with a defined contribution model. City of Maryville might also benefit from taking a look at plan funding, stop loss levels, administration, developing and measuring wellness programs, coordinating dependent audits, evaluating pharmacy benefits management programs and other mechanisms.

One of Gallagher's key competitive strengths is the ability to provide clients with an in-depth analysis of benefit-related issues.

## Plan Marketing and Procurement

When it comes to representing City of Maryville to carriers, Gallagher has the experience, the relationships and the independence you need. We know the markets and we know their specific strengths. As a result, we can objectively evaluate carriers that offer the right products for your individual needs. Gallagher maintains complete independence to remain objective in providing the most qualified carriers, vendors, networks and risk arrangements for each unique negotiation.

Your Gallagher team will leverage our extensive experience in handling renewals and open enrollments. We'll manage every detail of the marketing process, including:

- Strategic development to identify goals, analyze program costs, and review current and alternative funding arrangements;
- Management of the renewal with the current carrier geared to achieving lower costs;

- Recommendation on exploring alternatives to your current carrier;
- Renewal timeline that covers every aspect from Request for Proposal (RFP) preparation to the delivery of employee communications;
- RFP development that involves tailoring the RFP to the exact desires, needs, and financial directions provided by City of Maryville management;
- Exploration of funding alternatives;
- Evaluation of vendor responses to identify variations in coverage and cost;
- Conduct finalist interviews to explore intangibles, such as personalities, service orientation and responsiveness;
- Renewal analysis report, covering program, and claims cost projections as well as complete information on benefit designs;
- Finalize decisions involving close collaboration with the Gallagher team and City of Maryville's HR management and executives.

We don't stop here. After your employee benefits program is in place, Gallagher will proactively take the lead in monitoring the program's performance and work to resolve any issues that may arise, such as coverage disputes, billing issues, or service problems.

## Vendor Management

Proper vendor management begins with the selection of the right partner for City of Maryville's employee benefits program. Gallagher interacts with vendors to truly understand their capabilities and offerings. You can be confident we'll recommend only those companies whose products and services combine the broadest and most effective range of options at a fair value. Gallagher has the experience, the relationships and the independence you need to get the most effective combination of rates, policy terms and plan design.

Your Gallagher team will negotiate performance guarantees with each selected vendor. We'll also meet with them on a periodic, scheduled basis to review their performance against these standards and resolve any issues. During our regular meetings with you, vendor management will always be included on the agenda.

To make sure the best interests of City of Maryville are represented in all interactions with vendors, Gallagher will handle all ongoing service in addition to negotiations. This includes support and training for your staff on how to work effectively with your selected vendors. We'll coordinate all of your open enrollment activities and support all of your communication needs.

The financial stability of Gallagher-recommended vendors is also very important in the selection process. We closely monitor vendors' financial status throughout the year and quickly communicate if a potential change might impact your program.

## Open Enrollment and New Hire Orientation

Two of your best opportunities to communicate how much you care about your employees' well-being coincide with two of the biggest jobs for your benefits administrative staff. Open enrollment and new hire orientation are key touch points for influencing the employee experience, so they call for a carefully

considered strategic approach. Designing programs specifically for your workforce and culture will return the greatest value on the time, effort and financials you invest in these priorities.

We can help you plan and carry out the most effective approaches to open enrollment and new hire orientation based on City of Maryville's unique communication style, including:

- Enrollment strategy
- Customized communications such as announcement letters, letters from your City Manager, enrollment forms, open enrollment brochures, posters, articles for your internal newsletter and intranet, electronic information, payroll stuffers and other vehicles
- Customized presentation of open enrollment programs
- Open enrollment meetings
- Employee health fairs

To deliver the most impact through your communications, Gallagher continually researches and applies industry best practices. City of Maryville will have dedicated in-house communications professionals supporting this effort. The services of Gallagher's corporate graphics department, which is highly experienced in benefits enrollment communications design, are at their disposal.

You can also automate your open enrollment and new employee orientation, optimizing the experience for your employees by giving them 24/7 access to answers for their questions. These services are provided by one of Gallagher's preferred vendors.

## Employee Education

Employee benefit programs can be confusing to even the most knowledgeable of City of Maryville employees. However, higher employee satisfaction and lower claims experience can be directly linked to your employees' understanding of your benefit programs.

Gallagher will offer City of Maryville a complete set of online tools for employee education and plan management, such as benefit portals, total compensation statement software and an automated form population module. In addition, our integrated eligibility management platform provides an ideal foundation for coordinating online enrollment tools if you decide to implement this option. We'll also help you evaluate the most current enrollment tools and techniques.

## Flexible Spending Account (Section 125 Plan) Administration

Flexible spending accounts provide your employees with added flexibility in managing their healthcare costs and are a component of a top-quality benefits program. Gallagher can administer all aspects of these plans, including structuring, compliance management and employee communications.

## COBRA Administration

Handling the medical coverage of former employees can be time-consuming. Gallagher can manage all aspects of City of Maryville's COBRA enrollment, monitoring and billing, and ensure compliance with all federal regulations.

## Transition to Gallagher

Gallagher assures City of Maryville an employee benefits plan transition that causes no disruptions to your HR staff or employees, and maintains employee confidence in your program. Our methodology has successfully transitioned thousands of plans over the years.

The process features a dedicated transition team expert in plan design, employee communications, carrier negotiations and customer service. First, your Gallagher team will present City of Maryville's HR management with a detailed transition plan including delivery dates and accountabilities. As the process is completed, regular meetings and status reports will keep you informed and confident that any issues will be identified and rectified before they become problematic.

## Fees and Commissions

Annually, City of Maryville will receive a full disclosure of all commissions and fees paid to Gallagher during the specific plan year.

Gallagher may be compensated through direct fees or insurance company commissions, including supplemental and contingent commissions, or a combination of sources. Each client makes that choice based on philosophical and budget considerations.

Direct consulting fees include compensation to Gallagher paid directly by the plan sponsor. Indirect fees are defined as compensation to Gallagher paid by a third party and include, among other things, the payment of "finders' fees" or other fees to Gallagher for a transaction or service involving the plan.

Commissions include all commissions and fees paid to Gallagher that can be attributed to a contract or policy between a plan and an insurance company, or an insurance service. A supplemental commission is a commission paid by an insurance carrier that is above the base commission paid. The insurance carrier determines the supplemental commission that is eligible to be paid annually based on historical performance criteria in advance of the contractual period. A contingent commission is a commission paid by an insurance carrier based on the overall profit and/or the overall volume of business placed with that insurance carrier during a particular calendar year. This type of commission is determined after the contractual period.

All revenue received directly or indirectly that is related to services or products provided to City of Maryville, or placed on your organization's behalf, must be disclosed to City of Maryville. This requirement applies to ERISA and non-ERISA plans.

Disclosure is done through the Client Coverage Acknowledgement Form or the Brokerage Service Agreement. Accurate, timely disclosure is a required component of Gallagher business operations. A sample of the Client Coverage Acknowledgement Form is attached in the Exhibit Section

- *Describe any other facets of your firm and experience that are relevant to the proposal which have not been previously described that you feel warrant consideration.*

While all businesses have many of the same employee benefits needs, each industry has its own particular challenges in providing its employees the right set of benefit options. For instance, standard work hours might differ from industry to industry, so enrollment and communications challenges will vary. Also, certain laws or regulations may impact one industry and not another. At Gallagher, we have understood the need for specialized services that address these differences since 1927.

Budgeting for the public sector is a complex process with multiple stakeholder groups and the need to factor the changing regulatory landscape, including healthcare reform. With over 1,750 public entity and school clients, Gallagher's Public Sector Practice is solely dedicated to serving the needs of public employers and school districts. City of Maryville will have a partner who is a national leader in working with states, counties, cities, government employers and K-12 public schools and special education districts.

The public sector practitioners at Gallagher, led by a full-time practice leader, have spent years understanding and providing for the nuances of your industry. We actively participate in the community, including organizations such as ASBO, PRIMA, GFOA and NPELRA, so we know the market, the players, the legislation and the cost factors.

As a provider of services to the public, we understand that City of Maryville faces unique challenges. Your organization is exempt from certain laws and governed by others that may allow for flexibility and cost efficiency. Tax revenue streams and other sources that are subject to change drive the design and financing of your employee compensation and benefit programs. Also, in many cases, City of Maryville's decisions are affected by collective bargaining agreements and intense public scrutiny.

Your Gallagher team takes these factors into consideration. We bring a broad range of public sector-focused solutions and expertise such as collective purchasing, benchmarking data and healthcare utilization review and analysis. With our industry specialization and large number of public entity and scholastic clients, you have instant access to industry benchmarks through your consultants.

Gallagher will strengthen City of Maryville with:

- Guidance throughout the bargaining process and recommendations on best practices moving forward
- Communication with employees so they understand the value of their benefits package
- Deep understanding of compliance and legal issues, including healthcare reform and labor laws
- Collaborative communication with key stakeholders to build consensus and resolve issues

As a partner to City of Maryville, Gallagher will create a total compensation program that aligns your financial realities with employee expectations and your organization's goals. We'll help you clear away the barriers presented by complex issues and serve the public in a fiscally responsible way — now and well into the future.

# Affidavit of Work Authorization

# AFFIDAVIT OF WORK AUTHORIZATION

Comes now Gary Hardman (NAME) as Area Vice-President (OFFICE HELD) first being duly sworn on my oath, affirm Gallagher Benefit Services, Inc. (COMPANY NAME) is enrolled and will continue to participate in a federal work authorization program in respect to employees that will work in connection with the contracted services related to Benefits Broker RFQ (BID/SFS NUMBER) for the duration of the contract, if awarded in accordance with RSMo Chapter 285.530 (2). I also affirm that Gallagher Benefit Services, Inc. (COMPANY NAME) does not and will not knowingly employ a person who is an unauthorized alien in connection with the contracted services related to Benefits Broker RFQ _____ (BID/SFS NUMBER) for the duration of the contract, if awarded.

***In Affirmation thereof, the facts stated above are true and correct (The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo).***

Signature (person with authority) — Gary Hardman (Printed Name)

Area Vice-President (Title) — August 18, 2014 (Date)

Subscribed and sworn to before me this 18th (DAY) of August, 2014 (MONTH, YEAR). I am commissioned as a notary public within the County of Sedgwick (NAME OF COUNTY), State of Kansas (NAME OF STATE), and my commission expires on 9.28.16 (DATE).

Michelle Harpenau — Signature of Notary

8.18.14 — Date

MICHELLE HARPENAU
Notary Public, State of Kansas
My Appointment Expires
9.28.16

# Privacy Policy

The Benefits & Human Resources Consulting Division of Arthur J. Gallagher & Co., Gallagher Benefit Services, Inc. (Gallagher), treats City of Maryville's personal privacy with care and respect. We do not disclose a client's nonpublic personal, financial and health information to third parties, except for the purposes of placing your insurance coverage(s) and as otherwise permitted by law.

Gallagher has always been mindful of our clients' privacy. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to guard your nonpublic personal, financial and health information, and that of your employees.

Applicable law requires Gallagher to provide our clients with a copy of our Privacy Policy, which is included with this proposal. This policy does not apply to our efforts to market our products and services to City of Maryville, so you may receive information from us about products that may suit your needs.

A copy of our Privacy Policy is attached in the Exhibit Section.

# Conclusion

Thank you for the opportunity to provide City of Maryville with this response to your proposal request.

Gallagher uniquely combines specialized, locally available employee benefits expertise with global resources to help you break through business barriers that arise from complex regulatory, legislative, financial and organizational issues. We'll be your expert, advocate and guide in developing and managing holistic, cost-effective benefit and compensation solutions as your needs and goals change in an evolving marketplace.

Recognizing that the decisions you make will affect the health and welfare of your employees and their families, we're committed to helping you balance an engaged workforce with a healthy bottom line. We look forward to partnering with you to create an employee benefits program that firmly positions City of Maryville as an employer-of-choice and strengthens your growth potential.

# Disclosure

Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc., a non-investment firm and wholly owned subsidiary of Arthur J. Gallagher & Co., is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Securities and Investment Advisory Services may be offered by GBS Retirement Services, Inc. and executed through NFP Securities, Inc., Member FINRA/SIPC. Investment advisory services and corresponding named fiduciary services may also be offered through Gallagher Fiduciary Advisors, LLC, a Registered Investment Adviser. Gallagher Fiduciary Advisors, LLC is a single-member, limited-liability company, with Gallagher Benefit Services, Inc. as its single member. Not all individuals of Gallagher and none of Gallagher Fiduciary Advisors, LLC individuals are registered to offer securities or investment advisory services through NFP Securities, Inc. NFP Securities, Inc. is not affiliated with Arthur J. Gallagher & Co., Gallagher Benefit Services, Inc. or Gallagher Fiduciary Advisors, LLC. Neither Arthur J. Gallagher & Co., NFP Securities, Inc., nor their affiliates provide accounting, legal, or tax advice.

# Exhibits

- The Gallagher Way
- Team Bios
- Newsletters and Bulletins
- Compensation Disclosure
- Privacy Policy
- Sample Employee Benefit Guide
- City of Maryville Pathway

Arthur J. Gallagher & Co.

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Arthur J. Gallagher & Co.

# The Gallagher Way

Shared values at Arthur J. Gallagher & Co. are the rock foundation of the Company and our Culture. What is a Shared Value? These are concepts that the vast majority of the movers and shakers in the Company passionately adhere to. What are some of Arthur J. Gallagher & Co.'s Shared Values?

1. We are a Sales and Marketing Company dedicated to providing excellence in Risk Management Services to our clients.
2. We support one another. We believe in one another. We acknowledge and respect the ability of one another.
3. We push for professional excellence.
4. We can all improve and learn from one another.
5. There are no second-class citizens—everyone is important and everyone's job is important.
6. We're an open society.
7. Empathy for the other person is not a weakness.
8. Suspicion breeds more suspicion. To trust and be trusted is vital.
9. Leaders need followers. How leaders treat followers has a direct impact on the effectiveness of the leader.
10. Interpersonal business relationships should be built.
11. We all need one another. We are all cogs in a wheel.
12. No department or person is an island.
13. Professional courtesy is expected.
14. Never ask someone to do something you wouldn't do yourself.
15. I consider myself support for our Sales and Marketing. We can't make things happen without each other. We are a team.
16. Loyalty and respect are earned—not dictated.
17. Fear is a turnoff.
18. People skills are very important at Arthur J. Gallagher & Co.
19. We're a very competitive and aggressive Company.
20. We run to problems—not away from them.
21. We adhere to the highest standards of moral and ethical behavior.
22. People work harder and are more effective when they're turned on—not turned off.
23. We are a warm, close Company. This is a strength—not a weakness.
24. We must continue building a professional Company—together—as a team.
25. Shared values can be altered with circumstances—but carefully and with tact and consideration for one another's needs.

When accepted Shared Values are changed or challenged, the emotional impact and negative feelings can damage the Company.

*– Robert E. Gallagher*
*May 1984*

# Michael Keller

Benefit Consultant, GBS Wichita

316.977.9790 direct
316.393.5531 cell
Michael_Keller@ajg.com

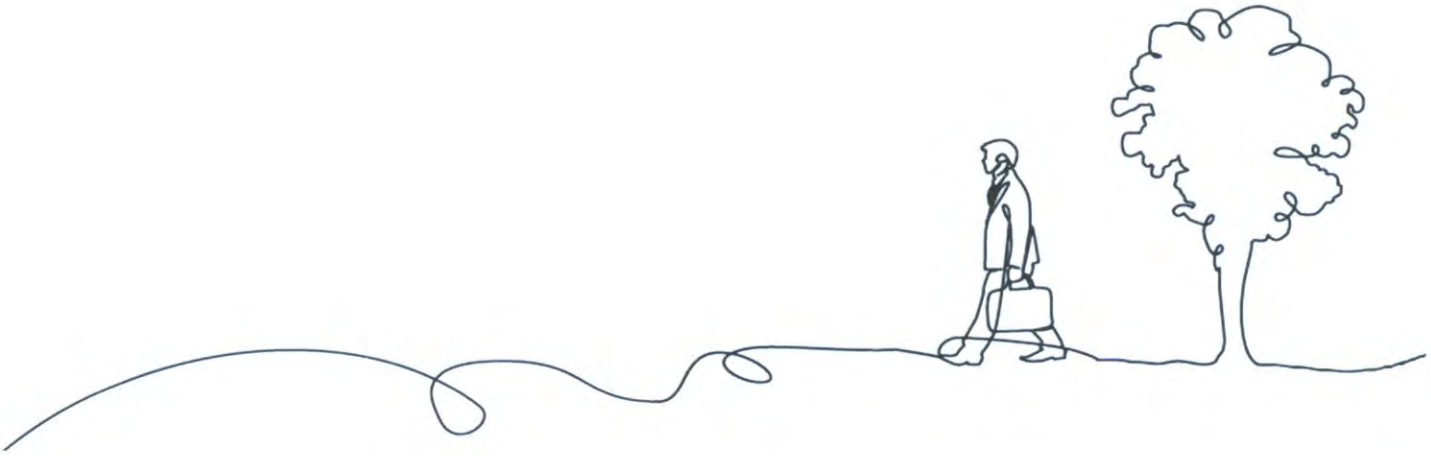
Mike was raised in Wichita and is a graduate of Kapaun Mt. Carmel High School. He earned a Bachelor of Science degree in Business Administration from the University of Kansas. He was a partner in a franchise pizza restaurant for 6 years following college. Mike gained valuable knowledge during this time in the areas of human resources, payroll, sales, marketing, accounting and service.

He has spent the last eight years as a Health & Welfare Plan consultant serving his clients. Mike understands the challenges employers face and works with his clients to create innovative solutions to those challenges.

Mike is a past president of the Wichita Association of Health Underwriters, on the board of directors of Wichita Crime Commission and a member of Church of the Magdalen.

Mike lives in Wichita with his wife and four boys, ages 6, 4, 2 and 4 months. He enjoys spending time with family, golf and hunting.

*"We are a warm close Company. This is a strength – not a weakness."*
*- Tenet 23*



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# Sally McHugh

Benefit Consultant, GBS Wichita

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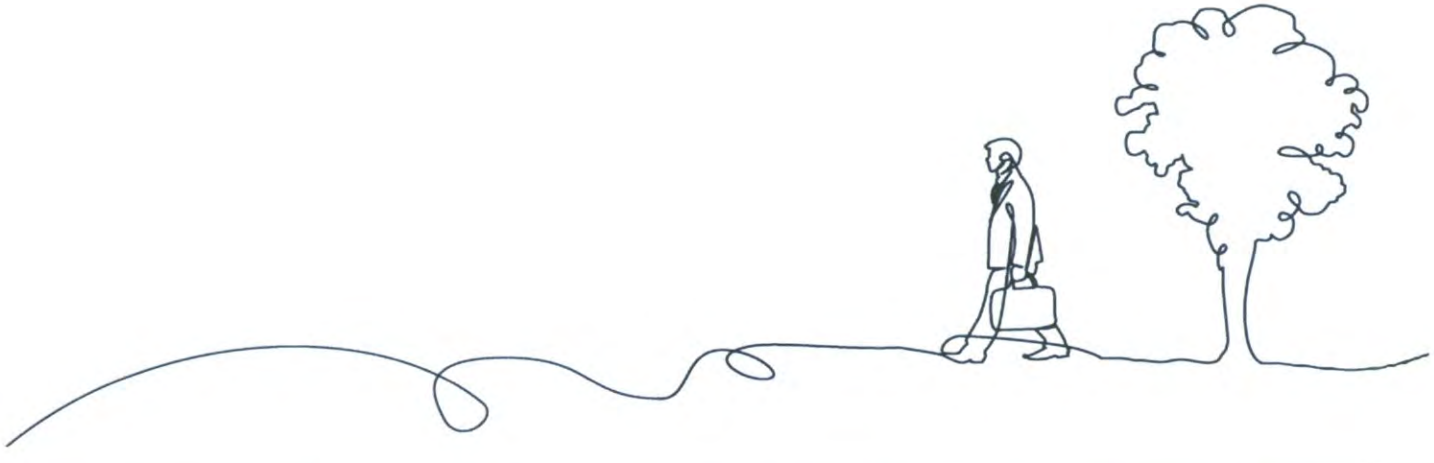
sally_mcHugh@ajg.com

Sally began her career in the insurance industry at BCBS of Rhode Island in February of 2000 as a Workers' Comp Specialist and then later as a Group Consultant in Sales & Marketing at BCBS of Kansas for several years. Sally joined the Gallagher Benefit Services Wichita team in April 2014 in Benefit Consulting.

As a Benefit Consultant for GBS, Sally will produce revenue through sales to new and existing clients with emphasis on mid-size companies. She will deliver a full range of insurance and risk management products and services. As well as providing services to clients according to their needs and retain them as clients.

Sally received her Bachelor's degree in Business Administration with a focus in Marketing at Wichita State University. She currently lives in Wichita with her husband, two kids, and dogs. In her free time, she enjoys watching her son play high school football, reading, exercise, and spending time with friends and family.

*"We run to problems – not away from them."*
*- Tenet 20*



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# Kylie Hurtig

Benefit Consultant, GBS Wichita

Kylie joined Arthur J. Gallagher Co. in April 2014 as a Benefit Consultant. She began her employee benefits career in 2004 at Blue Cross and Blue Shield of Kansas where she worked in claims processing for 2 years before transferring to Marketing where she worked with both large and small employers, selling and retaining business as a Group Sales Consultant in the Wichita, Kansas area.

Kylie is a graduate of Wichita State University with a Bachelor of Arts degree in International Business, with a minor in French. She lives in Wichita with her husband Chris and their 2 children. Kylie is involved in many community organizations including the United Way of the Plains Allocation Committee, American Red Cross, and the Greater Wichita YMCA where she serves as the board Chair for the Child Care & Camp Branch. In her free time, Kylie enjoys shopping, watching movies, boating, and hanging out with friends and family.

