For many months, it seemed that Health Care Reform was on a death watch. But now that the Supreme Court has validated the law, employers need to take immediate action to comply. Here’s a to-do list of what you should be working on now and in 2013.

☑ INCLUDE A SUMMARY OF BENEFITS AND COVERAGE WITH OPEN ENROLLMENT MATERIALS
Beginning this fall, employers must include in their open enrollment materials a Summary of Benefits and Coverage (SBC). This is a standardized summary, no longer than four double-sided pages, intended to make it easier for employees to compare coverage options. You will most likely receive this from your insurers or third-party administrators, but you may have to customize an SBC if you have a plan option that includes PBM, HRA or other benefits provided by a separate contractor. You must distribute the SBC by the first day of the open enrollment period.

☑ LIMIT EMPLOYEE HEALTH FSA CONTRIBUTIONS TO $2,500
For plan years beginning on or after January 1, 2013, annual employee contributions to Health Flexible Spending Accounts cannot exceed $2,500. Your enrollment materials must reflect this new limit and you must amend your Cafeteria Plans accordingly.

continued on page 9
The Office of Federal Contract Compliance Programs (OFCCP) is on track to have a strong year in settlements.

- Shipping giant FedEx to pay $3 million to settle charges of hiring discrimination brought by U.S. Department of Labor.
- Baldor Electric to pay $2 million to settle hiring discrimination case with U.S. Labor Department.
- U.S. Labor Department settles charges of hiring discrimination with federal contractor Leprino Foods.

These are just a few of the headlines on the Department of Labor’s OFCCP web site. These settlements may be the result of the Memorandum of Understanding issued on November 9, 2011, between the OFCCP and the Equal Employment Opportunity Commission (EEOC). The Memorandum stated that the two agencies would work together to ensure equal employment opportunities for applicants and employees under Title VII of the Civil Rights Act of 1964 (Title VII) and Executive Order 11246 (E.O. 11246). The agencies have begun to coordinate their efforts to ensure compliance with the laws.

Under E.O. 11246, “federal government contractors” with at least $10,000 in government contracts are prohibited from discriminating against any employee or applicant because of race, color, religion, sex, national origin, disabled veteran, veteran of the Vietnam era or other covered veteran status, or physical or mental disability. Additionally, federal government contractors are required to have an Affirmative Action Plan if they have at least 50 employees and have a contract to supply at least $50,000 of goods or services to the federal government (either directly or as a subcontractor). Further, any financial institution that has 50 or more employees is covered if it serves as a depository of federal government funds in any amount or is an issuing and paying agent for U.S. Savings Bonds and Notes.

Employers under the OFCCP’s jurisdiction are obligated to take affirmative action to ensure that applicants are employed and that employees are treated the same during the application process and employment without regard to any of the protected categories. However, employers have no obligation to place unqualified minorities and women in the workforce nor are they required to provide preferential treatment to women and minorities.

So, what did FedEx, Baldor Electric and Leprino Foods do to receive such huge penalties? FedEx had hiring processes and selection procedures that violated E.O. 11246. According to the DOL, FedEx discriminated “on the basis of sex, race and/or national origin against specific groups identified at 23 facilities in 15 states... affected workers include[d] men and women as well as African-American, Caucasian and Native American job seekers, as well as job seekers of Hispanic and Asian descent.”

The OFCCP found that Baldor Electric’s applicant screening process violated E.O. 11246. “As a result, 795 qualified women, African-Americans and job seekers of Asian and Hispanic descent were denied the opportunity to advance to the interview stage when applying for production and laborer positions.”

“Adverse impact refers to a review of employment decisions to determine whether there are any disparities based on gender, race or ethnicity.”
When we think of bribery, we generally think of a shadowy figure passing an unmarked envelope of cash to a politician or judge. Bribery, however, is not limited to just government officials. The federal government has enacted laws that make it a crime for businesses operating in the United States to bribe foreign officials in an attempt to obtain favors or favorable treatment. Many states followed suit by enacting laws that make it a crime for an employee to accept or offer benefits in order to obtain or retain business. Whether you are a large multi-national corporation or a small business owner that sells in multiple states, commercial bribery is a potential issue.

Legislation on international bribery, such as the Foreign Corrupt Practices Act or the United Kingdom’s 2010 Bribery Act, has received significant media attention in recent years, but many states, including California, Nevada, Washington, Texas and New York, have enacted similar legislation aimed specifically at commercial bribery. These state laws have received much less media coverage, but in many ways could have a larger impact on the day-to-day functions of a business. These laws generally prohibit the following:

- An agreement where an employee offers or accepts some form of benefit;
- The benefit is offered or accepted without the consent or knowledge of the employer; and
- The gift is offered or accepted with the understanding that the person receiving the gift will use his/her influence to benefit the person giving the gift.

