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CONTACTS

Lisa R. Nelson, Esq.
Director
Compliance & Regulatory Affairs
lisan@barneyandbarney.com 858.875.3017

Christopher K. Bao, Esq.
Compliance Manager, Orange County
Compliance & Regulatory Affairs
chris.bao@barneyandbarney.com 949.540.6924

CA Insurance LIC: 0C03950
www.barneyandbarney.com

FINAL REGULATIONS ISSUED ON THE ROLE OF NAVIGATORS, NON-NAVIGATORS & COUNSELORS IN THE EXCHANGE

On July 12, 2013, the Department of Health and Human Services (HHS) published final rules on the role of Navigators, Non-Navigators, and Certified Application Counselors (CACs). Each of these roles is specifically addressed in the below summary:

SUMMARY

The Role of Navigators, Non-Navigators & Certified Application Counselors

These final rules specifically apply to Federally Facilitated Exchanges, including State-partnership Exchanges and State-based Exchanges that have received federal establishment grants.

Navigators, Non-Navigators, and Certified Application Counselors all fulfill the role of assisting consumers purchasing coverage inside of these Exchanges.

The role of the Navigator is not to make eligibility determinations or select Qualified Health Plans (QHPs) for consumers, but rather to:

- Educate the public about the Exchange
- Provide fair and impartial information in relation to QHPs, premium tax credits, and cost sharing reduction payments
- Facilitate enrollment in the Exchange

Non-Navigators will have similar duties as Navigators, but will only exist in either State-based Exchanges or State-partnership Exchanges.

Certified Application Counselors (CACs) will include community-based organizations that help enroll eligible consumers in qualified and affordable health plans in the Exchange. CACs will exist in all states.

State Law & the Patient Protection and Affordable Care Act

The final rule declares that states may impose licensure and certification requirements, as long as the requirements do not inhibit the Navigators, Non-Navigators, and CACs from performing their normal job duties under the Patient Protection and Affordable Care Act (PPACA).

Although the final regulations are vague as to what specific state laws would conflict with PPACA, the regulations do mention that state laws which require navigators to be agents and brokers, or obtain errors and omissions insurance, would conflict with PPACA.

Final Regulations Issued on the Role of Navigators, Non-Navigators, & Counselors in the Exchange (Continued)

State Law & the Affordable Care Act (Continued)

Conflicts of Interest

Navigators and Non-Navigators must not:

- Be health or stop-loss insurers, or subsidiaries or associations of health or stop-loss insurers
- Receive any consideration (e.g., grants, gifts, or free travel) for enrollment
- Have a private or personal interest that might influence or appear to influence their duties

Despite these restrictions, Navigators and Non-Navigators are not restricted from receiving payment for medical services or grants for other, unrelated purposes. These payments or grants, however, must be disclosed to consumers and to the Exchange.

Certification & Training

The final rule requires that Navigators and Non-Navigators complete a certification requirement. Navigators will be trained in both the individual Exchange and Small Business Health Options Program (SHOP).

Fifteen topics will be covered in the training, with approximately 30 hours of training in total. This training will also include a section on privacy and security standards.

Fair Access to Exchanges

The final rule requires that Navigators and Non-Navigators provide culturally and linguistically appropriate services, and also ensure reasonable access to these services by persons with disabilities.

General knowledge about culture and language of communities will be taken into account pursuant to different service areas, and the Exchanges will collect information about the composition of those areas. Based on this information, services will be provided to different communities based upon their preferred languages and practices.

Special Rules for Certified Application Counselors

Certified Application Counselors (CACs) must be offered in every kind of Exchange. Individual employees or volunteers of CAC organizations, which may include staff at community health centers, hospitals, other health care providers, or social service agencies, may serve as CACs.

Federal Exchanges may certify CAC organizations, while State-based Exchanges may certify both individuals and organizations. Individuals need not be certified to assist with Exchange consumers, but if not certified, they may not hold themselves out as being certified.

Duties of CACs are much more limited than Navigators or Non-Navigators: CACs may only inform, help apply for, and assist in enrolling individuals into a range of QHPs.

CACs may work for an insurance carrier or broker, and do not have the same conflict of interest rules as Navigators / Non-Navigators, so long as they disclose to consumers any potential conflicts.