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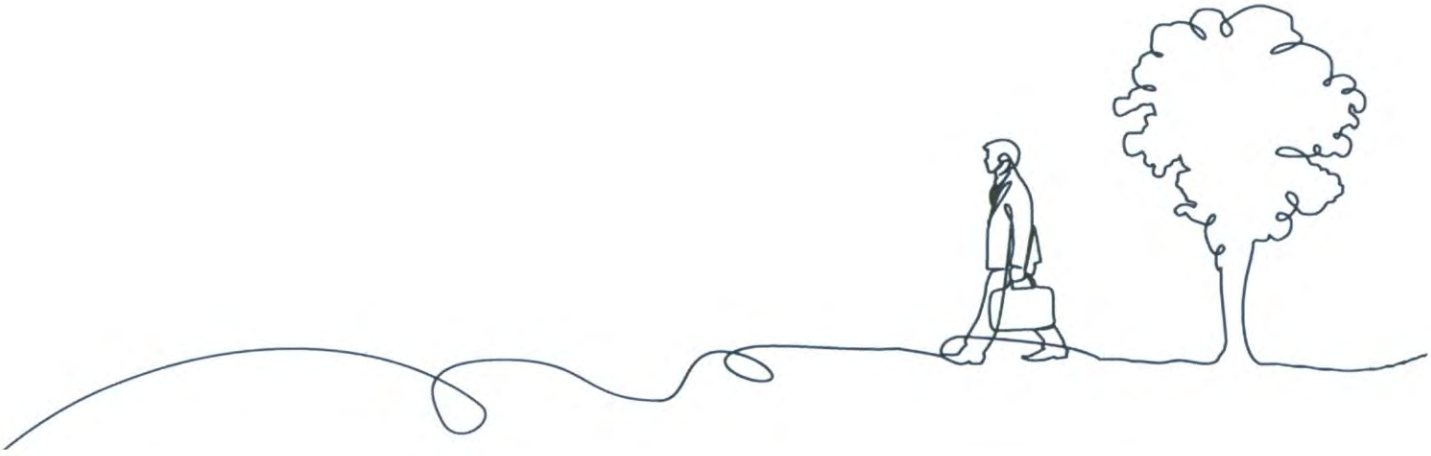
*"Empathy for the other person is not a weakness."*

*-Tenet 7*



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# Shelly Wilson

Account Manager, GBS Wichita

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Shelly Wilson began her career in the insurance industry in December 2003 when she joined the Gallagher Benefit Services Springfield, Missouri team as an Account Coordinator. In March of 2011, Shelly transitioned to an Account Manager role. Shelly became part of the Wichita Gallagher team in July of 2013.

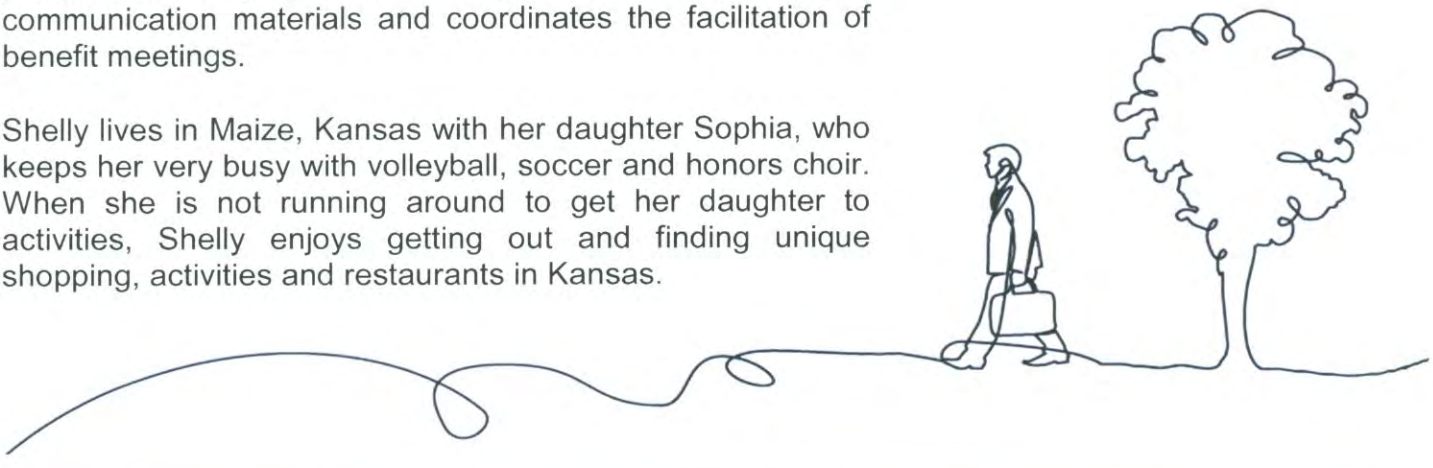
Shelly has 18+ years of experience in the benefits field; 8 of those years were as an HR Manager. Shelly has a Life & Health license and was awarded a Wellness Recipient Certificate in 2009.

As an HR Manager, Shelly was in charge of more than 300+ employee's benefits and payroll. She also developed monthly financial budgets, created job descriptions and performance reviews. One of her biggest tasks and accomplishments as an HR Manager was revamping the McDonald's Training Program for new hires and creating incentives and benefits for the employees.

Shelly is very dedicated to her clients and works hard to go above and beyond to meet their needs. She has a niche in educational and public entities. As an Account Manager, Shelly is responsible for providing high level of client service support, analyzing and evaluating benefit plans and programs as well as participating and/or leading the presentation of proposals. Shelly develops the employee communication materials and coordinates the facilitation of benefit meetings.

Shelly lives in Maize, Kansas with her daughter Sophia, who keeps her very busy with volleyball, soccer and honors choir. When she is not running around to get her daughter to activities, Shelly enjoys getting out and finding unique shopping, activities and restaurants in Kansas.

*"We are a warm close Company. This is a strength – not a weakness."*
*- Tenet 23*



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# Ofelia Mayorga

Account Coordinator, GBS Wichita

Ofelia joined Gallagher Benefit Services in 2012 in the role of Flexible Plan Administrator where she provided support with Flexible Spending Accounts and COBRA Administration. Her daily activities included customer support, client data entry, claims processing and ACH files. In 2014, Ofelia was promoted to an Account Coordinator.

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In her role as an Account Coordinator, Ofelia has various job duties that range in scope as she helps the team by supporting them with key elements in the client service plans they manage. Ofelia's primary focus is on eligibility, enrollment and general customer service inquiries. She also assists with data entry and miscellaneous projects and initiatives. One of Ofelia's strengths is being bilingual with English and Spanish. This allows her the ability to translate employee benefit books and other documents. When needed Ofelia also translates during employee benefit meetings. She carries out a diverse range of responsibilities in a timely and effective manner. She is a competent team member who is always prepared to go the extra mile. Ofelia always remains focused and self- directed in a fast paced work environment.

Ofelia currently resides in Wichita, KS. She graduated from Friends University with a B.B.A in Human Resources Management. In her spare time, she enjoys spending time with her family, cooking out, shopping and riding her motorcycle.

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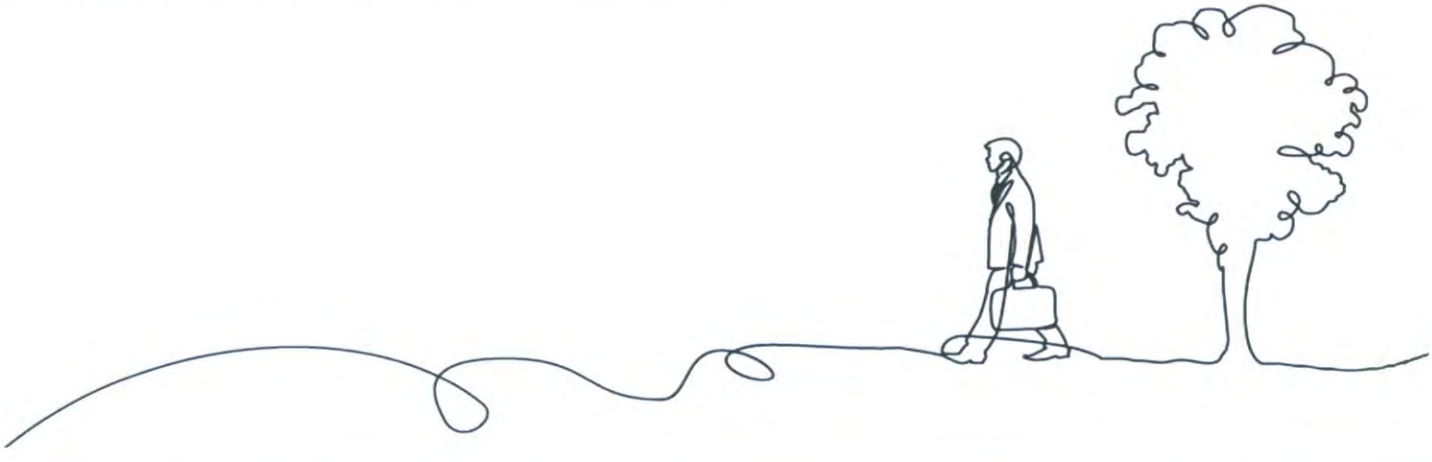
*- Tenet 23*



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# Amanda Schuster

Wellness Consultant, GBS Wichita

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Amanda joined the Gallagher Benefit Services Wichita office in 2013 in the role of Wellness Consultant. Amanda's primary focus is to assist and support GBS clients with wellness initiatives by acting as a wellness resource and liaison.

Clients interested in wellness initiatives work with Amanda to design, implement, and evaluate their wellness programs. Amanda's background in worksite wellness, fitness, and coaching has provided her with the fundamental skills needed to develop and execute successful wellness programs. Her ingenuity and passion for wellness enable her to communicate effectively and develop strong partnerships with clients.

Amanda graduated from Fort Hays State University with a bachelor's degree in Recreation and Sports Management and received a master's degree in Sports Administration from Wichita State University. She is a Certified Health Fitness Specialist by American College of Sports Medicine. She lives in Wichita with her husband and three children. In her spare time, Amanda enjoys spending time with family, traveling, camping, and attending her kid's activities.

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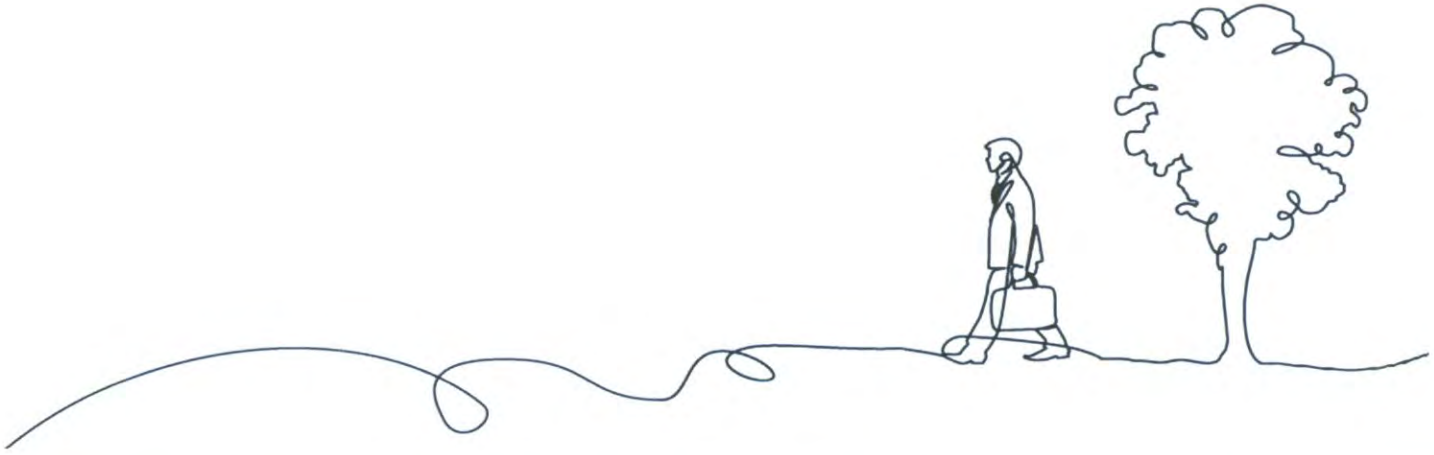
*- Tenet 23*



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Gallagher Benefit Services, Inc.
thinking ahead

# Directions

December 2012

Directions is a monthly publication of Gallagher Benefit Services, Inc.

**Recorded Webinars**

Labor & Employment Law Update: 2012 in Review

December 4, 2012

2012 Year-End Review & Reminders (Benefits)

November 8, 2012

Healthcare Reform Update:

December 6, 2012

Technical Bulletin:

Year-End Review & Reminders (Benefits)
December 5, 2012

**Coming Soon!**

**Recorded Webinars:**

Healthcare Reform: Charting a Course for 2014
Feb. 21

Employment Law and Social Media: "Like" or "Dislike"
March 14

**ADDITIONAL RESOURCES:**

Healthcare Reform Update Archive

Recorded Webinar Archive

Directions Newsletter Archive

Technical Bulletin Archive

GBS Healthcare Reform Resources Website

## Health Care Reform

**ACA's Health Insurance Rate Review Program May Have an Influence on Increases in Premiums**
*CCH, Incorporated* <<more>>

## Health Care Report

**Some Rare Good News: Retiree Health Savings Needs Slip**
*Employee Benefit Research Institute* <<more>>

**The Growing Medicare Issue**
*Employee Benefit Plan Review*
*Perry Braun* <<more>>

## Human Resources View

**What Is At Stake For Employers In The New Supreme Court Term?**
*Meckler Bulger Tilson Marick & Pearson LLP* <<more>>

**New Legislation Barring Access To Employees' Facebook Accounts Reflects The Changing Landscape Of Social Media In The Workplace**
*Meckler Bulger Tilson Marick & Pearson LLP* <<more>>

**How Employers Can Integrate Highly Rated but Underused Practices**
*Employee Benefit Plan Review*
*Michael Klachefsky* <<more>>

## Retirement

**PBGC Maximum Insurance Benefit Increases for 2013**
*Spencer's Benefits* <<more>>

**IRS Again Extends Deadline To Amend DB Plan To Satisfy Code Sec. 436 Rules**
*Spencer's Benefits* <<more>>

## Executive Compensation

**New and Higher Taxes Coming in 2013: The Ramifications for Employee Benefit Plans**
*Employee Benefit Plan Review* <<more>>

## State Law Review

**What's New in State Laws**
*CCH, Incorporated* <<more>>

## ACA's Health Insurance Rate Review Program May Have an Influence on Increases in Premiums

*CCH, Incorporated*

State health insurance rate review programs may have a material influence on the premiums that ultimately get charged to individuals and small businesses, according to a Kaiser Family Foundation report on the health insurance rate review program. Under the program established by the Patient Protection and Affordable Care Act (ACA), states and the federal government review proposed premium increases above a threshold amount, which is currently 10 percent or more, in the small group and individual markets to determine whether the increases are reasonable.

**States' programs.** ACA provides a minimum set of requirements for rate review programs and provides grants to states to enhance their rate review activities. States with effective rate review programs are responsible for reviewing proposed rate increases of 10 percent or more and verifying whether the increase is reasonable under the standards set by state law or regulation. HHS conducts the reviews for the rate increases of 10 percent or more for states without effective or only partially effective rate review programs. States are also required to make some information on the review process available to the public. Although all states with effective rate review programs must meet transparency requirements for proposed increases of 10 percent or more, states vary substantially in how they file, review, and make the proposed increases publicly available.

Most states had some form of rate review process in effect before ACA was enacted. The state programs varied substantially in their review processes, the market segments to which they applied, and the type of information made available to the public. Generally, state programs are still in effect and some may go beyond the requirements of ACA. In most states, regulators have the authority to prevent rate increases from going into effect if an insurer's requested increase is determined to be unjustifiable; however, in other states, the judgment that a rate increase is unreasonable is publicly disclosed but the insurer does not need permission to implement the increase.

**The report.** The report compared the average rate change insurers requested to the rate that was ultimately implemented following state or federal reviews as well as variations in rate requests throughout 2011 to see if there were measurable changes in rate requests after the implementation of the rate review requirements. Rate filings reviewed by state regulators were reviewed separately from those reviewed by HHS. Kaiser's findings include:

- For filings submitted to state regulators during 2011, the rates that went into effect were on average one-fifth lower than rate initially requested.
- Nationwide, about one in five requests by insurers to change premiums were denied, lowered, or withdrawn during state review.
- The effect of state rate review program varied by state as well as market segment.
- Early evidence from filings submitted just before and just after the implementation of ACA's rate review requirements suggest that these requirements are having an effect. Since the implementation of ACA's rate review standards, insurers appear to be submitting fewer requests above the 10 percent threshold and those rate requests above the 10 percent threshold were more likely to be denied, modified or withdrawn.

- PPACA's rate review transparency requirement may be encouraging insurers to moderate their rate increases. All requests by insurers to raise premiums are published on HealthCare.gov.

Kaiser concluded by noting that "while regulators may be able to exert pressure on insurers to control costs more aggressively, rate review itself cannot alter the factors driving increases in health care costs (such as the underlying prices charge by doctors and hospitals, the amount of health care utilized by enrollees, and new medical technologies)."

## Health Care Report

### Some Rare Good News: Retiree Health Savings Needs Slip

*Employee Benefit Research Institute*

Projections for how much elderly Americans need to save for out-of-pocket health care in retirement have edged lower, due to a provision the federal health reform law that will cover more of their prescription drug costs, according to a new report by the nonpartisan Employee Benefit Research Institute (EBRI).

The Patient Protection and Affordable Care Act (PPACA) reduces cost sharing in the Medicare Part D "donut hole" to 25 percent by 2020. This year-to-year reduction in coinsurance will continue to reduce savings needed for health care expenses in retirement, all else equal, for individuals with the highest prescription drug use, EBRI reports.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added outpatient prescription drugs (Part D) as an optional benefit. When the program was originally enacted, it included a controversial feature: a coverage gap, more commonly known as the "donut hole." PPACA included provisions to reduce (but not eliminate) this coverage gap.

Medicare generally covers only about 60 percent of the cost of health care services (not including long-term care) for Medicare beneficiaries ages 65 and older, while out-of-pocket spending accounts for 13 percent.

The EBRI analysis finds 1–2 percent reductions in needed savings among individuals with median (mid-point, half above and half below) drug use and 4-5 percent reductions in needed savings among individuals at the 90$^{th}$ percentile in drug use since its last analysis in 2011.

Specifically, EBRI projects that a 65-year-old man would need $70,000 in savings and a woman would need $93,000 in 2012 if each had a goal of having a 50 percent chance of having enough money saved to cover health care expenses (excluding long-term care) in retirement.

By comparison, a 65-year-old couple, both with median drug expenses, would need $163,000 in 2012 to have a 50 percent chance of having enough money to cover health care expenses (excluding long-term care) in retirement, $227,000 to have a 75 percent chance of covering those expenses, and $283,000 to have a 90 percent chance of doing so. These estimates are 1–2 percent lower than the savings targets estimated in 2011.

The full report, "Savings Needed for Health Expenses for People Eligible for Medicare: Some Rare Good News," is published in the October *EBRI Notes,* online at www.ebri.org

The Employee Benefit Research Institute is a private, nonpartisan, nonprofit research institute based in Washington, DC, that focuses on health, savings, retirement, and economic security issues.

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## The Growing Medicare Issue

*Employee Benefit Plan Review*
*Perry Braun*

With the United States Supreme Court decision to affirm the constitutionality of the Affordable Care Act (ACA), there continues to be significant commentary regarding the impact on employers, individuals, and state program funding—such as Medicaid and Children's Health Insurance Program (CHIP)— but little is written about ACA's impact on Medicare.

Medicare will continue to represent a significant expense for the federal government. Representatives in Congress have yet to present a constructive set of ideas to reform Medicare. On its current trajectory the remaining remedy to fix the system will be to raise the Medicare Payroll Tax to keep pace with expenses— clearly not something our fragile economy could realistically bear at this time.

Over the next 20 years—2013 through 2032—there will be a significant rise in the number of individuals entering the Medicare program. According to the U.S. Census Bureau, there were 77,000,000 Baby Boomers born between 1946 and 1962 who are about to enter Medicare over the next two decades. Meanwhile, Medicare spending—on average— is $10,000 per person. Medicare spending has been increasing at an average of eight percent per year between 1991 through 2009 according to Kaiser Family Foundation data. Couple this with the fact that over the past 20 years the mortality age has increased significantly, and the result is our country faces a significant and growing expense.

### FUTURE PROBLEMS BECOME SIGNIFICANT

If the Medicare program does not modify its eligibility rules, it appears the Medicare population is expected to double over the next two decades. Individuals are living longer, which means they will consume more health resources. And more resources mean more dollars to fund the program.

At Medicare's current trend of eight percent inflation—much higher than the overall inflation for the country for the same time period—expenses will continue to increase at an alarming rate, which will compound year over year. The result is that the health care industry has grown to become one-sixth of the overall economy—and it shows no signs of slowing down.

We have to look no further than our neighbors to the north as an example. The Canadian government has been struggling with similar issues. Funding for the national health program is a challenge for the

same reasons: an increasingly older population and skyrocketing health care and pharmaceutical costs. The only "solution" Canada has found to manage the demand is to ration out care and establish a queue system. Is this what we want to happen in the U.S.? Would a consumer in the United States accept the fact that they may need to wait to receive a service? Probably not.

While the government recognized the problem and attempted to tackle Medicare costs within the ACA, the proposals were simply a cost shifting strategy to the service suppliers, insurance carriers, and consumers. This is a narrowly-focused supply side strategy while no attention was given to two important areas that significantly drove cost within Medicare over the past 10 years: the demand side and the pharmaceutical category.