Some states require a minimum amount of money to change hands in order for the activity to qualify as commercial bribery. For example, California law states that the commercial bribery statute does not apply unless the benefit exchanged is worth more than $250.

These laws clearly cover backroom deals between corrupt companies, but they can also reach more common occurrences such as a company salesman paying for several rounds of golf for employees of a prospective customer. Anytime an employee offers or accepts a benefit from an existing or potential client, commercial bribery statutes may be involved. If a gift is given or received by a rogue employee, it can have effects that ripple throughout the company.

The good news is that potential problems with commercial bribery can be managed. One option a company has to protect itself and its employees is to create a policy and system where employees are required to disclose gifts or other benefits they give and/or receive from outside the company. The policy should also set limits on how much an employee can receive from a single vendor. A system like this allows a company to monitor which employees are giving and receiving gifts, the amounts and sources of the gifts and can identify potential problems before they become real problems. Having this kind of system in place can help protect unwitting and well-intentioned employees from getting into questionable situations as well as help protect the company from employees with more dubious motives.

If an employee is charged with commercial bribery, it will harm both the employee’s individual career and the reputation of the company. Taking appropriate steps now will ensure that a company is better equipped to protect itself and its employees.
By now, everyone who deals with these sorts of things knows that in 2008 Congress amended the Americans with Disabilities Act (ADA) to greatly broaden the definition of “disability.” How broad, you ask? You may not believe it.

The ADA still excludes “current unlawful drug users” from its protections, but that exclusion only applies if the individual is shown to be a current unlawful drug user. So how do you prove an employee is a “current unlawful drug user?” With a drug test, of course. Here is the problem, though: Absent a showing of current use, difficulty in urinating for a drug test due to a physical or mental disability (as broadly defined in the new ADA) triggers ADA obligations.

It’s true that purported inability to urinate in only one situation – when asked to take a drug test - probably (though, amazingly enough, not certainly) does not pose ADA risk. The problem is that an employee discharged for “failure to give a timely urine sample” may claim to have asserted an ADA disability during the testing process.

The most likely example is a claim that s/he has a physical or mental “disability” that causes “unpredictable occasions of difficulty urinating” or “difficulty urinating in high stress situations” or something similar. In other words, the employee claims to have a “shy bladder.” The employee or applicant may produce testimony of friends or family members to that effect and/or a diagnosis from a medical or psychological practitioner purporting to confirm the “disability.”

Although the employee or applicant is normally required to clearly disclose the disability and request an accommodation, courts bend these rules for “unsophisticated” individuals, and may rule that an employee’s inartful disclosure of difficulty urinating put the employer (or its agent, the clinic) on notice of an ADA disability. In other words, claiming to be unable to urinate for a required drug test may amount to a request for an accommodation under the ADA.

Who knew?

And here is the risk.

The ADA doesn’t require you to forego drug testing just because the subject says that s/he can’t urinate. But if there is an “ADA disability,” it does require you to make any available “reasonable accommodation.”

Drug test clinics have protocols for “difficulty in urinating,” usually involving delay and instructions to the subject to drink water. You should be familiar with those protocols.

If the protocols don’t work, and you wish to further reduce ADA risk, your policy should be amended to offer an alternative method of testing, if available. Clinics usually do not automatically offer an alternative test.

There are at least three other methods for obtaining a drug test sample: blood testing, saliva testing and hair testing. All have advantages and disadvantages. You should consult with your company physician, medical review officer (MRO) or drug test clinic professionals. You also need to know what tests the clinic is equipped to administer (on a 24/7 basis, if necessary). If the best alternative is a blood test, you should consider, and perhaps consult further with counsel on, possible problems such as religious objections or even potential ADA issues. However, an applicant or employee refusing to provide blood as an alternative to a claimed inability to provide urine would be a highly suspicious plaintiff in a lawsuit.

For truck drivers and others covered by the Department of Transportation’s drug testing rules, the situation is unfortunately more complicated. Asserted inability to urinate triggers specific rules for the clinic to follow under 49 CFR Part 40, including up to a three-hour delay in testing with a direction to the subject to drink water. Asserted medical-related inability-to-urinate cases are to be referred to the MRO, and the MRO or another physician consulted under Part 40 can, in some situations, order a blood test by following the rules in Part 40. Consult with your clinic, MRO or legal counsel on these issues.

continued on page 13
Health Care Reform – Mandate Timeline*

Are you overwhelmed by health care reform? Here’s a quick glance at the major changes affecting employers. Use this as a checklist for changes that should have been already implemented and for upcoming, pending changes. Consult your Warner Norcross & Judd Employee Benefits attorney to review the impact of these changes on your employee benefit plans.