Individuals continue to pay little attention at addressing the demand side and pharmaceutical component of the cost equation, which is trending at a faster rate than the other components. Below are several tactics that can be implemented to address the cost within Medicare:

1. The traditional method for managing cost has been to adjust payment rates that affect hospitals, physicians, and medical suppliers—which these groups will lobby against. If the federal government is successful in its desire to channel more and more individuals into publically financed insurance systems—Medicare, Medicaid, Exchanges, and with the practice of setting premium and payment rates—providers will have an increasing percentage of their revenue tied to the payment rates established by the government in the future. This traditional approach is beginning to give way to a payment methodology that bases compensation on quality outcomes and measures. This approach makes sense from a theoretical or academic standpoint—who wouldn't want to pay for great outcomes? The problem is in the administration of the program. For example, if physicians or hospitals are "bonused" based on good outcomes, will they stop treating high-risk patients if this would negatively impact their bonus?
2. Adjust the eligibility to age 70, which defers payments in the future since people cannot enter into the program until they are older. The result will be that individuals will need to find insurance in the market or through an Exchange, and are likely to need to work until they are older, which affects employment opportunities and unemployment rates. If the workforce ages up, younger workers entering the marketplace will find that jobs are not available due to less turnover of the workforce who have delayed retirement.
3. Adjust the Medicare Payroll Tax to match expenses to funding. If the government is unable to impact the cost side of the ledger, change the funding side of the ledger by raising the Medicare Payroll Tax. In fact, under the current roll out of the ACA, there is an increase in the Medicare Payroll Tax put into place. Since the United States Supreme Court validated the ACA as constitutional under the Tax and Spend provision, it is conceivable that the Government could simply adjust the Medicare Payroll Tax in future years and have everyone pay a fairer portion. If the current unemployment rate of eight percent remains, more of the expense to fund Medicare will be borne by fewer workers.

## CONCLUSION

The issues faced by those in government with respect to funding Medicare will continue to be challenging. Hard choices need to be made in order to salvage the program for future generations. The traditional approaches— bending the cost curve, slowing the growth of expenditures by paying providers less, changing benefits by shifting costs to the beneficiary—have limited impact. As a country, we need to bite

the bullet, stop passing the buck, and implement comprehensive sets of solutions if we are to solve this issue once and for all.

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## Human Resources View

### What Is At Stake For Employers In The New Supreme Court Term?

*Meckler Bulger Tilson Marick & Pearson LLP*

In the October 2012 term, the United States Supreme Court will decide a number of cases that have the potential to profoundly impact employment law in the areas of employer liability for supervisor harassment, class action litigation and affirmative action.

#### Court To Determine Who Is A Supervisor In Harassment Cases

In *Vance v. Ball State University*, the Court is expected to resolve a longstanding split among circuits on the issue of the degree of authority a "boss" must exercise over an employee to be deemed a "supervisor" under Title VII of the Civil Rights Act. Specifically, the Court may finally determine whether a supervisor must have the power to "hire, fire, demote, promote, transfer, or discipline" employees, as the lower court held, or whether the authority to "direct the employee's daily work activities" is enough.

A Supreme Court ruling in the plaintiff's favor on this issue could greatly expand employer liability for harassing behavior by its employees, as the risk of employer liability is much higher when the harasser is a supervisor as opposed to a non-supervisory co-worker.

#### Several Decisions Coming Up Involving Class Actions

In *Genesis Healthcare Corp. v. Symczyk*, the Court will decide whether a potential class action wage and hour case can be made entirely moot when the employer makes an offer of judgment to the named plaintiff (in other words, a confession of liability and an offer to pay damages satisfying the named plaintiff's claim). A number of courts have allowed defendants to use this tactic to block a wage and hour claim from proceeding as a class action during the period prior to preliminary class certification. Obviously, how the Supreme Court decides *Genesis Healthcare* will have a considerable impact on litigation strategy in large-scale wage and hour cases. Indeed, if the Court rules that a full offer of judgment makes the case moot, more employers faced with wage and hour collective or class actions may choose to make offers of judgment at the outset, while plaintiffs will push for class certification earlier on in an effort to block such a strategy.

The second case bearing on class-action litigation is *Comcast Corp. v. Behrend*. In last year's *Dukes v. Wal-Mart* ruling, the Court reiterated that lower courts must engage in a "rigorous analysis" to ensure compliance with class-action certification requirements. In *Behrend*, the Court is expected to resolve the question of whether this "rigorous analysis" requires plaintiffs to submit proof, including expert analysis, that damages are capable of being awarded on a class-wide basis. We expect the Supreme Court in

*Behrend* to give direction to lower courts concerning the extent to which evidence of class-wide damages is required of plaintiffs **before** a court may certify a class action. Importantly, *Behrend* could substantially impact the use of class actions in employment discrimination cases because courts in employment cases have certified class actions solely because liability was capable of resolution on a class basis. In these cases, courts were clearly willing to certify the class, despite the absence of evidence that damages could be determined on a class-wide basis. If the Supreme Court rules in *Behrend* that a class determination based solely on liability is insufficient, this could significantly limit class actions in employment cases because in many such cases the level of damages for each class member can only be determined on an individual basis.

### The End Of Affirmative Action?

Finally, in *Fisher v. University of Texas*, the Court may issue a ruling clarifying how and when universities may use race in admissions decisions. And while *Fisher* arises in the context of higher education, it may have a ripple effect on both private and public sector employers which use affirmative action as a tool to ensure diversity in their workforces. Nine years ago, in a 5-4 decision in *Grutter v. Bollinger*, the Court approved using race, as one factor among many, in higher education admissions.

In the *Fisher* case, the lower court (the Fifth Circuit Court of Appeals) held the University of Texas' use of race as a "plus-one factor" to be a permissible "faithful" application of *Grutter*. The Fifth Circuit, however, also suggested that the "trajectory" of increased minority enrollment makes the need for using race as a plus-one factor to be an "eroding necessity." Given the change in the personnel of the Supreme Court, it is likely that the Court will key on this statement. Therefore, the determination by the Court of whether the social need for affirmative action has eroded below the level of necessity will likely determine the outcome of this case.

MBT will be closely monitoring these cases and will update you on development in future e-alerts. If you would like more information regarding the current Supreme Court docket and the potential impacts of these upcoming decisions on your workplace, please contact Jake Rubenstein at 312-474-7873 or Jeremy Glenn at 312-474-7981 or any of MBT's labor and employment attorneys.

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## New Legislation Barring Access To Employees' Facebook Accounts Reflects The Changing Landscape Of Social Media In The Workplace

*Meckler Bulger Tilson Marick & Pearson LLP*

For a number of years, there has been a growing tension between, on the one hand, employers who wish to conduct thorough background checks on applicants and ensure that employees' social media postings do not reflect poorly on the employer, and, on the other, workers who insist that what they do and say on social media sites on their own time should be off-limits. This tension has recently reached a new high amidst the passage of legislation prohibiting employers from requesting passwords for Facebook and other social media accounts from employees and job applicants.

Laws recently passed in Illinois and Maryland, as well as similar legislation proposed at the federal level, California and other states, create new challenges for employers in shaping and executing their social media and hiring policies. The Illinois law, which goes into effect **January 1, 2013**, amends the state's Right to Privacy in the Workplace Act, making it unlawful for any employer to seek from an existing or prospective employee any password or related account information in order to gain access to the employee's or candidate's account or profile on Facebook, Twitter, or any other similar social networking website. According to the National Conference of State Legislatures, at least a dozen other states, including California, New Jersey, Washington, and Delaware, are expected to pass similar legislation. Likewise, Congress is currently considering the Social Networking Online Protection Act (SNOPA), which, if signed into law, would not only prohibit employers from accessing the social media accounts of their current and potential employees, but would also prohibit colleges, universities, and K-12 schools from asking the same of their students.

The advent of robust state and federal legislation protecting employees' activity on social media sites reflects the culmination of gradually increasing privacy expectations in the workplace. Observers of the interplay between social media and the law may recall that the City of Bozeman, Montana became infamous when, in 2009, it was revealed that job seekers applying for city government positions were being required to provide the city with passwords for social media sites they used, including Facebook and Google. While, in the wake of a public and media outcry, the City of Bozeman dropped the requirement, the practice of employers asking candidates for Facebook and other social media passwords has quietly grown more prevalent. The recognition of this trend, and public opposition to it, has been a major catalyst for the legislative action described above.

The government response to employers seeking access to, or seeking control over, an employee's social networking habits is not only being played out in the legislatures, but also at the National Labor Relations Board (NLRB). The NLRB has said that employee comments and complaints on social media sites about wages, benefits and other workplace conditions can be "concerted activity" granted legal protection under federal labor law and thus employers may not retaliate for such statements. Recently, the NLRB filed a complaint against an auto dealership that terminated a salesman for using a social media site as a platform to criticize the quality of the food served by the dealership at a sales event. Following a trial, the Board upheld the judge's ruling that the salesman's firing was lawful because his comments were not "concerted" (i.e., intended to urge improvements in conditions for himself and fellow employees) and because he was not fired solely for posting the comments at issue. However, the Board found unlawful a rule in the employer's handbook, which required "courtesy" in employee communications, because the rule could be interpreted to restrict protected speech.

What employers sometimes forget is that the protection afforded to "concerted" speech by the NLRB under federal labor law speech applies equally in both union and non-union workplaces. Moreover, the NLRB's efforts to protect employee speech are not just confined to specific employee acts. For example, in September 2012, the NLRB cited Costco Wholesale Corp. for an unlawful social media policy within its employee handbook. Costco's handbook prohibited employees from electronic posts which "damage the Company, defame any individual or damage any person's reputation..." The NLRB concluded that the policy violated federal labor law because employees could construe the rule as one prohibiting or interfering with protected employee speech.

Not only has there been a very significant government response to employers accessing an employee's or applicant's social networking sites, but also it is becoming increasingly apparent that other risks confront employers who regularly seek access to the social networking information of their employees and applicants. For example, an individual's social media profile may reveal his or her age, ethnicity, religion, disability, or sexual orientation, all of which are personal characteristics that are protected by federal, and often state law, from being considered in hiring and other employment decisions. Though the legal landscape may be different when the social media user makes his or her information public, even vetting an applicant by viewing the public portion of his or her social media account could allow an employer to learn facts it otherwise would not know, potentially resulting in a discrimination claim by an unsuccessful applicant.

While recognizing the utility of reviewing an applicant's social media accounts as part of an effort to maintain a safe work environment, it may no longer be worth the risks. Not only will employers who wish to explore the social media activity of their employees to investigate complaints of online harassment or abuse find such inspections difficult or downright unlawful in certain states due to newly enacted legislation, but also as it is impossible to segregate unwanted information from such a review, the employer who routinely reviews such information may find it more often than not a pathway to employment litigation or an NLRB charge. At a minimum, in those states that allow it, an employer seeking continuing access to its employees' and applicants' social networking sites, should do so under carefully constructed policies aimed at obtaining only information that it needs to make a sound and legal employment decision.

If you wish to learn more about the various laws relating to social media in the workplace, or how to instruct your managers or human resources personnel on comporting their policies with these regulations, please contact Jeremy Glenn at 312-474-7981 or any of MBT's labor and employment attorneys.

**About MBT.** MBT is a leading litigation firm with over 100 attorneys and offices in Chicago, Dallas, Phoenix and San Francisco. In addition to concentrating in labor and employment law, our attorneys focus on commercial litigation, insurance coverage, professional liability defense, attorney fee disputes and environmental law. For more information, please visit **www.mbtlaw.com. Join our Mailing List!** *MBT provides e-alerts for general information only; this information should not be construed as legal advice.*

## How Employers Can Integrate Highly Rated but Underused Practices

*Employee Benefit Plan Review*

*Michael Klachefsky*

Employers and their human resources teams have multiple challenges concerning employee absence and disability and productivity. Those challenges can include delayed reporting of employee absences and disabilities, and a lack of an objective way to evaluate return-to- work (RTW) programs. If not addressed by human resources professionals, these challenges can result in unnecessary absence and disability costs and reduced employee productivity.

Addressing those problems can include integration of key health and productivity management (HPM) practices positively rated by employers in a 2009 Integrated Benefits Institute (IBI) survey, but also found to be underused.[1] Two of those practices were early disability reporting and use of disability duration guidelines.

Human resources professionals should advocate for HPM programs that can incorporate these practices because they may help increase employee productivity and reduce cost and impact of absence and disability in the workplace.

### HIGHLY RATED, BUT UNDERUSED, HPM PRACTICES

In 2009, IBI presented a group of 450 employers with a list of 26 HPM-related practices and asked them to identify which they offered and which were the three most important for managing their workforce's health and productivity. Those HPM practices were divided into three program types—health promotion, disease management, and RTW.

Employers were then asked whether their top three practices had improved, worsened, or had no effect on their intended health and productivity outcomes, or if they did not know if there was an effect. The health and productivity outcomes IBI identified were:

- Reducing sick-day/disability absences
- Reducing medical/pharmacy costs
- Reducing health-related lost productivity
- Improving employee satisfaction
- Reducing presenteeism

The survey findings subsequently became the basis for a research paper published by IBI. Early disability reporting had the highest impact score, according to the survey,[2] along with transitional RTW.

Early disability reporting is defined as knowing about an employee's absence or disability claim as soon as possible after it occurs to quickly take steps that help shorten the duration. In some cases, at risk employees can be identified before they actually need to file a disability claim.

Many employers have encountered absences and disabilities that were reported to carriers only after a lengthy period. This phenomenon is known as disability reporting lag, which can be the result of employees submitting the necessary forms late or supervisors not reporting absences to human resources in a timely manner. No matter the cause, disability reporting lag increases the likelihood of extended absence and

disability durations. Such extended durations can lead to an employee "disability mindset," which happens when an ill or injured employee becomes focused on their disabilities, rather than their abilities.[3] A carrier with an effective RTW program will act on this information immediately—called early intervention—which cannot occur without early disability reporting.

Use of disability duration guidelines had the fourth highest impact score in the IBI survey.3 Disability duration guidelines provide a physiological basis for RTW expectations and offer expectancy figures for normal recovery from a medical condition, injury or procedure. Disability duration guidelines leverage data from various sources to predict the anticipated disability duration and consider many variables, such as diagnosis, employee age and job demands, among others. Disability duration guidelines are considered a best practice in any program that manages absence and disability and/or is considered an RTW program.

Ideally, those HPM practices that employers find to be most effective in meeting their intended goals would be the most widely used. However, highly effective practices like early disability reporting and disability duration guidelines were not nearly as prevalent as lower-rated practices like smoking cessation and fitness centers. This discrepancy provides an opportunity for human resources professionals to present their employer with a program that incorporates these highly rated practices that benefit the employee, his or her supervisor and the company at large.

## THE ONSITE CONSULTANT MODEL

A proactive approach by an employer to integrating early disability reporting and disability duration guidelines into an RTW program may contribute to the reduction in the length and cost of employee disabilities.

A proactive approach also may be effectively driven by an employer through deployment of an onsite consultant. This model places a disability management professional in the workplace, often a nurse or vocational specialist, who integrates the disability management program within a company's existing culture. The onsite consultant works collaboratively with an employer's human resources team to identify opportunities to keep employees who may be at risk of absence and disability on the job, and get those who go out on leave back to work sooner.

By being at the employer's workplace, the onsite consultant is able to integrate the highly rated but underused HRM practices identified by the IBI survey:

- Early disability reporting: The carrier's home office staff informs the onsite consultant of an absence within days of learning about it. After contacting the employee, the onsite consultant can discuss a transitional RTW plan with the employee's supervisor and physician. In some cases, the employer's human-resources team informs the onsite consultant about employees at work but struggling with medical conditions. This can result in ergonomic assistance that could prevent the at-risk employee from needing to go out on disability leave.
- Disability duration guidelines: The onsite consultant may be backed by medical and vocational professionals in the carrier's claim offices, who analyze the absent employee's diagnosis and use disability duration guidelines to determine the anticipated duration of the absence. Once the anticipated duration is determined, the consultant can use this information to help craft a customized RTW plan for an employee.

The onsite consultant model also can be very effective for helping employees with behavioral health conditions, in addition to physical conditions. A key in addressing RTW for employees with behavioral health conditions, like mood and anxiety disorders, is early identification and intervention.

The onsite consultant will work with an employee's supervisor and physician or therapist to craft a work plan that is mutually beneficial for all parties; for example, a part-time work schedule for a certain period. In some cases, these trained specialists will refer employees to their company's employee assistance program (EAP) in order to identify an appropriate mental health provider.

## NEXT STEPS FOR HUMAN RESOURCES PROFESSIONALS

Programs that manage absence and disability and leverage onsite consultants provide the proactive approach employers and their human resources teams need to successfully implement early disability reporting and disability duration guidelines, as well as other highly rated HPM practices.

Human resources professionals can reach out to their benefits broker or consultant to learn more about the onsite consultant model and the benefits it can provide their employers. Those entities can help employers and their human resources teams understand the positive impacts that early disability reporting and disability duration guidelines can have, and how they can be utilized through the use of an onsite consultant.

## NOTES

*1. The Impact of Employer Health and Productivity Management Practices. Integrated Benefits Institute. July 2010.*

*2. The Impact of Employer Health and Productivity Management Practices. Integrated Benefits Institute. July 2010.*

*3. Benefitsworld.com. Looking to Lower Your Cost on Group Benefits? Try Adding Value! Part 2. Available at: http://www.benefitsworld. com/group-benefits/looking-to-lower-your-cost-on-group-benefits-try-adding-value-part-2/. Accessed May 8, 2012.*

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## Retirement

### PBGC Maximum Insurance Benefit Increases for 2013

*Spencer's Benefits*

The yearly maximum benefit a 65-year-old retiree can receive has increased to almost $57,500 from $56,000, according to the Pension Benefit Guaranty Corporation (PBGC). Most retirees who get their pension from PBGC—more than 85 percent—receive the full amount of their promised benefit.

PBGC takes responsibility as trustee for a single-employer pension plan when the plan runs out of money, when the sponsoring company liquidates and no other company is willing to maintain the plan, or when the sponsoring company demonstrates it cannot remain in business and continue funding the pension plan, among other circumstances.

The amount PBGC pays retirees is based on a formula prescribed by federal law. Yearly amounts are higher for people older than age 65, and lower for those who retire earlier or choose survivor benefits.

If a pension plan ends in 2013, but a retiree does not begin collecting benefits until a future year, the 2013 rates still apply. For plans that terminate as a result of bankruptcy, the maximum yearly rates are guided by the limits in effect on the day the bankruptcy started, not the day the plan ended.

Beginning in 2013, the maximum yearly guarantee for a 65-year-old retiree is $57,477.24. The increase is not retroactive.

For more information, visit http://www.pbgc.gov/news/press/releases/pr12-35.html.

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### IRS Again Extends Deadline To Amend DB Plan To Satisfy Code Sec. 436 Rules

*Spencer's Benefits*

In Notice 2012-70, the Internal Revenue Service has extended the deadline to amend a defined benefit plan to satisfy the requirements of Code Sec. 436 regarding limitations on the accrual and payment of benefits under certain underfunded, single-employer defined benefit plans. Notice 2012-70 also provided relief from the anti-cutback rules of Code Sec. 411(d)(6) (IRS Notice 2012-70).

The IRS set forth the original deadline in Notice 2011-96. Notice 2011-96 provides a sample plan amendment that may be adopted to satisfy Code Sec. 436 and extended the deadline for adoption of an interim plan amendment.

The new guidance further extends the deadline to adopt an interim amendment for Code Sec. 436 to the latest of: (1) the last day of the first plan year that begins on or after Jan. 1, 2013, (2) the last day of the plan year for which Code Sec. 436 is first effective for the plan, or (3) the due date (including extensions)

of the employer's tax return for the tax year that contains the first day of the plan year for which Code Sec. 436 is first effective for the plan.

The extended deadline also applies in cases of a plan amendment with respect to Code Sec. 436 that eliminates or reduces a Code Sec. 411(d)(6) protected benefit. Thus, such an amendment would not cause the plan to fail to meet the anti-cutback requirements of Code Sec. 411(d)(6) if the amendment is adopted by the deadline described above and the elimination or reduction is made only to the extent necessary to enable the plan to meet the requirements of Code Sec. 436.

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## Executive Compensation

### New and Higher Taxes Coming in 2013: The Ramifications for Employee Benefit Plans

*Employee Benefit Plan Review*

**B**efore each new year, countless experts peer into the increasingly cloudy crystal ball that is our political process and attempt to predict which direction tax rates will move and craft strategies for dealing with an uncertain future. In some ways, 2013 presents a similar scenario, particularly given the election cycle; however, two tax hikes are all but certain to occur beginning on January 1, 2013, following the Supreme Court's decision to uphold the Patient Protection and Affordable Care Act (PPACA) this past June. This column describes the impending Medicare tax increases resulting from the new health care law, details the potential tax increases resulting from the possible expiration of various tax cuts, and explains the implications of these changes with respect to employee benefit and executive compensation plans.

#### MEDICARE TAX INCREASES RESULTING FROM PPACA

The reforms enacted under PPACA usher in two new Medicare taxes beginning January 1, 2013: the Additional Medicare Tax and the Unearned Income Medicare Contributions Tax (UIMCT). This column will cover each in turn below.

**Additional Medicare Tax**

The Additional Medicare Tax is essentially an additional 0.9 percent tax on amounts of taxable income over a certain level. This tax is added only to the employee's portion of the Medicare tax, meaning that the existing 1.45 percent will increase to 2.35 percent on the marginal amount of income over the specified threshold. *Employers* will not be responsible for any additional taxes on its portion of Medicare taxes—this rate remains at 1.45 percent for all levels of income.

The threshold is $200,000 for single filers and $250,000 for married couples filing jointly (the Threshold). By way of example, a single taxpayer earning $300,000 in 2013 would face a total Medicare tax burden of $5,250 on his or her ordinary income,[1] which is $900 more than such taxpayer would have faced in 2012. Taxpayers earning under the Threshold amount will continue to pay just 1.45 percent on their taxable income and will be unaffected by the Additional Medicare Tax.

As with all taxes that can be over-withheld or under-withheld when dealing with two taxpayers that file jointly, administrative concerns regarding the coordination of withholding arise. Thankfully, the IRS has released an FAQ detailing the withholding mechanics for employers (for employees, this coordination is less critical since the final amount due will be determined upon filing his or her tax return for the relevant year).[2] In a nutshell, an employer must withhold the Additional Medicare Tax on amounts over $200,000 for employees and the employer need not coordinate with the spouse's employer or notify employees of the additional amount being withheld when this $200,000 threshold is met. The Additional Medicare Tax is otherwise assessed in the same manner as the existing Medicare tax.

## THE UNEARNED INCOME MEDICARE CONTRIBUTIONS TAX

The UIMCT is a bit more complex. In short, the UIMCT is a new 3.8 percent tax on the lesser of (i) "net investment income," or (ii) the excess of modified adjusted gross income (MAGI) over the Threshold amount. Since the tax is on the *lesser of* items (i) and (ii) above, this means that taxpayers will not be affected by this tax unless they earn over the Threshold amount *and* have "net investment income."