### Effective for Taxable Years beginning on or after January 1, 2010

<table>
<thead>
<tr>
<th>Change</th>
<th>What It Means</th>
<th>Applies to Grandfathered Plans?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Business Tax Credit</td>
<td>Employers who maintain a qualified health plan and have fewer than 25 full-time equivalent employees who earn less than an average of $50,000, are eligible to receive a tax credit for up to 35% of group health insurance premiums paid under the plan and 25% for small tax-exempt employers such as charities. The amount increases to 50% and 35% respectively on January 1, 2014.</td>
<td>A plan’s grandfathered status will not affect eligibility</td>
</tr>
<tr>
<td>Adoption Tax Credit Increased</td>
<td>The limit on the tax credit for adoption assistance expenses and the amount that may be excluded from income under an adoption assistance reimbursement program is increased to $13,360 for 2011. For 2012, the amount of the credit dropped to $12,650 and will no longer be refundable to the taxpayer. The adoption tax credit is scheduled to sunset after 2012.</td>
<td>A plan’s grandfathered status will not affect eligibility</td>
</tr>
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### Effective June 21, 2010

<table>
<thead>
<tr>
<th>Change</th>
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<tbody>
<tr>
<td>Early Retiree Reimbursement Program</td>
<td>This application-based program reimbursed employer-sponsored plans for some benefits provided to retirees between the ages of 55 and 64. Reimbursement was available for 80% of benefits costing between $15,000 and $90,000. The program was temporary. The Secretary of Health and Human Services stopped taking new applications for the program on May 5, 2011 and stopped accepting claims incurred after December 31, 2011 as the program’s $5 billion funding has been depleted.</td>
<td>A plan’s grandfathered status will not affect eligibility for the credit</td>
</tr>
<tr>
<td>Temporary High Risk Insurance Pool</td>
<td>This national program was created to provide health coverage to individuals with pre-existing conditions who have not had insurance for at least six months. If the $5 Billion earmarked for these programs is exhausted before 2014, the programs will sunset absent Congressional action to increase federal funding.</td>
<td>N/A</td>
</tr>
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### Effective for Plan Years beginning on or after September 23, 2010

<table>
<thead>
<tr>
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<th>Applies to Grandfathered Plans?</th>
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</thead>
<tbody>
<tr>
<td>Coverage of Dependents Up to Age 26</td>
<td>Plans offering dependent coverage for children must provide coverage for adult children of covered employees until age 26. The requirement applies regardless of the child’s marital or student status. This coverage is not taxable to the employee or child.</td>
<td>Yes, but until 2014 grandfathered plans do not have to provide coverage if the child is covered under another employer-sponsored plan (other than the plan of a parent)</td>
</tr>
<tr>
<td>No Lifetime Limits</td>
<td>Plans may not impose lifetime limits on the amount of “essential health benefits” that will be covered. Limits on benefits that are not “essential health benefits” are permitted. We are expecting further clarification on “essential health benefits” in the last quarter of 2012.</td>
<td>Yes</td>
</tr>
<tr>
<td>Restricted Annual Limits</td>
<td>Annual limits on “essential health benefits” are being phased out from 2010 through 2013 and will be completely prohibited beginning in 2014. Limits on benefits that are not considered “essential health benefits” are permitted.</td>
<td>Yes</td>
</tr>
<tr>
<td>No Rescission of Coverage</td>
<td>Plans are prohibited from retroactively terminating a participant’s coverage, except for fraud or intentional misrepresentation. Plan Administrators that desire to rescind coverage for these reasons should include appropriate language within the plan document.</td>
<td>Yes</td>
</tr>
<tr>
<td>Pre-Existing Condition Exclusions Limited</td>
<td>Plans may not have pre-existing condition exclusions for children under age 19. Pre-existing condition exclusions may not be imposed for any participant in plan years that begin on or after January 1, 2014.</td>
<td>Yes</td>
</tr>
<tr>
<td>Nondiscrimination Rules Imposed</td>
<td>Nondiscrimination rules similar to those that currently apply to self-insured plans will now apply to fully insured plans as well. These rules will prohibit discrimination in favor of highly compensated individuals. While these rules were technically effective for Plan Years beginning on or after September 23, 2010, guidance regarding these requirements has not yet been issued. IRS officials have stated that they will not enforce this requirement, nor will employers be subject to excise taxes, until this guidance is issued. Any future guidance will be prospective in nature.</td>
<td>No</td>
</tr>
</tbody>
</table>
### Effective for Plan Years beginning on or after September 23, 2010

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<tr>
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<tbody>
<tr>
<td>Preventive Care Coverage Requirements</td>
<td>Plans must provide certain preventive care coverage without cost to employees, including health screenings, preventive care for children and some immunizations.</td>
<td>No</td>
</tr>
<tr>
<td>Patient Protections</td>
<td>Participants may designate a participating primary care provider of their choice. If the plan covers emergency hospital care, it must do so without requiring prior authorization and with the same requirements and costs as in network services, regardless of whether the service provider is a participating provider. If the plan covers obstetrical and gynecological care, no referrals or prior authorization may be required.</td>
<td>No</td>
</tr>
<tr>
<td>Claims and Appeals Procedures</td>
<td>Plans must implement required internal and external claims and appeals procedures and provide written notice to participants describing the procedures. Some of these requirements were modified in 2011.</td>
<td>No</td>
</tr>
<tr>
<td>Quality of Care Reporting Requirements</td>
<td>Plans must provide reports to the Secretary of Health and Human Services (HHS) and participants regarding quality of care, and to the Secretary of HHS regarding data to be made public. Still waiting for guidance on reporting requirements and actual implementation date.</td>
<td>No</td>
</tr>
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### Effective January 1, 2011

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<tr>
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<tbody>
<tr>
<td>Grants to Small Employers to Establish Wellness Programs</td>
<td>The Secretary of HHS will award grants to eligible employers for wellness programs. An employer is eligible if it has fewer than 100 employees who work 25 hours or more per week and if it did not have a wellness program prior to March 23, 2010. We are still waiting for HHS to roll out this program.</td>
<td>N/A</td>
</tr>
<tr>
<td>Long-Term Care Payroll Deductions</td>
<td>Although the Act designed a program that would allow employees to participate in a new national long-term care insurance program by making contributions through voluntary payroll deductions, this program was deemed unworkable and HHS announced in 2011 that it would not be implemented.</td>
<td>N/A</td>
</tr>
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### Effective for Taxable Years beginning on or after January 1, 2011

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>No Reimbursement for Over-the-Counter Medicines</td>
<td>The costs of over-the-counter medications (except for immunizations and insulin) acquired without a prescription are no longer eligible for tax-free reimbursement under a group health plan, including flexible spending accounts (FSAs), health reimbursement arrangements (HRAs) or health savings accounts (HSAs).</td>
<td>N/A</td>
</tr>
<tr>
<td>Penalties Increased for HSA Withdrawals</td>
<td>The tax penalties for withdrawals from HSAs and Archer MSAs that are not used for qualified medical expenses are increased to 20% (from 10% for HSAs and 15% for Archer MSAs).</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### “Simple Cafeteria Plan”
Eligible small employers may establish a “simple cafeteria plan,” which will be treated as automatically meeting the nondiscrimination rules for group term life insurance, health plans, cafeteria plans and dependent care assistance programs. Employers with an average of 100 or fewer employees in the preceding two years are eligible. Minimum contribution and eligibility requirements must be met. | N/A |

### Effective beginning January 1, 2012

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</thead>
<tbody>
<tr>
<td>Cost of Benefits on W-2</td>
<td>Employers who issued more than 250 Form W-2s in the previous calendar year are required to disclose the aggregate value of employer-sponsored medical coverage beginning with the 2012 Form W-2 issued in January 2013.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Effective March 1, 2012

<table>
<thead>
<tr>
<th>Change</th>
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<tbody>
<tr>
<td>Notice Regarding Exchange</td>
<td>Employers must notify employees of the existence of Exchanges, the standards for receiving a subsidy under the Exchange and the consequences of purchasing a policy through an Exchange.</td>
<td>Yes</td>
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### Effective for Plan Years beginning on or after August 1, 2012

<table>
<thead>
<tr>
<th>Change</th>
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<tbody>
<tr>
<td>Women's Preventive Care</td>
<td>Extensive preventive care requirements such as the provision of well-woman visits, gestational diabetes screening, contraceptives, HPV DNA testing, sexually transmitted infection testing, HIV testing, breastfeeding counseling and equipment, and other services must be provided with no-cost sharing if provided in-network.</td>
<td>No</td>
</tr>
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</table>

### Effective for Plan Years ending after September 30, 2012 (generally this means Plan Years beginning on or after 10-1-2011)