Net investment income comprises the following amounts: (i) Gross income from nonbusiness annuities, dividends, interest, rent and royalties, (ii) gross income derived from a trade or business (a) that is a passive activity within the meaning of Section 469 of the Internal Revenue Code (the Code), or (b) that trades in financial instruments or commodities as defined in Code Section 475(e)(2), and (iii) net gain on the disposition of nonbusiness property.

This means that even gain from the sale of a taxpayer's principal residence (to the extent not excluded from gross income) could add to the taxpayer's net investment income figure and be subject to the UIMCT. An example provided in a Congressional Research Service Report helps illustrate the concept:

> Consider a couple who earn a combined salary of $260,000 a year. They sell their principal residence for $1.2 million, and net a gain of $700,000. Their MAGI in the year of the sale is therefore $460,000 (salary plus $200,000 gain above $500,000 exclusion). Because this couple's MAGI exceeds the $250,000 threshold, they will have to pay the unearned income Medicare tax.
>
> The tax will be applied to the lesser of (1) net investment income, or (2) the amount by which their MAGI exceeds the $250,000 threshold. Therefore, to determine to what amount the 3.8 percent tax should be applied to, the two figures must be compared:
>
> Amount MAGI exceeds income threshold: $460,000 – $250,000 = $210,000
>
> Net investment income (capital gain above capital gain exclusion): $700,000 – $500,000 = $200,000
>
> *Tax* = 3.8% * [*Lesser of* $210,000 *or* $200,000] = 3.8% * $200,000 = $7,600.[3]

## CONCLUSION

In sum, higher-earning taxpayers with net investment income will be faced with two additional Medicare taxes. Coupled with the higher income taxes, capital gains taxes, and Social Security payroll taxes that could result from the expiration of the tax cuts described below, there could be significantly

increased tax burdens that change investment strategies and therefore impact the administration of various employee benefits and compensation plans.

## EXPIRATION OF VARIOUS TAX CUTS

Without further action on the part of Congress, the Bush tax cuts and the Social Security payroll tax cuts are set to expire at the end of 2012. As further described below, this could potentially impact all tax brackets with respect to ordinary income tax rates. Long term capital gains and Social Security payroll taxes.

### Ordinary Income Tax Rates

Unless Congress acts to extend the Bush tax cuts, beginning on January 1, 2013, the lowest tax bracket would increase from 10 percent to 15 percent, the highest tax bracket would increase from 35 percent to 39.6 percent and the other tax brackets would increase 3 percent across the board. Most experts believe that low and middle income tax rates will remain in place but cite the possibility of only the second highest income tax bracket increasing from 33 percent to 36 percent and the highest tax bracket increasing from 35 percent to 39.6 percent. Ordinary income up to and including the current 28 percent tax bracket likely will be unaffected by the lapse of the Bush tax cuts.

### Long Term Capital Gains Taxes and Qualified Dividends

Long term capital gains tax rates are also set to increase beginning on January 1, 2013. Without Congressional intervention, the zero percent long term capital gains tax rate currently enjoyed by taxpayers in the 10 percent and 15 percent ordinary income brackets would increase to 10 percent. The 15 percent long term capital gains tax rate currently enjoyed by taxpayers in all of the higher ordinary income brackets would increase to 20 percent.

Further, qualified dividend income would no longer be treated as long term capital gains but instead as ordinary income. The difference to taxpayers in the top income tax bracket would truly be substantial—qualified dividends would be taxed at a rate of 39.6 percent (plus the 3.8 percent UIMCT described above) rather than just 15 percent.

### Social Security Payroll Taxes

The employee's portion of Social Security payroll taxes were temporarily reduced from 6.2 percent to 4.2 percent in 2011 and again in 2012. Without further Congressional action, the Social Security payroll tax rate will revert to 6.2 percent beginning on January 1, 2013.

## CONCLUSION

It is a fool's errand to try and predict what actions Congress will take with respect to tax rates, especially during an election year. A virtually unlimited number of options are available to Congress aside from the decision to simply extend the existing tax cuts or to let all of the tax cuts expire—Congress could choose to extend certain tax cuts and eliminate others or implement entirely different rates. In today's political climate, however, the risk of Congressional inaction must be considered and accounted for in advance of 2013.

## IMPLICATIONS FOR EMPLOYEE BENEFITS AND COMPENSATION PLANS

As employees and other participants in employee benefits and compensation plans digest the magnitude of the increased taxes in 2013, employers and other plan administrators could be faced with a flurry of activity at the end of 2012 and beyond to avoid or help blunt the impact of the tax increases, particularly with respect to higher-earning individuals. This portion of the column attempts to identify these potential behaviors with respect to qualified retirement plans, nonqualified plans and equity compensation plans in an effort to help employers and other plan administrators prepare for such activities.

### Qualified Retirement Plans

Generally, taxpayers will be seeking ways to reduce MAGI in order to decrease their taxable income. While this desire is nothing new from a tax planning perspective, the incentives become stronger due to possibly higher income tax burdens resulting from the expiration of the Bush tax cuts, the Additional Medicare Tax and the implementation of the UIMCT, which is also tied to MAGI. One way that taxpayers may achieve this objective is by choosing to participate in or increasing elective deferrals under qualified retirement plans such as traditional 401(k) plans.

Two considerations could reduce this impact. First, the high income earners that would be the most impacted by the higher marginal income tax rates and the Medicare taxes are often participating in any available qualified retirement plans and are already deferring the maximum amount allowable under the Code, meaning that such taxpayers cannot take any further actions to reduce MAGI in this manner. Second, despite the increased tax rates, a taxpayer might predict that tax rates in the future (*i.e.*, when the taxpayer wishes to take a distribution) will be even higher. In such a case, the taxpayer might not have a strong incentive to invest in a tax deferred vehicle such as a traditional 401(k) plan.

Distributions from qualified retirement plans may be impacted as well. Some participants may find it advantageous to take distributions from their qualified defined contribution plans before 2013 if they believe that Bush tax cuts will not be extended since they would face higher ordinary income tax rates on distributions after 2012. Note that distributions from such qualified plans are excluded from the definition of net investment income and will not increase a taxpayer's UIMCT liability, however.

### Nonqualified Plans

The IRS has a "special timing rule" with respect to FICA taxes assessed on amounts deferred under nonqualified deferred compensation plans and other nonqualified plans such as supplemental executive retirement plans. Such amounts are deemed subject to FICA taxation (which include Medicare taxes and Social Security payroll taxes) at the time the amounts are no longer subject to a substantial risk of forfeiture (*i.e.*, vested) and are reasonably ascertainable.[4]

Since employers have considerable leeway in determining when and how vested amounts under nonaccount plans which are not "reasonably ascertainable" and therefore subject to FICA taxation, there may be a considerable incentive to calculate such deferred amounts and subject the amounts to FICA taxation in 2012. Amounts subject to FICA taxation in 2013 and beyond could face the 0.9 percent Additional Medicare Tax and an additional two percent Social Security payroll tax, though the Social Security payroll tax hike may not have an impact on most nonqualified plan participants since such

individuals would likely hit the Social Security payroll tax cap regardless of whether deferred amounts are included in the calculation.

**Equity Plans**

Increased ordinary income tax rates and Medicare tax rates may also impact companies' equity plans and create other issues with respect to company stock. The most obvious issue is that employees with vested stock options may prefer to exercise such options in 2012 to avoid higher ordinary income taxes and the increased Medicare taxes. Employers that grant options to a wide base of highly-compensated employees should prepare for potential administrative burdens towards the end of 2012, particularly if it appears that the Bush tax cuts will expire.

A second, more subtle issue is that executives holding company stock may wish to sell this stock in 2012 to avoid potentially higher long term capital gains rates. This could create several problems. First, if the company is public it will need to report such transactions to the SEC with respect to its Section 16 insiders, which could prove to be administratively burdensome if such executives decide to sell company shares en masse. Second, such stock sales could send the wrong message to shareholders, who would likely view the decision of executives to sell the company's stock as a signal that the company's insiders do not have a positive outlook on the stock price. Companies should consider taking steps to actively manage the optics of such stock sales before the end of the year. Finally, companies with stock ownership guidelines may need to remind executives of the amount of shares of company stock that they are required to retain. Companies will need to monitor every stock sale to ensure that executives and other employees affected by the stock ownership guidelines are not selling too many shares to fall below the specified thresholds.

## CONCLUSION

For the first time in several years, one can predict with reasonable certainty that moderate tax increases will be hitting higher earning individuals' pocketbooks this upcoming new year—and Congressional inaction could turn these moderate tax increase into large tax increases. Regardless of which tax increases join the Medicare tax hikes, the changing rates could very well promote a flurry of activity among affected individuals wishing to manage their tax burdens. Companies and plan administrators would do well to understand the implications of the changing tax laws and prepare to call upon the support of experts and other support services as tax planning strategies begin kicking in to high gear.

## NOTES

*1. ($200,000 * 1.45%) + ($100,000 * 2.35%) = $5,250. This same taxpayer would pay $4,350 in the absence of the Additional Medicare Tax: $300,000 * 1.45% = $4,350.*

*2. See http://www.irs.gov/businesses/small/article/0,,id=258201,00.html.*

*3. Mark P. Keightley, The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions, pp. 3-4, Congressional Research Service Report dated October 7, 2010.*

*4. Treas. Reg. § 31.3121(v)(2)-1(a)(2).*

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## State Law Review

### What's New in State Laws

*CCH, Incorporated*

For busy Human Resources professionals who want ready access to what is new and what has recently changed in State laws, here is a brief update.

**Alabama Labor Relations** An individual's right to vote by secret ballot to designate or authorize employee representation is now guaranteed by the state constitution. Voters in the November 6, 2012, General Election, approved an amendment (Amendment 7; H.B. 64, L. 2011) to Article VIII, Section 177, of the Official Compilation of the Constitution of Alabama of 1901, as amended, to guarantee the right of a person to vote by secret ballot.

**Arizona Minimum Wage** The Arizona minimum wage will increase to $7.80 per hour on January 1. At a public meeting held on October 17, 2012, the Industrial Commission of Arizona determined that Arizona's minimum wage, currently $7.65 per hour, would be increased by 15 cents to $7.80 per hour for calendar year 2013.

Arizona voters enacted the Raise the Minimum Wage for Working Arizonans Act in 2006. The voter initiative established an Arizona minimum wage and provided for an annual increase based on the increase in the cost of living. The cost of living is based on the federal Consumer Price Index for All Urban Consumers, U.S. City Average for all items during the 12 months ending each August 31 (CPI-U). The CPI-U increased 1.7 percent comparing August 2011 to August 2012 (Source: The Industrial Commission of Arizona, Office of the Director, Press Release, October 18, 2012).

**Arizona Posters** The Arizona Minimum Wage Poster for 2013 has been added, in both English and Spanish versions,
http://www.ica.state.az.us/Labor/Forms/Labor_MinWag_MinimumWagePoster_2013_English.pdf and
http://www.ica.state.az.us/Labor/Forms/Labor_MinWag_MinimumWagePoster_2013_Spanish.pdf.

**California Farm Labor** Farm labor contractors in California are required to be licensed by the Labor Commissioner and must comply with specific employment laws. A person who violates farm labor contractor requirements would be guilty of a misdemeanor punishable by a fine, or imprisonment in the county jail, or both. Effective January 1, 2013, contractors who violate the licensing requirement would be subject to citations issued by the Labor Commissioner and civil penalties that increase as the number of citations for violations increase ($100, $200, $500 for initial, second, and third or subsequent citations, for each farm worker employed by the unlicensed person, plus equal amounts for each day the violation occurs, with such total penalties not to exceed $10,000, $20,000, or $50,000, respectively). Such penalties

collected are to be deposited into the Farmworker Remedial Account and are to be made available, upon appropriation by the Legislature, for purposes of regulating farm labor contractors (Ch. 857 (A. 1675), L. 2012, enacted September 30, 2012, and effective January 1, 2013).

**California Minimum Wage**

**Long Beach**, California, voters approved Ballot Measure N in a Special Municipal Election, which was consolidated with the statewide November 6, 2012, General Election, to establish minimum wage and minimum sick leave benefits for hotel workers in the city.

The measure will require hotel employers (with 100 or more guest rooms) to pay workers a minimum wage of not less than $13.00 per hour, with future annual increases tied to increases in either the federal minimum wage or, if greater, by the cumulative increase in the cost of living—if less than 2%, then the rate would be adjusted by 2%. Tips or gratuities and service charges or commissions received by workers may not be used to offset the minimum wage.

In addition to the minimum wage, hotel workers will also be entitled to receive five sick days each calendar year, available as they are accrued with such days accrued at the rate of 5/12 of a day of compensated time for each full month that the worker has been employed in a calendar year. Hotel workers would receive their normal daily compensation for each compensated day off.

The measure, http://www.longbeach.gov/civica/filebank/blobdload.asp?BlobID=34813, approved by 62.99% of the voters, adds Section 5.48.020 to the Municipal Code, and is expected to take effect December 14, 2012 (10 days after the expected December 4, 2012, certification of the election results).

Voters in **San Jose**, California approved a minimum wage ordinance (Measure D) in the November 6, 2012, General Election that will establish an initial minimum wage at $10.00 per hour and provide for future increases, starting January 2014, based on increases in the cost of living.

Under the new ordinance, employers will be required to pay employees who work at least two hours of work in a calendar week a minimum wage of at least $10.00 per hour. The ordinance allows for a waiver of all or a portion of the requirements through collective bargaining agreements. Employers will be required to post notice of the minimum wage and employee rights in a conspicuous location in the workplace.

The ordinance also requires that employers retain payroll records for a period of four years, and allows the city access to such records to monitor compliance. In addition, the ordinance prohibits employer discrimination or retaliation against employees for exercising their protected rights. Remedies for violations include payment of back wages, civil penalties of $50 to each affected employee for each day of violation, reinstatement and/or injunctive relief, as well as reasonable attorneys' fees and costs. The ordinance becomes effective 90 days after it is certified.

The minimum wage in the City of **San Francisco** will increase to $10.55 per hour effective January 1, 2013. The minimum wage requirement applies to all adult and minor employees, including temporary and part-time workers, who work two or more hours per week. Each year the City adjusts the minimum wage based on increases in the regional consumer price index. Currently the minimum wage is set at $10.24 per hour. The San Francisco Minimum Wage Ordinance (Chapter 12R, San Francisco Administrative Code) also

protects employees who assert their rights to receive the City's minimum wage from retaliation, providing that affected employees may file a civil lawsuit against their employers for any violation of the ordinance.

Also, for city contractors subject to the San Francisco Minimum Compensation Ordinance (MCO), the minimum wage that must be paid to employees will increase to $12.43 per hour effective January 1, 2013. Currently the MCO requires that commercial businesses that contract with the city or that lease property at SFO pay a minimum compensation of $12.06 per hour to employees. The minimum wage rate applicable to nonprofit organizations is currently $11.03 per hour. The MCO requires the minimum compensation rate to be adjusted annually each January 1.

**California Overtime** The overtime exemption for computer software employees has been adjusted to increase to $39.90 per hour; $6,927.75 per month; and $83,132.93 annually on January 1, 2013, and the overtime exemption rate for physicians and surgeons has been adjusted to increase to $72.70 per hour, also effective January 1, 2013. State law provides that these employees are exempt from the overtime requirements stipulated in California Labor Code Section 510 if certain criteria are met. One of the criteria is that the employee's hourly rate of pay is not less than the statutory specified rate, which the Department of Industrial Relations is responsible for adjusting each October 1, to be effective on January 1 of the following year, by an amount equal to the percentage increase in the cost of living. A 2008 amendment extended the exemption to cover computer software employees whose annual and monthly salaries are not less than statutory specified rates, which the department is also responsible for adjusting on October 1. The changes for 2013 reflect a 2.6% increase in the California Consumer Price Index for Urban Wage Earners and Clerical Workers (*Source:* State of California Department of Industrial Relations, Office of the Director—Research Unit, Memorandums, from Maria Y. Robbins, Deputy Chief, Office of the Director, to Christine Baker, Director, DIR, October 24, 2012).

**California Posters** The San Francisco Minimum Wage Poster for 2013 has been added. http://sfgsa.org/modules/showdocument.aspx?documentid=9316

**California Prevailing Wages** California law requires payment of not less than the prevailing rate of per diem wages to workers employed on public works projects. This law is amended to provide that an increased employer payment contribution that results in a lower hourly straight time or overtime wage is not considered to be a violation of the applicable prevailing wage determination so long as specified conditions are met. Also, an increased employer payment contribution that results in a lower taxable wage is not a violation of the applicable prevailing wage determination if specified conditions are met (Ch. 827 (A. 2677), L. 2012, enacted September 30, 2012, and effective January 1, 2013).

**California Public Contracts** Under the California Labor Law, a person or entity is prohibited from entering into a contract or agreement for labor or services with certain types of contractors, namely in construction, farm labor, garment, janitorial, or security guard, if the person or entity knows or should know that the contract or agreement does not include funds sufficient to allow the contractor to comply with all applicable local, state, and federal laws or regulations governing the labor or services to be provided. Effective January 1, 2013, this law will also apply to warehouse contractors. In addition, upon request of the Labor Commissioner, the person entering into the written agreement or contract will be required to provide to the Labor Commissioner a copy of the provisions of the contract or agreement, and any other documentation, as provided. Documents received by the Labor Commissioner pursuant to this requirement from the California Public Records Act would be exempt (Ch. 813 (A. 1855), L. 2012, enacted September 30, 2012, and effective January 1, 2013.

**California Posters** Certain employers and establishments, namely farm labor contractors, hospital emergency rooms and urgent care centers, on-sale general public premises licensed under the Alcoholic Beverage Control Act, certain public transportation stations and adult businesses will be required, under a new law, to post notice regarding slavery and human trafficking. Such businesses and establishments, after a model notice is made available by the Department of Justice, will be required to post the notice near public entrances or in a conspicuous place in clear view of employees and the public that contains information and telephone hotlines of nonprofit organizations that provide services in support of the elimination of slavery and human trafficking (Ch. 515 (S. 1193), L. 2012, enacted September 24, 2012, and effective January 1, 2013).

**California Whistleblower Protection** Effective January 1, 2013, protections will be expanded for whistleblowers under the False Claims Act. Relief will be available to employees, contractors and agents.

An employee, contractor, or agent who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent, or associated others in furtherance of an action under the law or other efforts to stop one or more violations of the False Claims Act will be entitled to all relief necessary to be made whole under the Act, including reinstatement with the same seniority status that the employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, and where appropriate, punitive damages. A three-year statute of limitations will apply for civil actions (Ch. 647 (A. 2492), L. 2012).

**Colorado Marijuana** On November 6, 2012, Colorado voters made history by approving the recreational use of marijuana (Amendment 64). Colorado Attorney General John W. Suthers noted, however, that Coloradans should be aware of two caveats following the victory for legalization proponents. The federal government retains the ability "to criminally sanction possession, use and distribution of marijuana, even if grown, distributed and used in a single state." Also, Amendment 64 supporters had told voters that taxes on marijuana sales would go to Colorado schools, but because the amendment did not meet specified legal requirements under tax law, the state legislature will have to address the issue (*Colorado Department of Law Press Release*, November 7, 2012).

**Colorado Unemployment Insurance** Colorado has secured a bond transaction totaling $630 million in order to build up the Unemployment Insurance Trust Fund. Interest on the issued bonds will be assessed annually to employers identified as subject to bond interest repayment until repayment is complete. The following types of employers are not subject to the bond interest repayment: government employers, political subdivisions, employers with benefits-charged account balances of zero, employers with percent-of-excess greater than or equal to +7, and reimbursing employers. The first bond interest assessment was billed in September 2012, with a due date of October 1. The bond interest rate is 0.0915%. Details on bond principal repayment will be sent to employers along with their premium rate notice in November 2012.

**Connecticut Unemployment Insurance** Effective October 7, 2012, the maximum weekly benefit amount in Connecticut increased to $591.

**Florida Minimum Wage** The Florida minimum wage will increase by 12 cents to $7.79 per hour effective January 1, 2013. For tipped employees, the minimum wage will increase to $4.77 per hour, in addition to tips.

In the November 2, 2004, General Election, Florida voters approved a measure establishing a state minimum wage ($6.15 an hour) and providing for future increases indexed to inflation. The state minimum wage is recalculated each September 30, based on the rate of inflation during the 12 months prior to each

September 1st, using the consumer price index for urban wage earners and clerical workers, CPI-W, or a successor index as calculated by the United States Department of Labor. Each adjusted minimum wage rate is take effect on the following January 1st.

For the period August 2011 to August 2012, the change in the cost of living was 1.6 percent or 12 cents, based on the Consumer Price Index—South Urban Wage Earners and Clerical Workers (*Source*: Florida Department of Economic Opportunity, October 2012).

**Florida Posters** Florida employers required to pay the Florida minimum wage must prominently display a poster substantially similar to the one made available pursuant to Section 448.109(3) in a conspicuous and accessible place in each establishment where such employees are employed. The poster for 2013, in both English and Spanish versions, has been added, http://www.floridajobs.org/minimumwage/Poster-FL_MinWage2013.pdf, http://www.floridajobs.org/minimumwage/Poster-FL_MinWage2013(S).pdf

**Louisiana Posters** English and Spanish versions of the state's employee status poster (employee vs. independent contractor) have been added.

**Massachusetts Medical Marijuana** On November 6, 2012, Massachusetts voters approved Ballot Question 3 (Medical Use of Marijuana). The measure will eliminate state criminal and civil penalties for the medical use of marijuana by qualifying patients. To qualify, a patient must have been diagnosed with a debilitating medical condition, such as cancer, glaucoma, HIV-positive status or AIDS, hepatitis C, Crohn's disease, Parkinson's disease, ALS, or multiple sclerosis.

**Massachusetts Unemployment Insurance** The maximum weekly benefit amount in Massachusetts, effective October 7, 2012, is $674.

**Michigan Background Checks** The state has enacted a law authorizing transit service providers to fingerprint bus drivers they employ for the purpose of receiving criminal history record information from the Department of State Police and the FBI (P.A. 341 (H. 5391), L. 2012).

**Missouri Minimum Wage** The Missouri Department of Labor and Industrial Relations has announced that the state minimum wage will increase to $7.35 per hour effective January 1, 2013. Employers engaged in retail or service businesses whose annual gross income is less than $500,000 are not required to pay the state minimum wage rate. Employers not subject to the minimum wage law can pay employees wages of their choosing (*Source*: Missouri Department of Labor and Industrial Relations, Wage and Hour Notice, November 9, 2012).

**Montana Employment Verification/Immigration** Voters in Montana voted to pass a referendum that would deny state services to undocumented aliens. Referendum 121, Proof of Citizenship to Receive State Service, will require individuals seeking state-funded services to present evidence of either U.S. citizenship or lawful alien status. Individuals who fail to do so would be ineligible to receive state employment, unemployment benefits, vocational rehabilitation, and state professional licensure.

The measure passed 79.6 percent to 20.4 percent.

**New Jersey Equal Pay** Effective November 19, 2012, each employer with 50 or more employees must conspicuously post notice in each workplace, in a form issued by regulation promulgated by the Commissioner of Labor and Workforce Development, detailing the right to be free of gender inequity or bias in pay, compensation, benefits or other terms or conditions of employment under state and federal law prohibiting discrimination based on gender in the payment of wages or compensation. Employees must be provided with a written copy of the notice not later than 30 days after the form of notification is issued by the commissioner; at the time of the worker's hiring, if the worker is hired after the issuance; annually, on or before December 31 of each year; and at any time, upon the first request of the worker (Ch. 57 (A. 2647), L. 2012).

**New Mexico Minimum Wage** Voters in Albuquerque, New Mexico, approved a proposal (Question 2) in the November 6, 2012, General Election that will amend the city's 2006 minimum wage ordinance to raise the minimum wage in the city from $7.50 per hour to $8.50 per hour starting in 2013. The ordinance provides for future increases to be adjusted based on increases in the cost of living.

In addition, starting in 2013, tipped employees like waitresses and waiters will be required to be paid at least 45% of the minimum wage in cash wages from their employers, with the rest of the minimum wage provided in either tips or cash wage; starting in 2014, such tipped employees must be paid at least 60% of the minimum wage in cash wages from employers. Currently tipped employees are allowed to be paid mostly with tips.

A provision in the current ordinance allowing employers to provide certain health care or child care benefits to pay $1.00 less than the minimum wage will remain in place.

**North Dakota Smoking in the Workplace** North Dakota voters approved Statutory Measure No. 4 in the November 6, 2012, General Election, to amend statutory law prohibiting smoking, including the use of electronic cigarettes, in public places and in places of employment in the state, including certain outdoor areas.

Smoking prohibitions are expanded to include areas within 20 feet of entrances and exits, windows and ventilation systems of enclosed areas where smoking is prohibited. Further, smoking will now be prohibited in areas previously exempt, such as bars, gambling and gaming facilities, adult day care facilities, hotels and motels, publicly owned vehicles, retail tobacco stores, halls rented for private functions and truck stops. Also, an exemption for medical necessity, allowing patients to smoke in and around certain licensed state hospitals and care facilities, is repealed.

The law is also clarified to provide that an owner, operator, manager or other person in control of an establishment, facility, or outdoor area may declare that entire establishment, facility, or outdoor area as a nonsmoking place. The measure requires the owner, operator, manager, or other person in control of a public place or place of employment in which smoking is prohibited to post smoking prohibited signs and require such persons to enforce the smoking prohibitions.

The measure further requires state's attorneys to enforce the smoking prohibitions. (https://vip.sos.nd.gov/pdfs/Portals/FullTextofMeasure4-Smoking-Nov6,2012.pdf, http://results.sos.nd.gov/default.aspx).

**North Dakota Unemployment Insurance** The taxable wage base in North Dakota for 2013 will be $31,800. This is an increase of $3,900 over the 2012 taxable wage base of $27,900.

**Oklahoma Affirmative Action** In the November 6 General Election, Oklahoma voters approved a ballot initiative to amend the state's constitution to prohibit the state (including an agency, institution, instrumentality, or political subdivision of the state) from discriminating against, or granting preferential treatment, based on race, color, sex, ethnicity, or national origin "in the operation of public employment, public education, or public contracting." State Question 759 was passed with over 59 percent of voters approving the measure. It allows exceptions to the prohibition when "bona fide qualifications based on sex" are "reasonably necessary" or when necessary to establish or maintain eligibility for any federal funding. In addition, it exempts court orders or consent decrees in force when the measure becomes effective. The passage of the ballot initiative is expected to impact the use of affirmative action in a number of areas, including employment, education, and government contracting.

**Oklahoma Unemployment Insurance** For 2013, the taxable wage base for Oklahoma will be $20,100, up $1,000 from the 2012 amount of $19,100. In addition, contribution rates will continue to range from 0.3% to 9.2%, the state experience factor remains 47%, and the new employer rate will be 2.0%. The maximum weekly benefit amount will be $386 in 2013.

**Oklahoma Violence in the Workplace** The state has amended its law with respect to the carrying of firearms, effective November 1, 2012 (Ch. 259 (S. 1733), L. 2012).

**Pennsylvania Background Checks** The Older Adults Protective Services Act has been amended with respect to criminal history records checks for facility employees (Act 2012-175 (H. 2407), L. 2012, effective October 24, 2012).

**Pennsylvania Child Labor** A new "Child Labor Act" takes effect in the Commonwealth on January 22, 2013. The new Child Labor Act requires a 30-minute rest period for minors who work more than five continuous hours and revises work hour restrictions. In addition the Act adopts by reference federal standards for occupations deemed hazardous to minors (with additional state requirements added); provides new notice requirements for employers hiring minors; and consolidates work permits by establishing one basic work permit as opposed to the three different types under current law. The Act makes changes to child performer provisions, expanding its scope to include performances shown over the Internet or any medium that may be transmitted to an audience; breaking down work hour restrictions by age groups; requiring that the minor employee's educational requirements be met; and requiring that an irrevocable child performer trust account be established to set aside at least 15 percent of the minor's earnings if the minor is expected to receive or has received more than $2,500 in earnings for a production. The new Child Labor Act also adds administrative penalties for violations of up to $5,000. Existing provisions enacted by Public Law 286 (No. 177) of May 13, 1915 (Chapter 2 of Title 43), known as the "Child Labor Law" are repealed (Act 151 (H. 1548), L. 2012, enacted October 24, 2012, and effective January 22, 2013).

**Tennessee Unemployment Insurance** For the period of July 1, 2012, through June 30, 2013, NAICS-based new employer rates in Tennessee are as follows: construction, 8.6%; manufacturing sector 31, 2.7%; manufacturing sector 32, 6.1%; manufacturing sector 33, 8.6%; and mining and extraction, 6.1%.

**Texas Unemployment Insurance** Effective October 1, 2012, the maximum weekly benefit amount in Texas is $440, and the minimum weekly benefit amount is $62.

**Vermont Minimum Wage** Effective January 1, 2013, the minimum wage in Vermont will increase from $8.46 per hour to $8.60 per hour. A "service or tipped employee" of a hotel, motel, tourist place or restaurant who regularly and customarily receives more than $120 per month in tips for direct and personal customer service must be paid a basic wage rate of not less than $4.17 per hour (increased from $4.10 per hour for 2012); If the combination of tips and basic wage do not meet the state minimum wage rate of $8.60 per hour, then employers must make up the difference (Source: Vermont Department of Labor Press Release, November 9, 2012).

In addition, the Vermont Department of Labor has updated room and board deduction rates for 2013 to reflect a 1.7% increase in the cost of living. The Department is required to increase these rates annually. Effective January 1, 2013, an employer will be entitled to deduct from the wages earned an allowance for meals and lodging actually furnished and accepted as follows: Breakfast, $2.90; Lunch, $3.25; Dinner, $3.62, Full Board, $9.77 daily or $68.43 weekly; Nightly Lodging, $3.98; Full Room, $23.94 weekly; Full Room and Board, $82.69 weekly (*Source*: Vermont Department of Labor, Press Release, November 9, 2012, and Update of Room and Board Deduction Rates, November 5, 2012).

**Vermont Posters** An updated poster reflecting Meal and Lodging Allowance rates for 2013 has been added. Effective January 1, 2013, an employer will be entitled to deduct from the wages earned an allowance for meals and lodging actually furnished and accepted as follows: Breakfast, $2.90; Lunch, $3.25; Dinner, $3.62, Full Board, $9.77 daily or $68.43 weekly; Nightly Lodging, $3.98; Full Room, $23.94 weekly; Full Room and Board, $82.69 weekly (*Source*: Vermont Department of Labor, Press Release and Update of Room and Board Deduction Rates, November 5 and 9, 2012). Meal and Lodging Allowance Notice, http://labor.vermont.gov/Portals/0/ Wage%20Hour/WH-31-Meals%20and%20Rooms%20Web%20Sign.pdf.

**Washington Marijuana** On November 6, 2012, Washington voters made history by approving the recreational use of marijuana. Initiative 502 authorizes the sale of marijuana in the state by retailers licensed through the Liquor Control Board. The rules implementing the initiative will not be completed for about one year. The initiative does not amend or repeal Washington's medical marijuana laws in any way (http://www.doh.wa.gov/PublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/MedicalMarijuanaCannabis.aspx).

**Washington Meal and Rest Periods** In an en banc decision, the Washington Supreme Court concluded that a hospital violated the Washington Minimum Wage Act (MWA) by failing to compensate nurses at time and a half their regular rate for the first 10 minutes of rest periods missed during their standard 40 hour workweek (*Washington State Nurses Association v Sacred Heart Medical Center*, October 25, 2012, Madsen, B). Even though the nurses did not physically remain on the employer's premises past the time they would normally go home, the hospital could not avoid its obligation to provide 10 minutes of "hours worked" for rest or to treat time spent working as "hours worked." Consequently, the high court reinstated a jury verdict awarding damages and attorney fees and costs to a union.

*The intent of this Newsletter is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans. © 2012 Gallagher Benefit Services*

Gallagher Benefit Services, Inc.
thinking ahead

Technical Bulletin

Issue 3| 2012

# 2012 Year-End Review & Reminders

The legal, judicial and regulatory landscape for employer-sponsored health plans continued to change rapidly in 2012. Almost all of the developments were related to the Patient Protection and Affordable Care Act ("PPACA"). There were, however, a few developments in other areas, such as FMLA. This Technical Bulletin focuses on developments that are expected to directly impact employers sponsoring health plans – both PPACA and non-PPACA. PPACA contains a large number of provisions that affect health care providers and insurance companies directly and may affect employers indirectly.

We separated the major developments affecting employer-sponsored plans in 2012 into PPACA and non-PPACA sections. We further divided developments in the PPACA section based on the effective date of the provision. In the first PPACA section we review provisions that are already in effect. The second section covers provisions that will begin to impact employers sponsoring health care plans in 2013. The third summarizes regulatory guidance issued in 2012 for provisions that will begin to take effect in 2014. The final section touches on provisions that are not expected to be effective until sometime after 2014.

After a review of 2012 legal, judicial and regulatory developments, we provide some year-end reminders for employers. Some year-end activities, such as calculating imputed income for coverage for a non-tax dependent covered under a health plan, are based on the tax year. Others, such as annually distributing the Women's Health and Cancer Rights Act notice, are plan-year based. Many of the reminders will apply to almost all employers sponsoring health care plans. A few, such as a HIPAA opt-out notice for self-funded governmental health plans, will apply only to some employers.

Following year-end reminders we take a quick look at what <u>might</u> be coming in 2013. Our expectation is that the vast majority of developments in 2013 will be new or additional guidance implementing PPACA.

Finally, we suggest concrete action steps you as an employer sponsoring a group health plan may want to take, if you haven't already, even before more guidance is provided. We also provide a list of GBS resources where you can find more detailed information.

## What Happened in 2012

The most important development in 2012 was the Supreme Court's decision on PPACA in late June. The overwhelming majority of 2012 regulatory activity has been regulations issued to implement provisions of PPACA. But there were a few non-PPACA developments.

### Supreme Court Decision

On June 28, the Supreme Court upheld the constitutionality of the PPACA individual mandate, but limited the PPACA Medicaid expansion. The individual mandate is the requirement that virtually all individuals in the United States purchase a specified minimum level of health insurance or pay a penalty


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The Court ruled that the individual mandate is constitutional based on Congress' taxing authority. The Medicaid expansion significantly increases the number of individuals who would be eligible for Medicaid. Currently, most Medicaid programs are available for children, pregnant women, some adults with children and some disabled adults with limited income. Most states do not cover non-disabled adults without children. Under PPACA, all individuals whose income is less than 138% of the federal poverty level would be eligible for Medicaid. Initially the federal government would fund 100% of the cost of the expansion; over several years the federal government's funding would decrease to 90% of the cost of the expansion. If a State chose not to expand its Medicaid program, PPACA would have permitted the federal government to withhold all Medicaid funds, not just the funds for the expansion. The Supreme Court ruled that withholding all Medicaid funds was "coercive" and therefore impermissible; the federal government would be permitted to withhold only the expansion funds.

## Regulatory Guidance

The overwhelming majority of developments this year were either new or additional regulatory guidance implementing provisions of PPACA. Because of the amount guidance issued this year, we've broken our summary down into four sections based on effective dates: (1) provisions are already in effect; (2) provisions that will become effective in 2013; (3) provisions that are scheduled to begin in 2014; and (4) provisions that are not anticipated until 2015. Changes beyond 2015 are not covered since no guidance was issued this year.

### Provisions Already in Effect

Following is a quick summary of PPACA changes that are already in effect for many plans. Three of the changes apply to all employer-sponsored health plans that are not "excepted benefits"[1], the fourth applies only to non-grandfathered health plans.

***Medical Loss Ratio*** – Beginning in 2011 insurance companies were required to spend at least 80% of premium dollars on health care claims and quality improvement activities (85% in the large group market). Insurance companies that did not satisfy this requirement were required to provide rebates to policyholders by August 1, 2012. Under the regulations, insurance companies were required to send rebate checks to the plan sponsor of group insurance contracts where the plan was either an ERISA plan or a governmental plan. ERISA plans were required to determine what, if any, portion of the rebate constituted plan assets where use of the funds is subject to ERISA requirements. Governmental employers were provided with instructions on how to determine what percentage of the rebate must be returned to participants and given three options for distributing rebates to individual participants. Insurance companies were permitted to send rebate checks to church plans, but only if the plan agreed in writing to distribute the funds to participants using one of the three methods available to governmental plans. In the absence of a written agreement, the insurance company was required to send rebates directly to participants of church plans.

Insurance companies were also required to provide "fill-in-the-blank" rebate notices directly to plan participants. For 2012, insurance companies were required to send a notice to every plan participant, including individuals covered under plans that did not receive a rebate. Beginning in 2013, insurance companies will only be required to send notices to participants covered under plans that receive a rebate. Based on guidance made available on November 30, insurance companies will be required to make rebates payments by September 30, rather than August 1 beginning in 2014.

[1]Excepted benefits are defined under HIPAA and include benefits such as separate, stand-alone dental and vision plans and certain limited insurance policies such as cancer insurance. In addition, separate retiree-only plans that do not cover current employees are also exempt from many (but not all) of PPACA's requirements.


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In April, the IRS also issued guidance on the tax status of the rebate.

***Contraceptives*** – This provision only applies to non-grandfathered plans and is effective for the first plan year beginning after July 31, 2012. Non-grandfathered plans are required to cover contraceptives as preventive care with no cost-sharing (i.e., no deductible, copay or coinsurance). There is an exemption for a narrowly defined class of religious employers. In addition to the exemption there is a one-year enforcement delay for "religious-affiliated" employers. This non-enforcement delay is only available to religious-affiliated employers that are not-for-profit, have religious objections to some or all contraceptive coverage and were excluding some or all contraceptives as of February 10, 2012. Employers who want to use this safe harbor are required to self-certify that they satisfy these requirements and must provide notice to participants.

***Summary of Benefits and Coverage*** – All health plans that are not limited to "excepted benefits" must provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries starting with the first plan year that begins after September 22, 2012. In addition, plans that conduct an annual enrollment period that begins anytime after September 22, 2012, must provide the SBC as part of the materials distributed during that annual enrollment regardless of the plan year. For example, a calendar year plan that conducts its 2013 annual enrollment from November 5 through November 16, would be required to provide an SBC in 2012 as part of its annual enrollment materials.

Regulations issued in May included a template with detailed instructions and limited flexibility. The template has specific requirements such as minimum font size, standard language, a maximum of 8 pages (4 double-sided pages) and two standard cost examples that must be used.

Separate SBCs must be provided for different types of health plans – e.g., PPO and HMO. A single SBC may be used for a plan that has multiple options under one type of plan (e.g., PPO) where differences among options are limited--such as two different deductible levels--as long as the required information can be communicated clearly in a single SBC. Separate SBCs are not required for coverage differences based on coverage level (e.g., single, two person, family) as long as the information about differences based on coverage level are clear and the cost examples are based on single coverage. Premium and/or contribution information is not required on the SBC.

Because of the limited amount of time insurance companies and employers have to create SBCs for the first year, regulators have indicated that intend to be more flexible during the first year for plans that are making a good faith effort to comply.

***Dollar Limits on Essential Health Benefits*** – PPACA prohibits lifetime dollar limits on essential health benefits. Annual dollar limits on essential health benefits are permitted until 2014, subject to certain minimum levels. For plan years that began before September 23, 2012, the limit is $1,250,000; for plan years that begin after September 23, 2012 and before January 1, 2014, the limit is $2,000,000. Plans that already had lower limits in 2010 and wanted to continue to use lower dollar maximums could do so only if they obtained a waiver from the Department of Health and Human Services ("HHS"). Plans approved for a waiver by HHS are required to provide a standard notice to participants and submit an annual update application to HHS. HHS stopped accepting applications for new waivers at the end of September 2011.

*Note: two other provisions – the Patient-Centered Outcomes Research ("PCOR") Fee and Form W-2 reporting of health coverage cost - are included in the next section because the primary employer requirements – payment of the PCOR fee and Form W-2 reporting - will occur in 2013.*


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## Provisions that Take Effect in 2013

Six major provisions will take effect in 2013. Four take effect on the same date for all plans; one is based on the employer's health plan year, and one is based on the employer's tax year.

***Medicare Tax Increase*** – Individuals with incomes greater than $200,000 ($250,000 if married and filing a joint return, $125,000 if married and filing separately) will be required to pay an additional 0.9% Medicare tax on wages over those amounts. Employers will be required to withhold the additional 0.9% on wages that exceed $200,000. The IRS issued guidance in the form of FAQs in July. The effective date is tax years beginning after December 31, 2012.

***Form W-2 Reporting of Health Care Costs*** – Starting with 2012 Form W-2s issued in January 2013, most employers will be required to include the cost of health care coverage in Box 12. Employers that file fewer than 250 Forms W-2, self-funded church plans, and multiemployer plans will not be required to report the cost in 2013 under transitional relief provided by the IRS. The cost of coverage will generally be the COBRA cost (minus the permitted 2% administrative charge) and must be based on the calendar year rather than the employer's plan year. Regulations issued in February provide detailed guidance for calculating and reporting the cost of coverage.

Coverage that must be reported is not limited to major medical plans. Other types of health care coverage--such as most EAPS and some wellness plans--must be included, as well as executive plans, including physicals, and any supplemental medical benefits (except discriminatory amounts that are imputed as income to affected executives), on-site medical clinics, and employer contributions to a health care FSA. Coverage that would not be reported includes stand-alone dental or vision, employee salary reduction contributions to a health care FSA, HSAs, and certain specified types of insurance such as cancer policies where the employee pays 100% of the cost on an after-tax basis. Health reimbursement arrangements (HRAs) do not need to be reported in 2013 under transition relief provided in the regulations.

***$2,500 Health Care FSA Maximum*** – For plan years that begin after December 31, 2012, employee salary reduction amounts will be limited to $2,500. This maximum does not apply to employer funds. Since the limit is applied on a per employee basis, married employees that have access to separate FSAs either with separate employers or with the same employer may each elect a salary reduction amount up to the $2,500 annual maximum.

***Exchange Notice to Employees*** – Employers will be required to provide a written notice about a State exchange and some of the consequences if an employee purchases a Qualified Health Plan (QHP) through an exchange rather than electing coverage under the employer's plan. The notice must be provided to all current employees no later than March 1, 2013. No regulatory guidance or model notice has been provided as of November 30.

***Patient-Centered Outcomes Research (PCOR) Fee*** – This requirement applies to employer-sponsored group health plans and also applies to separate retiree-only health plans even though they are generally not required to comply with PPACA's coverage mandates or reporting and administrative requirements. The fee is $2 multiplied by the average number of lives covered under the plan during the plan year ($1 for the first plan year). The requirement begins with the first plan year that ends after September 30, 2012 and will stop applying for plan years that end after September 30, 2019 (for calendar year plans, the fee will be due for calendar years 2012 through 2019). The fee must be reported using Form 720 and paid by July 31 of the year following the end of the plan year (e.g., the first payment will be due by July 31, 2013 for a calendar year plan). Insurance companies will be responsible for reporting and paying the fee under insured plans. The plan sponsor is the responsible party for a self


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-funded plan. Guidance issued in April provides several methods for determining the number of covered lives.

***Retiree Drug Subsidy*** – Retiree drug subsidy payments will not be excludable from income for tax years after 2012.

## Provisions that Take Effect in 2014

Many of PPACA's provisions will begin to take effect in 2014 and will have a significantly greater impact on employers sponsoring health care plans than those effective prior to 2014. Regulators issued a substantial amount of new guidance in 2012 covering several key provisions. There were several major regulations which may affect employers, which we have organized into three areas: (1) employer shared responsibility ("play or pay"), (2) Exchange regulations affecting employers sponsoring health plans; and (3) a transitional reinsurance fee that health plans will be required to pay.

### *Employer Shared Responsibility Provisions*

Regulators issued guidance in August on three provisions of the Employer Shared Responsibility ("play or pay") requirements that will become effective in 2014: (1) "minimum value" which is one of two factors that will be used to determine if the employer will "play or pay"; (2) a limit of 90 days on coverage waiting periods; and (3) the definition of "full-time" for the employer shared responsibility rules.