<table>
<thead>
<tr>
<th>Change</th>
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<tbody>
<tr>
<td>Annual Fee on Health Insurance and Self-Insured Plans</td>
<td>An annual fee of $2 ($1 during the first year) times the average number of covered lives under a health plan will be assessed to finance the Patient Centered Outcomes Research Trust Fund. The fee is specifically imposed on policy issuers of health insurance and sponsors of self-insured health plans through 2019.</td>
<td>Yes</td>
</tr>
<tr>
<td>Summary of Benefits and Coverage</td>
<td>Plans must provide a summary of benefits and coverage and a uniform glossary that accurately describes benefits to employees prior to enrollment, using a specified template. The SBC and glossary must be provided by the first day of any annual open enrollment period that begins on or after September 23, 2012 and for later enrollees with the first day of the first plan year that begins on or after September 23, 2012.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Effective for Taxable Years beginning on or after January 1, 2013

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<thead>
<tr>
<th>Change</th>
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<tbody>
<tr>
<td>New Health FSA Contribution Limit</td>
<td>Health FSA salary reduction contributions are limited to $2,500 each year. This limit does not apply to employer health FSA contributions.</td>
<td>N/A</td>
</tr>
<tr>
<td>No Medicare Part D Subsidy Deduction</td>
<td>There will no longer be a deduction available to employers for the cost of providing prescription drug coverage to participants eligible for Medicare.</td>
<td>N/A</td>
</tr>
<tr>
<td>Medicare Payroll Tax Increase</td>
<td>An increased Medicare payroll tax of 0.9% will apply to wages of an individual taxpayer in excess of $200,000 ($250,000 in the case of a married taxpayer filing jointly).</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Effective for Taxable Years beginning on or after January 1, 2014

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<tr>
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<tbody>
<tr>
<td>Play or Pay Penalties Begin</td>
<td>Employers with at least 50 employees will be assessed a fee of $2,000 per full-time employee, excluding the first 30 employees, if they do not offer health plan coverage and have at least one full-time employee who receives a premium tax credit. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees.</td>
<td>N/A</td>
</tr>
<tr>
<td>Exchange Coverage for Small Employers</td>
<td>Small employers may obtain coverage for employees through an Exchange. An employer with less than 100 employees will be considered small unless a state limits small employers to those with less than 50 employees.</td>
<td>N/A</td>
</tr>
<tr>
<td>New IRS Reporting Requirement</td>
<td>Employers will have to begin reporting to the IRS about the health plan coverage made available to employees.</td>
<td>N/A</td>
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### Effective for Plan Years beginning on or after January 1, 2014

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Automatic Enrollment</td>
<td>Health FSA salary reduction contributions are limited to $2,500 each year. This limit does not apply to employer health FSA contributions.</td>
<td>No</td>
</tr>
<tr>
<td>All Pre-Existing Conditions Prohibited</td>
<td>Plans may not impose pre-existing condition exclusions on any participants.</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual Limits Prohibited</td>
<td>Plans may not impose any annual limits.</td>
<td>Yes</td>
</tr>
<tr>
<td>Wellness Reward Limit Increases</td>
<td>The maximum reward permitted under wellness plans increases from 20% to 30% of the cost of coverage. Regulators may choose to increase this limit to any amount up to 50%.</td>
<td>N/A</td>
</tr>
<tr>
<td>Waiting Period Prohibited</td>
<td>Plans may not impose a waiting period of more than 90 days.</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost-Sharing Limits</td>
<td>A plan may not have cost-sharing in excess of the out-of-pocket limits that are applicable to high-deductible health plans. Currently these limits are: $6,250/individual, $12,500/family in coverage. The maximum deductible will also be limited to $2,000 for individual coverage and $4,000 for family coverage.</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Trials Protected</td>
<td>Plans must cover participation costs for certain medical expenses incurred during clinical trials.</td>
<td>No</td>
</tr>
<tr>
<td>Temporary Reinsurance Payments Required</td>
<td>Health insurers and TPAs on behalf of self-insured group health plans will be required to report and make reinsurance contributions on a quarterly basis beginning January 15, 2014. Each contributing entity must pay a per capita amount for each plan enrollee who resides in a particular state.</td>
<td>Yes</td>
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### Effective beginning January 1, 2017

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<tr>
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<tbody>
<tr>
<td>States May Open Exchange to Large Employers</td>
<td>States may, but are not required to, open the Exchanges to employees of large employers (over the 50- or 100- employee threshold set in 2014).</td>
<td>Yes</td>
</tr>
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</table>

### Effective beginning January 1, 2018

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<tr>
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<tbody>
<tr>
<td>Cadillac Tax on High Cost Plans</td>
<td>If the value of employer-sponsored coverage exceeds a threshold amount ($10,200 for single coverage and $27,500 for family coverage), a 40% excise tax will apply to the amount of coverage that exceeds the threshold. The tax applies to coverage providers, including insurers of insured plans, administrators of self-insured plans or FSAs and employers contributing to an HSA or Archer MSA.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* This chart supersedes the chart published in the Spring, 2010 issue of this newsletter.