*Minimum Value* - Employers that don't offer "minimum essential coverage" to full-time employees in 2014 will be subject to PPACA's employer shared responsibility penalties. Minimum essential coverage is defined as "affordable" coverage that provides "minimum value." Minimum value is defined as coverage designed to reimburse at least 60% of covered expenses. Unlike coverage to be provided by insurance companies under Qualified Health Plans (QHPs) to be offered through Exchanges, the employer's plan is not required to cover all 10 of the categories included in "essential health benefits[2]" in order to provide minimum value. In guidance provided in May, the IRS indicated that rules for determining minimum value for employer-sponsored plans will be similar to those used for evaluating coverage under QHPs, but will be determined using claims data that reflects typical self-insured plans. In the guidance, regulators noted that for large group health plans, four types of services largely determine the value of the plan – physician and mid-level practitioner care; hospital and emergency room, pharmacy and lab and imaging services.

In May regulators suggested three possible methods for determining if an employer plan provides minimum value: (1) HHS and IRS may jointly develop a minimum value (MV) calculator similar to an actuarial value (AV) calculator which HHS will develop for insurance companies to use in evaluating plans to be offered on exchanges. The MV calculator would enable an employer to determine the value of its health plan by entering a limited amount of data; (2) the IRS may develop an array of design-based safe harbors in the form of checklists that employers could use to determine if their plan provides minimum value; and (3) actuarial certification. *(Additional clarification on the development of the AV calculator, MV calculator, use of these three methods and treatment of HSAs and HRAs is contained in proposed guidance made available on November 20. A separate GBS Healthcare Reform Update newsletter provides more detailed information.)*

[2]The 10 general categories included in essential health benefits are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.


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*90-Day Maximum Coverage Waiting Period* – Beginning in 2014, employers will not be able to use a waiting period for group health plan eligibility that exceeds 90 calendar days. The 90-day period cannot be extended with the use of a first of the month entry rule. The limitation will apply to all employers providing coverage, including small employers that are not subject to a penalty under PPACA for failing to offer minimum essential coverage. It will also apply to any employee who is eligible to enroll in the health plan, not just full-time employees. However, the 90-day clock starts when the employee becomes eligible to enroll under the terms of the plan which may not be the employee's date of hire.

In October regulations, the IRS stated that it would not levy a penalty against an employer for failing to provide coverage to an employee for the first 3 calendar months of employment. While the IRS will not impose a "play or pay" penalty, it does not appear that an employer would be permitted to use a 3-month waiting period since during much of the year a 3-month period would exceed 90 days. For example, if a full-time employee is hired into an eligible class and begins works on March 1, 2014, the IRS would not assess a penalty if the employee is not eligible for coverage during March, April or May 2014. However, the employer would not be permitted to use a 3-month waiting period since March, April, and May totals 92 days which is greater than the 90 day permitted maximum.

*Definition of Full-Time Employee* – One of the most anticipated regulations was the definition of a full-time employee. PPACA defines full-time as an average of at least 30 hours per week. The status of some employees will be clear when the employees are hired. However, many employers hire employees whose work schedule is not uniform. These individuals may work for 20 hours one week and 40 hours for the following week. Regulations issued in August 2012 provide guidance on measuring hours and determining full-time status for these variable hour employees.

While calculating hours worked by an employee paid on an hourly basis is straightforward, measuring hours worked for an employee paid on a different basis such as salaried is more difficult. The guidance provides three methods for measuring hours: (1) using actual hours worked; (2) crediting an employee with 8 hours for every day the employee worked at least one hour; or (3) crediting the employee with 40 hours for each week the employee worked for at least one hour.

The regulations provide a safe harbor method of determining full-time status for variable hour employees which will be available until the end of 2014. Under the safe harbor method, an employer would determine full-time status for an ongoing employee (not newly hired) based on hours credited during a "standard measurement period" which is a time period of at least three and no more than 12 consecutive months selected by the employer. If the employee is determined to be full-time during the standard measurement period, the employee must be offered coverage during the "stability period" that follows the standard measurement period. The stability period selected by the employer may be from six to 12 months, but may not be shorter than the standard measurement period. Employers may also use an "administrative period" of up to 90 days in order to have sufficient time to perform activities such as reviewing records to determine hours worked, distributing enrollment materials to employees determined to be full-time and eligible for coverage, collecting employee coverage elections, and transmitting election information to insurance companies or TPAs. Once an employer has selected standard measurement, stability and administrative periods, the employer is generally required to use the same periods for all employees. Regulations permit variations for four specific groups of employees: (1) collectively bargained and non-collectively bargained; (2) hourly and salaried; (3) different entities; and (4) different states.

Similar rules apply to newly hired employees, but the rules use an "initial measurement period" rather than a standard measurement period. The guidance also includes a transition rule for employees transitioning from new to ongoing status. Detailed rules along with sample calculations using varied


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scenarios are included in the regulations.

***Exchanges***

Regulators issued guidance in two areas – essential health benefits and health insurance premium tax credits - that will be needed to establish and operate State exchanges. While much of the guidance is intended for States that will be establishing exchanges and insurance companies that will be offering Qualified Health Plans (QHPs), some of the guidance may affect employers.

*Essential Health Benefits* – The definition of essential health benefits will affect small employers that choose to purchase coverage for employees through a State exchange since the plans offered on those exchanges will be required to cover essential health benefits. HHS's intended approach to essential health benefits is to have essential health benefits defined by a benchmark plan selected by each state. The benchmark plan would serve as a reference point and for the scope of services covered and any limits. HHS guidance provided four options for a state to select a benchmark plan. States were expected to select a benchmark plan by October 1 and a number have done so. HHS has proposed that the default plan for States that have not selected a benchmark plan will be the largest plan by enrollment in the largest product in the state's small group market.

The benchmark plan will largely determine the coverage that will be included in QHPs and will also determine which services covered by a QHP will not have a dollar limit, as PPACA prohibits lifetime and annual dollar limits (beginning in 2014) on essential health benefits.

HHS also provided additional guidance to States for establishing an exchange including using one of three models: a state-run exchange; a state-federal partnership exchange, and a federal-run exchange. States were expected to notify HHS of their intentions by November 16. On November 15, HHS extended the deadline to Dec 14.

*Health Insurance Premium Tax Credit* - The IRS issued additional guidance on the health insurance premium tax credit in May 2012 that modified proposed guidance issued in August 2011. While most of the guidance focuses on individuals, portions of the regulations cover how eligibility for and/or enrollment in an employer-sponsored health plan would affect an individual's eligibility for a health insurance premium tax credit.

The regulations also describe how employer contributions to an employee's Health Savings Account or a Health Reimbursement Arrangement may affect the affordability of employer-sponsored coverage; provide general rules for determining the affordability of the employer's plan for employees who have been employed for less than one full year (W-2 wages for a full year would not be available); and include guidance on handling situations involving automatic enrollment and waiting periods. In the preamble, regulators stated that future guidance would address several very important outstanding issues, including final rules for determining affordability for related individuals – the employee's family.

***Reinsurance Fee***

PPACA creates a transitional reinsurance program intended to help stabilize premiums in the individual market in 2014, 2015, and 2016. Insurance companies and TPAs on behalf of self-funded plans will be required to pay a reinsurance fee to the federal government in each of those years. The amount of the fee that the federal government will collect per covered person (national fee) will be determined by HHS. In addition, states are permitted to collect additional amounts from insurance companies under certain circumstances. Preliminary guidance on the transitional reinsurance program (but not the amount of the


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national fee) was issued in August. Guidance made available on November 30 indicates that the national per covered life fee for 2014 will be $5.25 per month or $63 per year. In the preamble, HHS indicates that they may consider deferring until a future year the portion of the fee intended to reimburse the government's cost for the Early Retiree Reinsurance Program (ERRP). Based on the regulator's statement that the ERRP portion is 16.6%, the reduced fee would be approximately $4.38 per month. More detailed information on the November 30 guidance will be provided in an upcoming issue of our Healthcare Reform Update newsletter.

***Wellness***

Additional guidance relating to wellness programs was made available on November 20. In general the proposed guidance: (1) increases the maximum permissible incentive/penalty for standards-based wellness programs (now called "health-contingent wellness programs" from 20-30% with an increase to 50% available for certain smoker/nonsmoker incentives/penalties; (2) includes a new standard for determining when a wellness program provides a "reasonable alternative" for obtaining the same reward in a health-contingent program; and (3) makes the increased incentives/penalties available to both grandfathered and non-grandfathered plans. These proposed rules would become effective for plan years beginning after December 31, 2013. More detailed information on the November 24 guidance will be contained in an upcoming issue of our Healthcare Reform Update newsletter.

## Provisions that Take Effect in 2015

Two additional provisions are not expected to take effect until 2015. Those two provisions are the automatic enrollment requirement and two new reports – a health insurance coverage report and large employer health care coverage report.

***Automatic Enrollment –*** PPACA requires large employers – defined as 200 or more full-time employees – to automatically enroll new full-time employees in one of the employer's health plans once the employee has satisfied eligibility requirements. The law also requires the employer to give employees adequate notice and an opportunity to opt-out of coverage. The law does not include a specific effective date for this requirement. The DOL has indicated that employers will not need to comply until final regulations are issued and that those regulations are not expected to be available in time to implement the automatic enrollment provision by 2014.

***Health Plan Reporting –*** There are two new health plan reports that will be required beginning in January 2015. Both reports are designed to collect information about health insurance and employer-provided health coverage information that will be needed by Exchanges and the IRS to administer health insurance premium tax credits and penalties for failure to offer minimum essential health coverage (employers) or maintain required health coverage (individuals).

The first report is the report on health insurance coverage which must be filed by insurance companies and employers that provide minimum essential coverage. This annual report will include information about insured individuals including the name address and Social Security number of the primary insured; the name and Social Security number of everyone insured; coverage dates, and if coverage is purchased through an exchange information about the QHP; and any health insurance premium tax credit or cost-sharing reduction. The employer report must also include the employer's name, address, and Tax Identification Number (TIN) plus what portion of the premium the employee is required to pay. There is also a separate requirement for notice to individuals.

The second report is the large employer report on health coverage. "Large employer" for the purposes of


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this requirement is defined as an employer with 50 or more full-time employees that offers minimum essential coverage. The large employer report on health coverage will include information such as the employer's name and TIN, and certification of whether the coverage is "minimum essential coverage." If the coverage is "minimum essential coverage," the report must also include information on the length of any waiting period; the monthly premium for the lowest cost option in each enrollment category (e.g., single, family); the employee's share of total allowed costs; the number of full-time employees (monthly), and, for full-time employees, the name, address and Social Security number along, with the months the employee (and any family members) were covered. Similar to the health insurance reporting requirement, a written statement of coverage must be provided to employees.

The IRS requested comments in April (the comment period closed on June 11), but has not issued guidance as of November 30.

## Non-PPACA Developments

There were several non-PPACA developments in 2012 – new FMLA regulations, a Supreme Court decision on FMLA affecting government employers, an appellate court decision on a wellness program in the 11th circuit, and regulations for implementation of a unique health plan identifier by late 2014. Enforcement activity under ERISA and HIPAA also increased significantly in 2012. Each is briefly summarized below.

### FMLA

The Department of Labor (DOL) issued proposed regulations in January implementing changes made by the 2010 National Defense Authorization Act ("2010 NDAA") and the Airline Flight Crew Technical Corrections Act ("AFCTCA") enacted on October 28, 2009. Changes in the 2010 NDAA that affect military veterans will not become effective until the DOL issues final regulations. Changes affecting airline flight crew members became effective on October 28, 2009; however, the DOL has stated that it will exercise discretion in assessing employer compliance until it issues a final rule.

#### *Military Leaves*

The 2010 NDAA expanded the definition of a covered servicemember to include recent veterans (servicemembers honorably discharged within the last five years.) Second, it modified the definition of a serious illness or injury to include a serious illness or injury that existed prior to the beginning of service, but was aggravated by active duty service. The guidance defines key terms such as "aggravated by active duty" and expands the list of health care providers that will be able to certify a serious illness or injury. Prior guidance had limited health care providers for military leaves to Department of Defense (DOD), Veterans Administration (VA) or TRICARE (network or non-network authorized) health care providers. This list was expanded to include a much broader network of health care providers since veterans may not have access to DOD, VA or TRICARE providers.

The regulations also include rules for handling situations involving more than one military leave (e.g., for two different conditions or as an active servicemember and then as a veteran). Finally, the maximum Rest and Recuperation (R&R) leave under a qualifying exigency leave was expanded from a maximum of five to a maximum of 15 days.

#### *Airline Flight Crew Rules*

The AFCTCA modified the hourly requirement for airline flight crew members – pilots, flight attendants and flight engineers – to adjust for the fact that flight crew members may be paid based on actual in-flight hours rather than every hour spent on the job. Additional time spent at work such as time between


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flights may not be paid time. Under the new rules flight crew members must have either worked or been paid for at least 60% of the monthly guarantee amount and have worked or been paid for at least 504 hours in the previous 12-month period. Additional guidance was included on calculations for flight crew members that are in "reserve" status. Airline employees who are not flight crew members must satisfy the 1,250 hours during the last 12 months requirement.

***U. S. Supreme Court Decision on FMLA for States***

FMLA requires affected employers to give eligible employees up to 12 weeks of leave in order to care for family members such as the employee's spouse or child with a serious health condition. FMLA also includes a provision that an employer must permit an employee to take an FMLA leave because of the employee's own serious health condition – sometimes referred to as a "self-care" provision. In March, the Supreme Court ruled that States (as employers) cannot be sued by individuals under FMLA's "self-care" provision based on States' Sovereign Immunity. The Court had previously upheld an employee's right to sue States for FMLA leaves based on the family care provisions of the FMLA.

## 11th Circuit Appeals Court Decision on Wellness Plan

An employer in Florida established a wellness program which included completion of a health risk assessment questionnaire and a biometric screening which consisted of a finger stick for glucose and cholesterol. Employees who did not complete both the questionnaire and biometric screening were assessed an additional $20 per paycheck contribution for coverage under the employer's medical plan. Employees who completed the questionnaire and the biometric screening were not charged the additional $20 regardless of the results of the tests or information on the questionnaire. HIPAA permits incentives and penalties for participation based programs (and standards based now called "health-contingent" programs with certain restrictions). However, an employee sued asserting that the employer violated the Americans with Disabilities Act ("ADA") prohibition against non-voluntary medical examinations and disability-related inquiries. The ADA generally prohibits an employer from requiring a medical exam or making inquiries about whether an employee has a disability or the nature or severity of any disability unless the exam or inquiry is shown to be job-related and consistent with business necessity. The ADA also contains a safe harbor provision that exempts certain insurance plans permitting an employer to establish and administer a bona fide benefit plan using principles for underwriting, classifying or administering risks that are based on or not inconsistent with State law.

A district court ruled in favor of the employer in 2011. In March, 2012, the 11th Circuit Court of Appeals agreed with the district court and ruled that this employer's wellness program fell within the safe harbor provision because it was a term of the employer's group health plan and the employer's health plan qualified as a bona fide benefit plan under the ADA. This ruling applies to employers in the 11th circuit – Alabama, Florida and Georgia. It is not clear at this time whether courts in other jurisdictions would come to the same or a different conclusion. Further, as of November 30 we do not yet have definitive guidance from the Equal Employment Opportunity Commission (EEOC).

## Unique Health Plan Identifier (HPID) Regulations

The Department of Health and Human Services (HHS) issued final regulations for a unique national health plan identifier (HPID) in September. The HPID will be used in the future (beginning in November 20**16**) in HIPAA standard transactions such as Coordination of Benefits. Health plans that meet the definition of a Controlling Health Plan (CHP) will be required to obtain an HPID using a web-based Enumeration System currently being developed by HHS. The web site is expected to become operational in the first


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quarter of 2013. Regulations indicate that self-insured group health plans that satisfy the definition of a Controlling Health plan (CHP) will need to obtain an HPID:

*Controlling health plan (CHP) means a health plan that –*

1. *Controls its own business activities, actions, or policies; or*
2. *(i) Is controlled by an entity that is not a health plan; and (ii) If it has a subhealth plan(s) (as defined in this section), exercises sufficient control over the subhealth plan(s) to direct its/their business activities, actions, or policies.*

*Subhealth plan (SHP) means a health plan whose business activities, actions, or policies are directed by a controlling health plan.*

CHPs are required to obtain an HPID by November 5, **2014** (November 5, 2015 for small plans which are defined as health plans with annual receipts of $5 million or less) and use the HPID in HIPAA standard transactions beginning on November 7, **2016**. Subhealth plans may, but are not required to, obtain an HPID.

### Increased Enforcement Activity

Two federal agencies increased enforcement activities during 2012. First, the Department of Labor (DOL) increased the number of ERISA audits and began to include PPACA compliance in those audits. DOL audits have in the past frequently included ERISA reporting, disclosure and fiduciary responsibility, COBRA, HIPAA portability (e.g., special enrollments, limited pre-existing conditions, prohibit discrimination based on health conditions and wellness program rules), Women's Health and Cancer Rights Act, Newborns' and Mothers' Health Protection Act and the Mental Health Parity and Addiction Equity Act.

Second, the Office of Civil Rights (OCR) which is part of HHS increased HIPAA privacy and security audits. OCR began with a pilot audit program in November 2011. The pilot program was to perform up to 150 audits of covered entities between November 1, 2011 and December 31, 2012. OCR stated that they intend to use the audit process to identify best practices and to discover potential risks that have not been identified in previous compliance reviews and complaint investigations. In addition, so far in 2012 OCR has levied several fines in excess of $1,000,000 for violations of HIPAA's privacy and security rules.

## 2012 Year End Reminders

*Note: Unless Congress extends the 2% FICA payroll tax holiday that has been in effect for 2011 and 2012, employees can expect to see a 2% pay reduction beginning on January 1, 2013. Employers may want to send a short reminder to employees.*

Employers may also want to perform year-end administrative activities such as the following:

**Cafeteria plans** - Perform year-end nondiscrimination tests for the 2012 year. Notify highly compensated participants or key employees if they will have any additional taxable income. Once enrollment data for 2013 is available, employers may also want to perform preliminary nondiscrimination testing for 2013 and notify highly compensated participants or key employees if it appears that the plan might need to modify any 2013 elections in order to pass the actual test at the end of the year.

**Certificates of Creditable Coverage (Drug)** – Provide a Certificate of Creditable Coverage (drug) to Medicare eligible individuals.


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**Creditable Coverage Notice to CMS** - Plan sponsors who provide prescription drug coverage must disclose annually to CMS whether the plan's prescription drug coverage is "creditable prescription drug coverage." The disclosure must be transmitted to CMS within 60 days after the beginning date of the plan year. For plan years beginning on January 1, 2013, this means the disclosure must be transmitted to CMS no later than March 1, 2013

If there is a change in the creditable coverage status of the plan (e.g., from creditable to non-creditable) or a termination of the drug plan during the year, a new notice is required within 30 days after the change or termination.

Instructions on how to complete the on-line disclosure to CMS are posted on CMS' website at:

https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp

**Certificates of Creditable Coverage (Health)** – Send a Certificate of Creditable Coverage (health) to individuals whose coverage under the employer's health care plan ends - for example, participants who drop coverage during open enrollment.

**CHIPRA Notice(s)** – Distribute an updated general CHIPRA notice to employees about the potential for premium assistance under a State CHIP (Children's Health Insurance Program) or Medicaid program.

**Early Retiree Reinsurance Program (ERRP)** – Employers receiving reimbursement under this program were required to provide all plan participants, not just early retirees, with a specific form notice stating that the employer is participating in the program. The form notice is available on the ERRP website and may not be modified. Employers are required to provide this notice to new plan participants within a reasonable amount of time after they enroll.

**FSA** – remind employees about the use-it-or-lose-it rule. Employers with FSA plans that currently permit salary reduction amounts greater than $2,500 may also want to advise employees that the maximum salary reduction amount will be $2,500 starting with the first plan year that begins after December 31, 2012.

**Group Term Life Insurance Imputed Income** - Determine the amount of imputed income for employer-provided employee life insurance in excess of $50,000 and the value of all dependent life amounts if the employer-provided amount is more than $2,000. For discriminatory plans, the total value of all employer-provided coverage must be included in key employees' income.

**Health Insurance Imputed Income** - Calculate the amount of imputed income for coverage of any non -federal tax dependent covered under the employer's health care plan. This may include a domestic partner, an older child (e.g., age 28) or an individual who is recognized as a spouse under state but not federal law. In addition, calculate the amount of imputed income for highly compensated employees under a self-funded health plan that did not satisfy nondiscrimination rules.

**HIPAA Opt-Out Notices** – Self-funded nonfederal governmental plans that want to opt out of any of four HIPAA requirements - Mental Health Parity and Addiction Equity Act, Women's Health and Cancer Rights Act, Newborns and Mothers Health Protection Act, or Michelle's Law - must provide an annual notice to the Department of Health and Human Services (HHS) and plan participants.

**HIPAA Privacy Notice** – Provide a notice of the availability of a copy of the privacy policy every third year. Employers may want to provide this notice every year to eliminate the need for tracking.


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**Medical Plans** – Send the annual "Women's Health and Cancer Rights Act" notice.
**Vacation/PTO** – For calendar year plans, determine the number of days that will be cashed out before the end of the year.

## What is (or Might be) Coming in 2013?

Although many would like to see the pace slow down for 2013, that is unlikely to happen. Given the amount of work that will be needed to implement many of PPACA's requirements by January 1, 2014, it is almost certain that the amount of regulatory guidance issued will increase in 2013. While it is difficult to predict accurately what regulators will provide, there are some areas where many hope that guidance will be provided – as soon as possible. Some of the key areas are:

- Final reinsurance rates for 2014;
- Guidance on how using incentives or penalties under wellness programs might be factored into determinations of coverage affordability;
- Nondiscrimination requirements for fully insured group health plans. PPACA added a prohibition against discriminating in favor of highly compensated employees applicable to non-grandfathered health plans. Implementation of the new rules is being delayed until the IRS issues guidance;
- Methods for exchanges to verify individual's access to employer-sponsored health coverage;
- Additional guidance on premium tax credits and SHOP exchange;
- Additional guidance on employer shared responsibility rules; and
- Guidance on the new health insurance and large employer health coverage reporting requirements – especially ways to reduce or eliminate duplication.

Given that regulators will have a lot to accomplish just issuing guidance on PPACA, new regulations in other areas such as FMLA and HIPAA privacy and security might proceed at a slower pace (but no guarantees).