Please note that we are expecting clarifying guidance on a number of these requirements and further developments may modify the content of this chart.
Steps to Take Now to Comply with Health Care Reform Continued

☑ Get Ready for W-2 Reporting
All W-2s that employers issue, beginning with 2012 W-2s issued in January of 2013, must include in Box 12, under Code DD, the value of health plan benefits provided to each employee. Many employers are configuring their payroll systems to automatically capture this information.

☑ Decide What to Do With Medical Loss Ratio Rebates
Some employers have received a medical loss ratio rebate from their insurers. If your employees contribute to the cost of health plan coverage, then a part of these rebates may be considered plan assets that must be used for the exclusive benefit of your participants within three months in order to avoid ERISA trust requirements. Distributing these rebates to your employees will likely require tax, FICA and FUTA withholding, so instead, consider simply reducing employee contributions for a few months.

☑ Cover Women’s Preventive Care at No Cost
For new plan years beginning on or after August 1, 2012, non-grandfathered health plans must cover women’s preventive services without cost-sharing by participants. Specifically, the plans must cover:

- well-woman visits;
- screening for gestational diabetes;
- human papillomavirus testing;
- counseling for sexually transmitted infections;
- counseling and screening for human immune-deficiency virus;
- FDA-approved contraceptive methods and counseling;
- breastfeeding support, supplies and counseling; and
- screening and counseling for interpersonal and domestic violence.

Certain religious employers are exempt from the obligation to cover contraceptives. Also, nonprofit employers that do not fit the definition of a religious employer but that have not covered contraceptives because of religious beliefs have an extra year to comply while the federal government considers alternatives to potentially accommodate such employers.

☑ Prepare to Pay Fees to Fund Clinical Effectiveness Research
Insurers and employers with self-insured health plans will have to begin paying a fee to fund the Patient-Centered Outcomes Research Institute, which will use the fees to support clinical effectiveness research. The fee kicks in during 2012 for plan years that end after September 30, 2012 and sunsets for plan years ending after September 30, 2019. For the first year, the fee will be $1 per average covered life, and then it ramps up to $2 per average covered life for subsequent years. Fees for 2012 must be submitted to the IRS by July 31, 2013, using Form 720.

☑ Provide Notice to Employees
Beginning in 2014, employers must provide “affordable” health coverage to their employees.

☑ Provide Notice to Employees That State Exchanges Will Be Available Beginning in 2014
2014 will bring changes to the insurance market, including state insurance exchanges, penalties for individuals without insurance and employer play-or-pay requirements. Employers will have to provide a notice about the state insurance exchanges to existing employees by March 1, 2013, and to all new hires who begin on or after March 1, 2013.

☑ Prepare for More Reporting Beginning in 2014
Individuals who are not eligible for affordable employer-sponsored coverage may qualify for subsidized coverage through a state’s insurance exchange. To help the IRS determine who is eligible for subsidized coverage, employers will have to start reporting information about an individual’s eligibility for coverage, dates of coverage, employee contributions and possibly other information.
Determine who should be eligible for health plan coverage in 2014

Beginning in 2014, an employer must offer health plan coverage to all full-time employees who work on average at least 30 hours per week, or pay an annualized penalty of $2,000 per full-time employee (reduced by 30). As you begin planning for 2014, you should consider whether you need to change the eligibility rules for your health plan. Also consider whether you have any workforce members from a temp or employee-leasing agency that may qualify as your common-law employees.

Determine whether employee contributions must be adjusted in 2014

Also beginning in 2014, employers must provide “affordable” health coverage to their employees. There are two components to affordability:

- on an actuarial basis, the plan must pay at least 60% of the covered costs; and
- an employee’s contribution for single coverage under at least one plan option cannot exceed 9.5% of his or her household income.

If the employer does not offer affordable coverage to an employee, the employee may qualify for subsidized coverage through the state's insurance exchange, in which case the employer will have to pay an annualized penalty of $3,000 for that employee. Because you will not know an employee's household income, as you plan for 2014 you will probably need to gauge affordability based on the employee's W-2 taxable income.

Plan to meet additional coverage mandates for 2014

The following mandates apply beginning in 2014:

- Pre-existing condition exclusions are completely prohibited.
- Annual limits on essential health benefits will no longer be permitted.
- Non-grandfathered health plans must provide coverage for routine costs and services provided in connection with a clinical trial.
- For non-grandfathered plans, out-of-pocket maximums may not exceed high-deductible health plan limits (indexed, currently at $5,950 for self coverage and $11,900 for family coverage).
- For non-grandfathered plans, deductibles may not exceed $2,000 for individual coverage and $4,000 for family coverage (indexed for years thereafter).