## Action Steps & Additional Resources

Many of the concrete action steps are already included in the Year-End Reminders section above. But there are some more general action steps that employers may want to take:

- Review and update existing HR and benefits policies to ensure continued compliance with legal and regulatory changes;
- Review and update current documents such as insurance contracts, plan documents, summary plan descriptions, and HR manuals;
- Communicate changes to employees including providing the new SBC, any required summary of material modifications, and required notices; and
- If losing grandfathered status be sure to make required changes such as new claims and appeals requirements; coverage of adult children who are eligible for other employment-based health coverage; preventive coverage at 100%; and new rules governing selection of a primary care provider (PCP) and coverage requirements for treatment in the emergency room of an out-of-network hospital. And don't forget to remove the special "grandfather" language from documents.

### Additional GBS Resources

GBS has a wealth of additional information and resources to help you as you strive to comply with PPACA


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and other federal requirements. You can access these resources by clicking on the links below.

Healthcare Reform Web page (click here)

Healthcare Reform Update newsletters (click here)

Recorded Webinars (click here)

Technical Bulletins (click here)

Directions Newsletters (click here)

We also provide charts showing selected plan limits for health and welfare plans for 2012 and 2013 and updated Medicare values. The first chart includes general information on the Social Security base wage, dollar values to determine highly compensated or key employee status, health savings account values, and values for adoption assistance, transportation assistance and long term care (click here). This chart will be updated when the dollar values for transportation assistance become available. You may want to click on the above link later this year to obtain an updated chart.

The second chart contains values for Medicare deductibles, copayments and premiums (click here). The third chart shows income-adjusted premium amounts for Medicare Parts B and D for individuals whose income exceeds specific dollar levels (click here).

*The intent of this Technical Bulletin is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law; plans sponsors should seek proper legal advice for the application of these rules to their plans. © Gallagher Benefit Services, Inc. 2012*

**January 2013**

# Definition of a Large Employer Under New Employer Shared Responsibility Regulations

On December 28, 2012, the Internal Revenue Service ("IRS") released proposed regulations providing guidance on the employer shared responsibility provisions of the Patient Protection and Affordable Care Act ("PPACA") (Section 4980H of the Internal Revenue Code as added by PPACA). The regulations generally adopt four previous Notices regarding the employer shared responsibility provisions with some modifications, as well as, proposing guidance on additional issues. The proposed regulations provide rules addressing what it means to be a large employer (to whom the employer shared responsibility rules apply), determining the number of full-time employees, determining whether an employer is subject to assessable payments, and the mount of any assessable payments. This article will discuss the proposed rules for determining large employer status and for counting the number of full-time employees of an employer. IRS also released a set of questions and answers on PPACA's employer shared responsibility provisions, which can be found here. The full proposed regulations can be found here.

For a discussion of the proposed rules applying to assessable payments, please see the article in this issue of Healthcare Reform Update titled *Regulations Address Employer Shared Responsibility Compliance and Penalties*. To read more on the transition rules, please see the article in this issue of Healthcare Reform Update titled *Transitional Rules Offer Relief for Compliance with Employer Shared Responsibility Rules*.

**Employer Shared Responsibility Background**

The employer shared responsibility provisions of PPACA provide that an applicable large employer is subject to an assessable payment if any employee of the employer purchases coverage through an Exchange and is certified by the Exchange as having received a premium tax credit or cost-sharing reduction under the following conditions:

1) The employer fails to offer its full-time employees (and dependents) minimum essential coverage ("MEC") under an eligible employer-sponsored plan, or

2) The employer offers its full-time employees (and dependents) MEC under an eligible employer-sponsored plan, but the coverage either doesn't provide minimum value ("MV") or is not affordable.

The liability for payment arises only where one or more full-time employees are certified by an Exchange to an employer as having received an applicable premium tax credit or cost-sharing reduction.

Most employer group health plans – other than plans that provide excepted benefits – will meet MEC standards. A plan provides MV if the group health plan's share of the costs of benefits is at least 60% of the total allowed costs of benefits provided under the plan. Provided coverage is affordable means that the employee's required contribution for self-only coverage does not exceed 9.5% of the employee's household income. The employer is required to offer coverage to the employee's dependents which the December 28

regulations generally define as the employee's children up to age 26. There is no requirement that the cost of coverage for dependents be affordable in order for the employer to avoid a penalty.

**Who is a Large Employer?**

An assessable payment is only levied against an applicable large employer. An applicable large employer is one with an average of at least 50 full-time or full-time equivalent ("FTE") – discussed below – employees through the course of a calendar year. An employee and employer are defined by common law standards. An employment relationship exists where an employee is subject to the will and control of the employer not only as to what shall be done but how it shall be done. It is sufficient that the employer has the right to control, without necessarily exercising control. Sole proprietors, partners in a partnership, and 2-percent S corporation shareholders are not employees. Leased employees are not counted as employees of the service recipient organization. However, an individual who is both an employee and non-employee (for example, an individual who is an employee and director) is an employee with respect to hours of service (counted to determine an employee's full-time status). The look-back measurement method that may be used to identify full-time employees for the purpose of determining potential assessable penalties does not apply when determining whether an employer is an applicable large employer. Instead the determination of whether an employer is an applicable large employer is based on the hours of service of employees in the prior year.

***Aggregation of Employers***

The employer shared responsibility provisions provide that entities treated as a single employer under sections 414(b), (c), (m), or (o) of the Code (controlled group and affiliated service group rules), are also treated as a single employer for counting the number of the full-time (or FTE) employees for purposes of determining applicable large employer status. However, until further guidance is issued, government entities, churches, or an association of churches may rely on a reasonable, good-faith interpretation of the Code sections above when determining applicable large employer status.

The proposed rules clarify that where multiple entities are aggregated and determined to be an applicable large employer, each entity is considered an applicable large employer on its own, regardless of the number of employees attributed to each entity. For example, if an applicable large employer consists of a parent corporation and 10 wholly-own subsidiaries, then each of the 11 entities will be deemed an applicable large employer, regardless of an entity's number of full-time (or FTE) employees. Although large employer status is determined on an aggregated basis, the liability for, and the calculated amount of, any assessable payment is computed and assessed separately for each applicable large employer member.

***Successor Employers***

The employer shared responsibility rules provide that a predecessor employer be taken into account when determining applicable large employer status. These proposed rules do not address the specific rules identifying a predecessor employer; however, IRS intends to address this in future rules. Until the future guidance is issued, a reasonable, good-faith interpretation of predecessor and successor employer rules from employment law may be relied upon.

***New Employers***

The proposed rules provide that an employer that has not been in existence for the entirety of the preceding calendar year is deemed an applicable large employer where it is reasonably expected to employ 50 full-time

(or FTE) employees during the current calendar year. However, the preamble seeks comments on any safe harbors or presumptions to assist new employers in the applicable large employer determination.

### *Seasonal Employees*

The employer shared responsibility rules provide that where the number of employees of an employer exceeds 50 full-time employees for 120 days or less during a calendar year, and those employees in excess of 50 were who were employed for less than 120 days are seasonal workers, the employer is not an applicable large employer. For the purposes of determining seasonal employee status, four calendar months is treated as the equivalent of 120 days. In making this determination, an employer may use either a period of four calendar months or 120 days, neither of which need to be consecutive. An employee may still be deemed a seasonal worker if they work more than four months or 120 days, however, the measuring periods are used only in determination of applicable large employer status and are not part of the seasonal employee definition. The rules define a seasonal worker as a worker who performs labor or services on a seasonal basis and retail workers employed exclusively during the holiday seasons. This definition is not limited to agricultural and retail workers, however, until further guidance is issued, a reasonable, good-faith interpretation may be relied upon.

### *Full-Time Equivalent Employees*

The employer shared responsibility rules provide that an employer must calculate the number of full-time equivalent employees it employed during the previous calendar year for purposes of determining whether the employer is an applicable large employer for the current calendar year. The method adopted by the proposed regulations to determine the number of full-time equivalent employees for a particular month during the previous calendar year is to include all employees (including seasonal employees) who were not full-time employees during that particular month. The number of full-time equivalent employees is then determined by: 1) calculating the aggregate number of hours of service (but not more than 120 hours of service for any employee) for all employees who were not employed on average at least 30 hours service per week for that month, and 2) dividing the total hours of service calculated above by 120. The result is the number of FTE employees for the calendar month.

Fractions are taken into account when determining the number of FTE employees for each month; however, upon adding together the 12-month full-time and FTE employee totals, any resulting fraction is disregarded and rounded down. For example, if the resulting total number of full-time (and FTE) employees for a preceding calendar year is 49.9, it will be rounded down to 49, thus, because the employer has less than 50 full-time (or FTE) employees, it is not an applicable large employer.

## Who are Full-Time Employees?

The proposed regulations provide that a full-time employee is an employee who is employed an average of 30 hours per week. 130 hours of service in a calendar month is deemed the equivalent of 30 hours per week.

### *Calculating Hours of Service*

The proposed guidance provides that an employee's hours of service include each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer and on account of a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Previously, Notice 2011-36 provided that no more than 160 hours of service may be counted as hours of service for any single, continuous period during which the employee was paid or entitled to be paid but performed no duties. This limitation has been removed in response to comments.

The proposed regulations provide separate rules for determining hours of service for hourly employees and non-hourly employees. Hours of service for employees that are paid on an hourly basis are calculated using the actual hours of service from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Regarding employees that are not paid on an hourly basis, hours of service are calculated under any of the following three methods:

1. Counting actual hours of service (as in the case of employees paid on an hourly basis) from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence;

2. Using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service under these service crediting rules; or

3. Using a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service under these service crediting rules.

Under the proposed regulations, an employer does not need to use the same method for all non-hourly employees, although an employer must use one of the above three methods for counting hours of service for all non-hourly employees. An employer may, however, apply different methods for different classifications of non-hourly employees; to the extent the classifications are reasonable and consistently applied. An employer may change the method of calculating non-hourly employees' hours of service from calendar year to calendar year.

The above dates-worked or weeks-worked equivalency methods may not be used, however, if the results would substantially understate an employee's hours of service such that it would cause the employee not to be treated as a full-time employee. When using the days-worked or weeks-worked equivalency methods, the number of hours of service calculated must generally reflect the hours actually worked and the hours for which payment is made or due. When determining whether an employee is a full-time employee, all hours of service performed for all entities that are treated as a single employer must be taken into account.

***Hours of Service Performed Outside of the U.S.***

The proposed regulations provide that hours of service does not include hours of service for which the compensation constitutes foreign source income under the rules of Federal taxation. Thus, generally, hours of service does not include hours of service performed outside the United States. Residency and citizenship status of the individual are not taken into account. Overseas employees will not qualify as full-time employees for determining large employer status or any potential 4980H liability. However, all hours of service for which an individual receives U.S. source income are hours of service counted towards full-time (or FTE) employee status and is used to calculate any assessable payment.

**Look-Back Measurement to Determine Full-Time Employees**

Under previous guidance, the IRS introduced the look-back/stability measurement period safe harbor. Under this safe harbor approach, an employer could determine an ongoing employee's full-time status (whether they

were employed an average of at least 30 hours of service per week) by looking-back at a defined period of not less than three but not more than 12 consecutive calendar months ("measurement period"). The length of the measurement period is to be chosen by the employer. An employee that met the above test (worked at least 30 hours per week during the measurement period) and was still an employee would be deemed a full-time employee regardless of the hours of service during the stability period. The stability period is the period that follows the measurement period and is at least the greater of six consecutive months or the length of the measurement period. The applicable large employer may chose to add an administrative period, up to 90-days, between the measurement and stability periods. An employee that meets the above standard is not required to be counted as a full-time employee by the employer, regardless of the number of hours of service during the stability period.

***Ongoing Employees***

In general, the measurement and stability periods should be uniform for all employees; however, an applicable large employer may apply different measurement, stability, or administrative periods for each of the following categories of employees:

1. Each group of collectively bargained employees covered by a separate collective bargaining agreement,
2. Collectively bargained and non-collectively bargained employees,
3. Salaried employees and hourly employees, and
4. Employees whose primary places of employment are in different states.

Previous guidance included employees of different entities as a separate category of employees. This category has been removed. The IRS believes there is no need for this separate category because the employer shared responsibility requirement is generally applied on an applicable large employer, member-by-member basis.

In the interest of administrative convenience, the proposed regulations permit employers to adjust the starting and ending dates of their 3 to 12 month measurement periods in order to avoid splitting employees' regular payroll periods. Adjustments are permitted only if each of the payroll periods is one week, two weeks, or semi-monthly in duration.

***New Employees: Full-Time, Variable Hour, and Seasonal***

The proposed regulations provide guidance for determining the full-time status of new employees. The methods utilized for new employees depends upon whether the new employees are reasonably expected to work full-time (and are not seasonal), are variable hour employees, or seasonal employees. The proposed guidance provides that an employer that offers group health coverage to a new employee, who is reasonably expected to average 30 hours of service per week (and who is not a seasonal employee), will not be subject to an assessable payment under the rules for the failure to offer coverage for up to three calendar months.

An applicable large employer that uses the look-back measurement period for ongoing employees may also use the same method for new variable hour and seasonal employees. A new employee is a variable hour employee if it cannot be determined, based on facts and circumstances, that the employee will average 30 hours of service per week, or if the employee will average 30 hours of service per week, but only for a limited duration. Beginning on January 1, 2015, the employer must assume that the employee (except seasonal) will

continue to be employed through the measurement period, and cannot take into account the likelihood that employment will terminate before the end of the initial measurement period.

As mentioned above, an employer may utilize an administrative period subsequent to the initial measurement period. However, with regards to variable hour or seasonal employees, the initial measurement period and administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month). Considering this time limitation, employers may want to consider an initial measurement period of less than the maximum 12 months to allow for an administrative period used for enrollment of full-time employees in the plan. The stability periods for new variable hour and seasonal employees that are employed an average of at least of 30 hours of service per week during the initial measurement period must be the same length as those for ongoing employees. Compliance with the above may help to avoid an assessable payment under the rules due to new variable hour and seasonal employees.

***Changes in Employment Status***

The proposed rules provide guidance addressing a situation in which a new variable hour or seasonal employee has a change in employment status during the initial measurement period (for example, where a new variable hour employee is promoted during the initial measurement period to a position in which employees are reasonably expected to work an average of 30 hours of service per week). The proposed rules define a change in employment status as a material change in the position of employment or other employment status that, had the employee begun employment in the new position or status, would have resulted in the employee being reasonably expected to be employed an average of at least 30 hours of service per week.

The rules provide guidelines outlining when full-time status takes effect. When the change in employment status for the new variable hour or seasonal employee occurs during the initial measurement period, the new variable hour or seasonal employee is treated as a full-time employee under the employer shared responsibility rules as of the first day of the fourth month following the change in employment status or, if earlier and the employee averages more than 30 hours of service per week during the initial measurement period, the first day of the first month following the end of the initial measurement period (including any optional administrative period applicable to the initial measurement period). This applies solely to new variable hour or seasonal employees, not to a change in employment status for an ongoing full-time employee.

***Break in Service Rules***

The proposed regulations address situations in which a terminated employee is rehired or the employee's employment is not terminated and there is a continuous period during which an employee is not credited with any hours of service under the applicable rules. The proposed rules are designed to prevent a situation that would inappropriately restart an employee's initial measurement period.

In a period where an employee is not credited with hours of service for at least 26 consecutive weeks, an employer may treat an employee who has an hour of service after that period as having terminated employment and rehired as a new employee. The employer may also choose to apply the proposed rule of parity in such situations. Under the proposed rule of parity, the employer may treat the employee as having been terminated and rehired as a new employee where the period with no credited hours of service (less than 26 weeks) is at least four weeks long and is longer than the employee's period of employment immediately

preceding the period with no credited hours of service. This rule applies solely for purposes of determining full-time employee status using the look-back measurement method.

An employee that is treated as a continuing employee (break of less than 26 weeks and rule of parity does not apply) would have the measurement and stability periods apply as if the employee had not experienced the period of no credited hours of service. The measurement and stability periods would continue to apply upon the employee's resumption of service.

The proposed regulations provide a method for averaging hours when applying the look-back measurement method to measurement periods that include special unpaid leave – applying only to employees treated as continuing employees, not employees treated under the rules as terminated and rehired. Special unpaid leave refers to a period of unpaid leave subject to the Family and Medical Leave Act ("FMLA"), the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and jury duty. In this scenario, the employer will determine the average hours of service per week during the measurement period excluding the special unpaid leave period and apply this average to the entire measurement period. In the alternative, an employer may opt to treat employees as credited with hours of service during the special unpaid leave period equal to the average hours of service during the measurement period that is not special unpaid leave.

Additional requirements apply to employment break periods for employees of an educational organization. With regards to educational organizations, an employment break period is a period of at least four consecutive weeks (disregarding special unpaid leave) during which an employee is not credited with an hour of service. Educational organizations are unique in that they generally function on an academic year basis, in which there are periods of time that the organization is not in session or in a limited capacity. As with the method for averaging hours when applying a look-back measurement options discussed in the previous paragraph. However, the educational organization is not required to credit an employee in any calendar year with more than 501 hours of service for any employment break period (not considering special unpaid leave). The educational organization break period rules apply only to an employee treated as a continuing employee upon resuming services, not to an employee treated as terminated and rehired.

**Conclusion**

The employer shared responsibility provisions are effective beginning January 1, 2014. Employers may rely on this guidance until final regulations are released and become effective. For a discussion of the transition rules, please read the article titled: *Transitional Rules Offer Relief for Compliance with Employer Shared Responsibility Rules*. Written or electronic comments must be received through March 18, 2013. Outlines of topics to be discussed at a public hearing scheduled for April 23, 2013, must be received by April 3, 2013.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

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***The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.***

**January 2013**

# Regulations Address Employer Shared Responsibility Compliance and Penalties

The Internal Revenue Service ("IRS") released proposed regulations providing additional guidance on the employer shared responsibility provisions of the Patient Protection and Affordable Care Act ("PPACA"). This article will discuss whether an applicable large employer is subject to an assessable penalty, as well as, other compliance-related issues. For background on the employer shared responsibility provisions, as well as, a discussion of the proposed rules regarding applicable large employer and full-time employee rules, please see the article in this issue of Healthcare Reform Update titled *Definition of a Large Employer Under New Employer Shared Responsibility Guidance.* To read more on the transition rules, please see the article in this issue of Healthcare Reform Update titled *Transitional Rules Offer Relief for Compliance with Employer Shared Responsibility Rules.*

**Employer Shared Responsibility Provisions – 4980H(a) and 4980H(b)**

The liability for payment arises only where one or more full-time employees who purchase coverage through an Exchange and are certified to an employer as having received a premium tax credit or cost-sharing reduction. Liability for the employer shared responsibility provisions can arise under sections 4980H(a) or 4980H(b). For any calendar month, an applicable large employer can be liable for an assessable payment under either 4980H(a) or 4980H(b), but cannot be liable under both for the same calendar month. Additionally, although large employer status is determined on an aggregated basis (see *Definition of a Large Employer Under New Employer Shared Responsibility Guidance*), the liability for, and the calculated amount of, any assessable payment is computed and assessed separately for each applicable large employer member.

**4980H(a) Liability ("No Plan Offered")**

An applicable large employer will become liable for an assessable payment under 4980H(a) when, for any month, it fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage ("MEC") and any full-time employee is certified to receive a premium tax credit or cost-sharing reduction. An applicable large employer is not liable for an assessable payment under 4980H(a) if it offers MEC under an eligible employer-sponsored plan to its full-time employees (and their dependents), regardless of whether the coverage offered is affordable or provides minimum value. The preamble to the proposed regulations provides clarification of the term "dependent" for purposes of the references made throughout 4980H. The statute uses the term "dependents" in parentheses and does not include the term "spouse". For purposes of 4980H, the proposed regulations define an employee's "dependents" as an employee's child who is under 26 years of age. The definition of "dependents" does not include any individual other than an employee's children, such as an employee's spouse.

### Offering Coverage

For an employer to be deemed to have offered coverage to a particular employee, the coverage offered, if accepted, must be applicable for that month (or that day). If an applicable large employer fails to offer coverage to an employee for any day of a calendar month, the employee is deemed to not have been offered coverage for the entire month. During a month in which an employee terminates employment, an employer is deemed to have offered coverage for the entire month if the employee would have been offered coverage for the entire month had the employee been employed for the entire month.

Additionally, the regulations provide that an employee must have an effective opportunity to accept coverage to be deemed to have been offered coverage. The employee must also have an effective opportunity to decline coverage that does not meet minimum coverage or affordability standards. Therefore, an employer cannot render an employee ineligible for a premium tax credit or cost-sharing reduction by offering mandatory coverage – coverage that does not offer the employee an effective opportunity to decline.

In a situation in which an employee enrolls in coverage but fails to timely pay their share of the premium, the employer is not required to provide coverage for that period of time. The employer is then deemed to have offered coverage for the remainder of the coverage period. The proposed rules generally adopt the rules of COBRA, such as providing a 30-day grace period.

### Relief for Failure to Offer Coverage

Should an applicable large employer trigger a 4980H(a) liability, the amount of the assessable payment is determined using the applicable large employer member's total number of full-time employees (including those offered employer-sponsored coverage). The IRS does not intend an assessable payment to apply to an employer that intends to offer coverage to substantially all of its full-time employees, but fails to offer coverage to a few full-time employees. Notice 2011-36 addressed this issue by offering a "substantially all" standard; however, in response to comments, the proposed regulations provide a more definitive rule. The Treasury Department and IRS exercise their administrative authority to allow a margin of error to address inadvertent errors – a 95 percent standard. Accordingly, an applicable large employer will be treated as offering coverage to its full-time employees (and their dependants) for a calendar month if, for that month, it offers coverage to all but five percent or, if greater, five of its full-time employees. The five full-time employees alternative is designed to accommodate relatively small applicable large employers where an inadvertent error would exceed the five percent margin of error allowed. This relief applies to a percentage or number of employees (and their dependents), without regards to whether the failure to offer was inadvertent.

### 30-Employee Reduction

The proposed regulations provide that, solely for the purposes of calculating the assessable payment under 4980H(a) and the liability limit under 4980H(b)(2), the number of individuals employed by an applicable large employer shall be reduced by 30. The rules provide that for an applicable large employer treated as a single entity due to the aggregation rules (determined under the rules of Internal Revenue Code Sections 414 (b), (c), (m) or (o)), only one 30-employee reduction is allowed with respect to the members of the aggregated single entity and the reduction is applied pro-rata on the basis on the number of full-time employees employed by each member of the aggregated applicable large employer. The proposed rules provide that an entity whose pro-rata share is more than zero but less than one, the share of the 30-employee reduction shall be rounded up to one.