If you need assistance implementing Health Care Reform, please contact Norbert Kugele at nkugele@wnj.com or 616.752.2186, or any other member of the Warner Norcross & Judd Employee Benefits/Executive Compensation Practice Group.

Leprino Foods was also found to have discriminatory hiring practices. Leprino Foods used a pre-employment test that selected hires for on-call laborer decisions that resulted in discrimination against African-American, Asian and Hispanic applicants. The pre-employment test was not job-related because it tested applicants’ skills in mathematics, locating information and observation. These skills did not relate to entry-level tasks performed by on-call laborers which included inspecting products, monitoring equipment and facility sanitation.

As the cases above illustrate, the OFCCP has increased its focus on adverse impact, particularly in hiring and selection processes.

What is adverse impact? Adverse impact refers to a review of employment decisions to determine whether there are any disparities based on gender, race or ethnicity. By performing this analysis, the OFCCP and employers are able to determine whether there is evidence of disparate treatment of applicants and employees.

So, why now? It is an election year and a number of sources have indicated that the female and minority vote will be critical to both political parties. The OFCCP began ramping up in December 2011 by issuing a proposed rule that would require federal contractors and subcontractors to set a hiring goal to increase people with disabilities in the workforce. Additionally, in January 2012, the OFCCP issued a pending proposal for the rescission of the 2006 Compensation Guidelines and consideration of a new pay data collection tool. The OFCCP claims that these actions would allow the OFCCP to more effectively identify potential violators of E.O. 11246.

In April, the OFCCP released its 2013 budget requests. It seems the OFCCP plans to be more active in 2013, stating that its goal is to complete more and higher quality audits. The OFCCP plans to use the audits to combat against pay discrimination. The OFCCP also plans to implement a “strategic” selection process to prioritize enforcement efforts and pinpoint multi-establishment and industry-wide deficiencies and violations, and there will be greater focus on the construction industry.

The OFCCP’s activity should be a warning to employers to review their policies and practices to make sure no discriminatory behavior exists.
If your company provides employees with group health plan coverage and you issued 250 or more Internal Revenue Service Form W-2s in 2011, your company will need to begin reporting the aggregate cost of each employee's coverage starting with W-2s that you issue in January 2013 for the 2012 calendar year. Most public employers, such as federal, state and local governmental entities, churches and other religious organizations, are also required to comply with this requirement.

The reporting is meant to provide employees with information regarding the comprehensive cost of their health care benefits and does not cause the benefits to be taxable to the employees. Although reporting was optional beginning in 2011, there is no requirement to report for years prior to 2012.

**WHO IS EXEMPT FROM COMPLIANCE?**
The following entities are not currently subject to the reporting requirement:

- Federally recognized tribal governments and certain tribally chartered corporations;
- Employers who are required to file fewer than 250 W-2s for the preceding calendar year (exempted until at least 2014 and until further guidance is issued);
- Self-insured group health plans not subject to any federal continuation coverage requirement (for example, certain church plans); and
- Employers who contribute only to multi-employer plans.

If you and a related employer concurrently employ an individual but the individual is paid by only one of the employers, the employer who pays wages is obligated to report on behalf of all related employers. Many of these exemptions are transitional in nature and employers are encouraged to monitor future guidance on this issue.

**IS THERE AN OBLIGATION TO REPORT THIS INFORMATION ON EARLY W-2S?**
Employees who terminate their employment have a right to request a W-2 within 30 days of termination of employment. However, employers are not required to report health coverage costs on these early W-2s before the end of 2012. But starting in 2013, early W-2s must include the employee's aggregate cost of health benefits through the date of termination.

**WHAT PLANS SHOULD BE INCLUDED IN THE REPORTING REQUIREMENT?**
Subject to the mandatory and permissible exclusions listed below, employers must report the cost of coverage for the group health plan benefits they make available to their employees. This includes the costs of some non-traditional plans, such as on-site medical clinics and mini-med plans.

Future guidance may revise reporting requirements, but will not apply for at least six months after the guidance issues.

**WHAT PLANS SHOULD NOT BE INCLUDED IN THE CALCULATION?**

- Health FSA funded solely by employee contributions;
- HSA contributions (employer or employee);
- Archer MSA contributions;
- Hospital indemnity or specified illness (insured or self-funded), paid on an after-tax basis;
- Long-term care;

*continued on page 12*
• Coverage that is always an “excepted benefit” under HIPAA:
  - Accidental Death & Dismemberment;
  - Short-Term Disability;
  - Long-Term Disability;
  - Liability Insurance, including auto insurance;
  - Coverage issued as a supplement to liability insurance (including medical coverage under an auto insurance plan);
  - Workers’ Compensation;
  - Credit-only insurance;
  - Any similar insurance where medical care benefits are secondary or incidental;
• Plans provided by governmental employers to members of the military and their families;
• For “S” corporations – cost of coverage that is included in a 2% shareholder’s income; and
• For discriminatory group health plans, the cost of “excess reimbursements.”