**4980H(a) Assessable Payment Amount**

The assessable payment amount under section 4980H(a) equals, with respect to any calendar month, the number of full-time employees of an applicable large employer (reduced by the 30-employee reduction discussed above) multiplied by 1/12th of $2,000 (the applicable payment amount for a calendar month). In subsequent years, this amount will be adjusted according inflation.

**4980H(b) Liability (Plan Offered Does Not Meet Minimum Value or is Unaffordable)**

An applicable large employer is generally liable for a 4980H(b) penalty if it offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan, but one or more full-time employees have been certified for a premium tax credit or cost-sharing reduction. This may occur because of the following reasons:

1) The coverage under the plan is unaffordable and the employer does not meet any of the affordability safe harbors (discussed below),

2) The coverage under the plan does not provide minimum value, or

3) The employer offers coverage to at least 95 percent (or, if greater 5) but less than 100 percent of its full-time employees (and their dependents) and one or more of the employees not offered coverage receives a premium tax credit or cost-sharing reduction.

**Affordable Coverage**

As stated above, an employer may trigger liability if the MEC offered is unaffordable or does not provide minimum value. A plan provides minimum value if the plan's share of the total allowed costs of benefits provided under the plan is at least 60% of such costs. The affordability test is met if the coverage offered to an employee under an employer-sponsored plan for self-only coverage does not exceed 9.5 percent of the employee's household income for the taxable year.

Since employers may not know the employee's household income, the proposed regulations provide for the following three affordability safe harbors: Form W-2 safe harbor, rate of pay safe harbor, and federal poverty line safe harbor. These safe harbors only apply for purposes of determining whether an employer's coverage satisfies the 9.5 percent affordability test used to determine 4980H(b) liability, they do not apply for purposes of determining 4980H(a) assessable payments. Also, the safe harbors do not affect an employee's eligibility for a premium tax credit. Thus, the safe harbors could be used to treat an employer's offer of coverage as affordable to avoid 4980H(b) liability; however, it does not prevent coverage from being deemed unaffordable for purposes of determining an employee's eligibility for a premium tax credit. The use of the safe harbors is optional. An employer may use one or more of the safe harbors for all employees or any reasonable category of employees, to the extent it is done on a uniform and consistent basis.

**Form W-2 Safe Harbor**

An employer must meet the following conditions in order for the Form W-2 safe harbor to apply:

1) The employer offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan, and

2) The required employee contribution toward the self-only premium for the employer's lowest cost coverage that provides minimum value (employee contribution) not exceed 9.5 percent of the employee's Form W-2 wages for that calendar year.

An employer that satisfies these conditions will not be assessed a payment with respect to a particular employee, even if the employee receives a premium tax credit or cost-sharing reduction due to the coverage being unaffordable based on the employee's household income.

The application of this particular safe harbor is done after the end of the calendar year and on an employee-by-employee basis. However, an employer may use this safe harbor prospectively, at the beginning of the year, to the employee contribution at a level not to exceed 9.5 percent – automatically adjusting through the year for any wage changes to avoid becoming unaffordable.

In the preamble, the IRS stated that the value in Box 1 of Form W-2 is the dollar amount that must be used and noted that would exclude amounts that an employee elects to contribute to a cafeteria plan through salary reduction and elective deferrals that an employee makes to plans such as a 401(k) plan.

**Rate of Pay Safe Harbor**

The proposed regulations provide a rate of pay safe harbor where an employer would take the hourly rate of pay for each hourly employee who is eligible to participate in the health plan as of the beginning of the plan year, then multiply that rate by 130 hours per month (or monthly salary rate for salaried employees), and determine the affordability based on the resulting monthly wage amount. The employee's monthly contribution amount for self-only coverage meets the affordability standard if it is equal or lower than 9.5 percent of the computed monthly wages. The safe harbor may only be applied if the employer did not reduce the hourly wages (or monthly wages) of hourly employees (of salaried employees) during the year.

**Federal Poverty Line Safe Harbor**

The proposed regulations provide a design-based safe harbor using the Federal poverty line for a single individual. Under this safe harbor, coverage provided is affordable if the employee's cost for self-only coverage under the plan does not exceed 9.5 percent of the Federal poverty line for a single individual. The Federal Poverty Level in 2012 for a single individual was $11,170 ($12,860 in Hawaii and $13,970 in Alaska).

**4980H(b) Assessable Payment Amount**

The 4980H(b) assessable payment equals, for any calendar month, the number of full-time employees of an applicable large employee member who receive a premium tax credit or cost-sharing reduction, multiplied by 1/12$^{th}$ of $3,000 (the applicable payment amount for a calendar month). In subsequent years, this amount will be adjusted according inflation. An assessable payment under 4980H(b) cannot exceed the amount of any assessable payment under 4980H(a). In other words, the penalty under 4980(H)(b) will not be greater than the penalty that would have been assessed if the employer did not offer a plan.

**Conclusion**

The employer shared responsibility provisions are effective beginning January 1, 2014. For a discussion of the transition rules, please read the article titled: *Transitional Rules Offer Relief for Compliance with*

*Employer Shared Responsibility Rules*. Employers may rely on this guidance until final regulations are released and become effective. Written or electronic comments must be received through March 18, 2013. Outlines of topics to be discussed at a public hearing scheduled for April 23, 2013, must be received by April 3, 2013.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

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***The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.***

**January 2013**

# Transitional Rules Offer Relief for Compliance with Employer Shared Responsibility Rules

The recently released guidance addressing the employer shared responsibility provisions of the Patient Protections and Affordable Care Act ("PPACA") provide transition relief to assist employers as they move towards compliance. For background on the employer shared responsibility provisions, as well as, a discussion of the proposed rules regarding applicable large employer and full-time employee rules, please see the article in this issue of Healthcare Reform Update titled *Definition of a Large Employer Under New Employer Shared Responsibility Guidance.* For a discussion of the proposed rules applying to assessable payments, please see the article in this issue of Healthcare Reform Update titled *Regulations Address Employer Shared Responsibility Compliance and Penalties.*

**Fiscal-Year Plan Years**

The proposed regulations provide relief for plans that are fiscal year plans – non-calendar year plans. Based on concerns that it may be difficult for employers to change plans mid-year and the fact that employees are making elections in 2013 which will extend into 2014, the proposed regulations include transition relief for these plans. The relief is only extends to (there is no assessable payment for) full-time employees who were or would have been eligible for coverage under the terms of the plan in effect on December 27, 2012. With respect to the employees above, an applicable large employer is not subject to a 4980H assessable payment where the employer maintains a fiscal year plan as of December 27, 2012 and offers its full-time employees affordable, minimum value coverage as of the first day of the first fiscal year of that plan beginning in 2014 under the terms of the plan in effect as of December 27, 2012.

Furthermore, relief is provided to employers that have a significant percentage of their employees eligible for or covered under one or more fiscal year plans that have the same plan year as of December 27, 2012 and want to offer coverage under these plans to certain other employees. These employees must be offered affordable minimum value coverage no later than the start of the 2014 plan year of the fiscal plan year and they would not have been eligible for coverage under any group health plan offered by the employer that has a calendar year plan year. To the extent an applicable large employer has: 1) at least one-quarter of its employees covered under one or more fiscal year plans with the same plan year as of December 27, 2012, or 2) offered coverage under those plans to one-third or more of its employees during the most recent open enrollment before December 27, 2012, no assessable payment will be due for any month prior to the start of the 2014 fiscal plan year with respect to certain other employees that the employer wants to offer coverage to as discussed above.

It should be noted, however, that employers using transition relief will still be subject to the reporting requirements under section 6056 (relating to applicable large employers offering coverage to their full-time employees) of the Internal Revenue Code ("Code") for the 2014 calendar year. Transition relief will permit an applicable large employer to avoid an assessable payment for a 2013 plan year that would end in 2014, however, section 6056 reporting requirements still apply for the 2014 calendar year.

**Salary Reduction Elections for Accident and Health Plans Provided Through Cafeteria Plans for Cafeteria Plan Years Beginning in 2013**

The proposed rules provide transition relief to the revocation, modification, or commencement of salary reductions for accident and health coverage offered through a cafeteria plan of an employer with a cafeteria fiscal year plan beginning in 2013. This transition relief is being provided because becoming eligible for health coverage through an Exchange is not a change in status which would normally permit an employee to make a new election under a cafeteria plan. The relief does not apply to any other cafeteria plan qualified benefit. The transition relief permits (but does not require) an applicable large employer to amend one or more of its written cafeteria plans to allow either or both of the following:

1) An employee who elected to salary reduce through the cafeteria plan for accident and health plan coverage with a fiscal plan year beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once, during that plan year, without regard to whether the employee experienced a change in status event §1.125-4; and
2) An employee who failed to make a salary reduction election through his or her employer's cafeteria plan for accident and health plan coverage with a fiscal plan year beginning in 2013 is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the cafeteria plan, without regard to whether the employee experienced a change in status event.

The proposed rules provide that an applicable large employer may retroactively amend the cafeteria plan to incorporate the above. The retroactive amendments must be made by December 31, 2014, and be effective retroactively to the date of the first day of the 2013 plan year of the cafeteria plan.

**Measurement Periods for Stability Periods Starting in 2014**

The proposed regulations provide transitional relief for employers intending to adopt a 12-month measurement period and then a 12-month stability period. The rules provide that employers may adopt a transition measurement period that is shorter than 12 months but that is no less than 6 months long and that begins no later than July 1, 2013 and ends no earlier than 90-days before the first day of the plan year beginning on or after January 1, 2014. The maximum administrative period is 90-days. This transition relief is solely for stability periods beginning in 2014. However, employers who adopt a full-12-month measurement period are not required to begin the measurement period by July 1, 2013.

**Multiemployer Plans**

The transition rule provided by the proposed regulations provides relief through 2014 for contributions made by applicable large employers participating in a multiemployer plan. Multiemployer plans have a unique operating structure. These plans are maintained pursuant to collective bargaining agreements and have joint boards of trustees representing employees and employers. The intent of this rule to provide a means for employers to comply with the employer shared responsibility provisions. An applicable large employer will not be deemed to have failed to offer the opportunity to enroll in MEC to a full-time employee (and their dependents) for purposes of the employer shared responsibility provisions if 1) the employer is required to make a contribution to a multiemployer plan with respect to the full-time employee pursuant to a collective bargaining agreement or an appropriate related participation agreement,

2) coverage under the multiemployer plan is offered to the full-time employee (and their dependents), and 3) the coverage offered to the full-time employee is affordable and provides minimum value.

**Applicable Large Employer Determination for 2014**

An applicable large employer is one that employs an average of at least 50 full-time employees during the preceding calendar year. Employers must count both full-time and full-time equivalent employees. For a discussion of the rules for counting full-time employees and applicable large employer status, please see the Healthcare Reform Update article titled *Definition of a Large Employer Under New Employer Shared Responsibility Guidance*. The proposed regulations provide transition relief for those employers for which the determination is not clear (employers close to the 50 employee threshold). The employer has the option for the 2014 calendar year to determine its large employer status using a period of at least six consecutive months during the 2013 calendar year.

**Coverage of Dependents**

The proposed rules provide transitional relief to employers who are revising their plans to provide coverage for both employees and dependents, rather than employees alone. An employer that takes steps during a plan year that begins in 2014 towards offering coverage for full-time employee dependents will not be liable for any 4980H assessable payments.

**Variable Hour Employee Definition**

A new employee is a variable hour employee if it cannot be determined, based on facts and circumstances, that the employee will average 30 hours of service per week, or if the employee will average 30 hours of service per week but only for a limited duration. Beginning on January 1, 2015, the employer must assume that the employee will continue to be employed through the measurement period, and cannot take into account the likelihood that employment will terminate before the end of the initial measurement period. The transition relief provided here is the delay of the effective date of the above rule to 2015, from 2014.

**Conclusion**

The employer shared responsibility provisions are effective beginning January 1, 2014. Employers may rely on this guidance until final regulations are released and become effective. Written or electronic comments must be received through March 18, 2013. Outlines of topics to be discussed at a public hearing scheduled for April 23, 2013, must be received by April 3, 2013.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

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Gallagher Benefit Services, Inc.
thinking ahead

**January 2013**

# CLASS Act Formally Repealed

The Community Living Assistance Services and Supports ("CLASS") Act was enacted as part of the Patient Protection and Affordable Care Act ("PPPACA"). The law was designed to establish a voluntary, national insurance program for American workers to help pay for long-term services and supports they may need in the future. The CLASS program sought to help enrollees live independently in the community and to give them considerable freedom to determine the necessary services and supports they purchase with their coverage. By statute, CLASS benefits were required to be funded entirely through enrollee premiums; there was no taxpayer subsidy.

The CLASS Act directed the Secretary of the Department of Health and Human Services ("HHS"), "in consultation with appropriate actuaries and other experts, [to] develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independent Benefit Plan under which eligible beneficiaries shall receive benefits under" the law. The Act required that each of the plan alternatives be designed to provide the benefits specified in the law consistent with a set of requirements, also specified in the law, concerning, among other things, premiums, the vesting period, benefit triggers, and the cash benefit. Of particular significance, the CLASS Act made it clear that the Secretary shall establish premiums for each plan "based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period."

In October 2011, the Secretary said, after 19 months of analysis, that HHS could not come up with a model for the CLASS Act that keeps it voluntary and budget-neutral. Under the Act, people would have been eligible to begin enrolling in the program after October of 2012, after HHS set the program's benefits. Participation in the program was voluntary and required participants to pay into the program for at least five years before qualifying for benefits. The Congressional Budget Office ("CBO") had estimated the program would have reduced the federal deficit by $70 billion in the program's first decade. However, the CBO also said the program would start to lose money after the first decade or two, once benefit payments exceeded income from premiums. As such, HHS was unable to construct a program that ensured solvency for 75 years. Based on HHS' analysis and the CBO's calculations, the Obama administration, in October 2011, declared that it would not implement the CLASS Act, although the Administration did not take steps to repeal the provision of PPACA.

Earlier this month, as part of the bill that was passed by Congress to avert the so called "fiscal cliff", Congress formally repealed the CLASS Act. In its place the Congress instituted a "Commission on Long-Term Care" that would develop a new comprehensive long-term care plan and possibly make formal recommendations to Congress.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor developments on healthcare reform legislation and regulation and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

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***The intent of this analysis is to provide general information regarding the provisions of current healthcare reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.***

# CLIENT COVERAGE ACKNOWLEDGMENT AND COMPENSATION DISCLOSURE STATEMENT FOR INSERT FULL LEGAL CLIENT NAME

This form documents that Gallagher Benefit Services, Inc. (Gallagher) will apply its professional judgment to access those insurance companies it believes are best suited to insure the Client's risks. The final decision to choose any insurance company has been made by the Client in its sole and absolute discretion. The Client understands and agrees that Gallagher does not take risk, and that Gallagher does not guarantee the financial solvency or security of any insurance company. The Client is responsible for immediate payment of premiums for all insurance placed by Gallagher on Client's behalf. If any premium amounts are not paid in full when due, the applicable insurance company for the Client's risks may cancel any applicable policies in accordance with the terms of such policies.

The following is the disclosure of fees and/or commissions to be paid to Gallagher as a result of its Broker of Record relationship to Client's Group Health and Welfare Plan and any relationships, or agreements Gallagher has with any insurance companies selected by Client as noted above. Gallagher, as Broker of Record, will receive the following initial and renewal sale commissions expressed as percentage of gross premium payments, or fees as agreed upon by Client:

| Line of Coverage | Insurance Company | Effective Date | Commission[1] / Supplemental Compensation[2] | Direct Fees[3] |
|---|---|---|---|---|
| | | xx/xx/20xx | | |
| | | xx/xx/20xx | | |
| | | xx/xx/20xx | | |
| | | xx/xx/20xx | | |
| | | xx/xx/20xx | | |
| | | xx/xx/20xx | | |

It should also be noted that:

- **Gallagher** is not an affiliate of the insurer whose contract is recommended. This means the insurer whose contract is recommended does not directly or indirectly have the power to exercise a controlling influence over the management or policies of **Gallagher**. **Gallagher's** ability to recommend other insurance contracts is not limited by an agreement with the insurance company.
- **Gallagher** is effecting the transaction for the Plan(s) in the ordinary course of **Gallagher** business. The transaction set forth is at least as favorable to the Plan(s) as an arm's length transaction with an unrelated party.
- **Gallagher** is not a trustee of the Plan(s) and is neither the Plan Administrator of the Plan(s), a fiduciary of the Plan(s), nor an employer which has employees in the Plan(s). **Gallagher** shall not exercise discretionary authority or control with respect to plan management, the disposition of plan assets or plan administration.

[1] Commissions include all commissions/fees paid to Gallagher that are attributable to a contract or policy between a plan and an insurance company, or insurance service. This includes indirect fees that are paid to Gallagher paid by a third party, and includes, among other things, the payment of "finders' fees" or other fees to Gallagher for a transaction or service involving the plan.

[2] Gallagher companies may receive supplemental compensation referred to in a variety of terms and definitions, such as contingent commissions, additional commissions and supplemental commission.

[3] Direct Fees include compensation to Gallagher paid for directly by the plan sponsor/Client.

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- **Gallagher's** liability to Client, or any party claiming by or through Client, on account of or relating to the provision of services to Client during the period of the relationship between Gallagher and Client shall not exceed $20 million in the aggregate. Without limiting the foregoing, Gallagher shall only be liable for actual damages incurred by Client, and shall not be liable for any indirect, consequential or punitive damages.

**For Employers and Plan Sponsors Subject to ERISA:** This Disclosure Statement is being given to the Client (1) to make sure Client knows about Gallagher's and Gallagher affiliates' income before purchasing the insurance product and (2) if plans subject to ERISA, to comply with the disclosure, acknowledgment and approval requirement of Prohibited Transaction Class Exemption No. 84-24[4], which protects both Client and Gallagher[5]. Disclosure must be made to an independent plan fiduciary for the ERISA Plan(s), and Client acknowledges and confirms that this is a reasonable transaction in the best interest of participants in its ERISA Plan(s).

For more information on Gallagher's compensation arrangements, please visit www.ajg.com/compensation. In the event a Client wishes to register a formal complaint regarding compensation Gallagher receives, please send an email to Compensation_Complaints@ajg.com or send a letter to: AVC Compliance Officer, c/o Internal Audit Department, Arthur J. Gallagher & Co., Two Pierce Place, Itasca, IL 60143.

Thank you for your business and continued confidence in the services Gallagher provides to you and your employees. We sincerely appreciate the opportunity to serve Insert Client Name. Please let us know if you have any questions regarding this information or would like more detail.

**GALLAGHER BENEFIT SERVICES, INC.**

By: _____

Name: _____

Title: _____

Date: _____

Accepted by: **INSERT FULL LEGAL CLIENT NAME**

By: _____

Name: _____

Title: _____

Date: _____

[4] Which allows an exemption from a prohibited transaction under Section 408(a) of the **Employee Retirement Income Security Act of 1974 (ERISA)**.

[5] In making these disclosures, no position is taken, nor is one to be inferred, regarding the use of assets of a plan subject to ERISA to purchase such insurance.

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August 21, 2014

Amy Strough,
Human Resources Manager
City of Maryville
415 N. Market
Maryville, MO 64468

**RE: Privacy Policy Disclosure**

Dear Ms. Strough,

Gallagher Benefit Services, Inc. (Gallagher) treats your personal privacy with care and respect. Because we value our client relationships, we do not disclose our clients' nonpublic personal, financial or health information with third parties, except for the specific purposes listed in the enclosed Privacy Policy Summary or as otherwise permitted by law. Personal information is any information that can be used to identify, locate or contact you or your employees. Personal information does not include publicly available information or individually identifiable business contact information of employees such as name, title, business address, business telephone number or business email address.

Applicable law requires Gallagher to provide our clients with notice of our Privacy Policy, a summary of which is enclosed here (the full text of the Gallagher Privacy Policy can be retrieved at the following URL: http://www.ajg.com/privacy-policy/). This policy does not apply to our efforts to market our products and services to you, so you may receive information from us regarding products that may suit your needs.

Gallagher has always been mindful of our clients' privacy. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your nonpublic personal, financial and health information and that of your employees.

Thank you for choosing Gallagher Benefit Services, Inc. We appreciate your business and value our relationship.

**Enclosure**


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# PRIVACY POLICY SUMMARY

This **Privacy Policy Disclosure** outlines and summarizes our information sharing practices to help you understand how we protect your privacy and that of your employees when we collect and use information about you and your employees, and the measures we take to safeguard that information.

**Information We May Collect.** We may collect the following nonpublic personal, financial or health information about you or your employees including:

- Information we receive from you and your employees on applications or questionnaires, such as occupation, current employer and social security number;
- Information about your transactions with us, our affiliates, or previous insurers; such as your policy coverage, claim information, premiums and payment history;
- Information we receive from consumer-reporting agencies such as Equifax that is obtained for the purpose of ascertaining credit histories. These reports are obtained as underwriting tools to determine bill paying habits and creditworthiness for certain individual, personal insurance products. These reports are not subject to race, gender or income;
- Information that allows us to communicate with you or your employees, such as name, user name, password, age, marital status, occupation, mailing address, telephone numbers, email address or other addresses that allow us to send a message;
- Information that assists us to conduct business with you or your employees, such as types of products or services that may be of interest, employee financial information or information on your company's size, revenue, type, industry codes, demographics, locations, and financial information;
- Information about your transactions with us, our affiliates, or your previous providers;

**Information We Disclose.** We do not disclose any nonpublic personal, financial or health information about our clients, former clients or their employees to anyone, except for the purposes of placing your insurance coverage(s), fulfilling your requests for products or services and related activities, responding to your requests for a call or email, processing transactions you request, telling you about products or services we offer and as otherwise permitted by law.

**Information Security**. We restrict access to nonpublic personal, financial or health information about you and your employees to those employees and subcontractors who have a need to know that information to provide products or services to you or your employees. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to guard your nonpublic personal, financial and health information and that of your employees.

6/3/2014


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