WHAT PLANS MAY BE EXCLUDED FROM THE CALCULATION?
Employers may exclude the cost of the following plans from the calculation if desired:
• Insured dental and vision plans provided under a separate policy, certificate or contract of insurance, and self-insured dental and vision plans that are offered separately from the medical plan with separate employee contributions;
• Contributions to a Health Reimbursement Arrangement (transitional relief);
• Costs of self-insured plans that are not subject to federal continuation coverage requirements (transitional relief);
• Multi-employer plans to which the employer contributes (transitional relief); and
• Employee assistance plans, wellness programs and on-site clinics if COBRA premiums are not charged for these benefits (transitional relief).

WHAT AMOUNT SHOULD BE REPORTED?
Employer and employee contributions toward the cost of coverage should be reported, regardless of whether the employee paid for his or her portion through pre-tax or after-tax contributions.
• For a fully-insured plan, the amount reported is the premium charged for coverage.
• For a self-insured plan, the amount reported is the 100 percent COBRA premium (that is, the full COBRA premium, less the 2 percent COBRA administration fee). If an employer subsidizes the COBRA premium, the employer should still report the 100 percent COBRA premium.

Similar rules apply to payroll periods that span calendar years. Whatever method is chosen should be consistently applied for all employees covered under that plan.

HOW SHOULD THE INFORMATION BE REPORTED?
Employers should report the costs in Box 12 of Form W-2, using the code “DD.” Employers are not required to report the costs on Form W-3 (the employer’s transmittal of Wage and Tax Statements to the Social Security Administration). Furthermore, these regulations do not impose a reporting obligation if the employer is not otherwise required to file a Form W-2 on behalf of any individual (such as for a retiree or former employee).

WHAT ACTIONS SHOULD EMPLOYERS TAKE NOW?
Hopefully, you have been working closely with your payroll administrator or third-party plan administrator in implementing the necessary infrastructure to determine which plans should be included and the reportable amounts. If you have not yet made these determinations, it is imperative that you begin preparations as soon as possible to be able to comply in a timely manner with the obligations.
TALES OF DRUG TESTING POLICIES continued

The bottom line is you should review your drug testing policy and see if it needs to be amended to take this “disability” into account.

And while you are at it, take a look at how you define “illegal drug use” in your policy. Don’t forget – Michigan, and several other states, now allow the use of medical marijuana. Effectively, that means that some employees may be using marijuana “under a doctor’s orders.” And some drug testing policies exclude from the definition of prohibited drug use “drugs being used under a ‘doctor’s orders.’” See the problem?

Keep in mind that when courts have reviewed medical marijuana statutes they have tended to very narrowly construe the statute limiting the protections they afford to individuals. In addition, the opinions that do deal with these statutes tend to hold that the statutes were not intended to regulate private employers. In Casias v. Wal-Mart Stores, Inc., the court stated that “the MMMA does not regulate private employment” and “[n]owhere does the MMMA state that the statute regulates private employment, that private employees are protected from disciplinary action should they use medical marijuana, or that private employers must accommodate the use of medical marijuana outside of the workplace.”

Clearly, that means that because medical marijuana statutes are not intended to regulate the actions of private employers, the statutes do not prevent employers from firing individuals who use marijuana in accordance with the enacted statutes.

But that is not really the question, now is it? The question we posed was whether employers can unwittingly put language in their drug testing policies that bind them to a promise not to fire an employee who is using medical marijuana under a doctor’s orders. There is no case law one way or the other. So here is our question to you: Do you want to be the test case? We don’t think so.

Because you don’t want to be the test case, you should take a look at your drug testing policy and consider adding language that specifically deals with this question. For example: “For purposes of this policy, ‘illegal drugs’ includes any drug classified as a controlled substance by state or federal law, any otherwise legal drug that is not prescribed by a physician or is not being used in accordance with a prescription and, in all cases, marijuana, regardless of whether it is being used with medical certification.”

Or if you are dealing with a legal drug exception to the definition of prohibited drug use, consider this language: “Under no circumstances, however, will marijuana use be excepted, even if the marijuana is used for medical purposes and that use is permitted under state law.”

We recommend that you consider these issues carefully, and if we can help you with your drug testing policy, please give us a call.
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