No Action Necessary

For more information regarding the final regulations, go to:

https://www.federalregister.gov/articles/2013/07/17/2013-17125/patient-protection-and-affordable-care-act-exchange-functions-standards-for-navigators-and

For a sample application form to become a Certified Application Counselor, go to:

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/sample-apply-to-be-a-cac-7-12-2013.pdf

Final Regulations Issued on the Role of Navigators, Non-Navigators, & Counselors in the Exchange (Continued)

What kind of assistance will be available through the Exchange?

	Navigators	Non-Navigator Assistance Personnel	Certified Application Counselors	Agents & Brokers
State-based Exchange	Yes	Optional for states	Yes	Optional for states
State-partnership Exchange	Yes	Yes	Yes	Yes, if a state permits it
Federally-facilitated Exchange	Yes	Not applicable; Navigators provide this assistance	Yes	Yes, if a state permits it

How are these roles funded?

	Navigators	Non-Navigator Assistance Personnel	Certified Application Counselors	Agents & Brokers
State-based Exchange	State-based grant program	State-based grants or contracts, which can be funded by Exchange Establishment grants	CACs will not receive new federal grant money through the Exchange. Federal funding through other grant programs or Medicaid may be available. Some examples of possible application counselors include staff at community health centers, hospitals, other health care providers, or social service agencies	Agents and brokers can be compensated by insurance companies or consumers, consistent with state law
State-partnership Exchange	Federal grant applications are being reviewed and awards will be announced in late summer 2013	State-based grants or contracts, which can be funded in states with consumer partnerships by Exchange Establishment grants		
Federally-facilitated Exchange	Federal grant applications are being reviewed and awards will be announced in late summer 2013	Not applicable		

Final Regulations Issued on the Role of Navigators, Non-Navigators, & Counselors in the Exchange (Continued)

What training and certification is required?

	Navigators	Non-Navigator Assistance Personnel	Certified Application Counselors	Agents & Brokers
State-based Exchange	State training and certification (state may choose to use federal training)	State training and certification (state may choose to use federal training)	State training and certification (state may choose to use federal training)	State training and certification (state may choose to use federal training)
State-partnership Exchange	Federal training and certification, which may be supplemented by the state	Federal training and certification, which may be supplemented by the state	Federal training and federal designation of organizations, which may be supplemented by the state	Federal training and registration
Federally-facilitated Exchange	Federal training and certification	Not applicable	Federal training and federal designation of organizations	Federal training and registration

NEW JERSEY ENACTS DOMESTIC VIOLENCE LEAVE ACT

New Jersey recently passed a bill which provides leave to victims of domestic violence or sexual assault. The bill, entitled the New Jersey Security and Financial Empowerment Act (the Act), goes into effect on Oct. 1, 2013.

Action Required

Employers should start preparing now by reviewing and updating employee handbooks and leave policies to be compliant by Oct. 1, 2013.

For complete details, see a copy of the bill at:

http://legiscan.com/NJ/text/S2177/id/664058

SUMMARY

Employers who are Subject to the Ordinance

Employers who fall under the Act include:

- Any employer with 25 or more employees
  - Although the statute is unclear, it appears the Act applies to the total number of employees of an employer, not only those in New Jersey

Employees who are Eligible for Domestic Violence Leave

Employees who are eligible for sick leave include:

- Any person employed in New Jersey for a period of at least 12 months; and
- Any person that has accumulated 1,000 base hours during the 12 months preceding the leave

New Jersey Enacts Domestic Violence Leave Act (Continued)

Employee Utilization of Domestic Violence Leave

Reasons for leave may be based upon:

- The employee being a victim of an incident of domestic violence or a sexually violent offense
- A relative (e.g., child, parent, spouse, domestic partner, civil union partner) of the employee being a victim of an incident of domestic violence or a sexually violent offense

Once an employee is eligible for leave, the employee is entitled to 20 days of unpaid leave to:

- Seek or receive medical treatment
- Obtain services from a victim services organization
- Obtain psychological or other counseling
- Participate in safety planning, moving, or taking other actions to increase safety
- Seek legal assistance; or
- Attend, participate or prepare for a criminal or civil court proceeding

The leave will run concurrently with any other leave entitlements, such as leave under the federal Family Medical Leave Act (FMLA), and employers may require employees to use available accrued leave concurrently with the Act.

Employer Notice Requirements

Employers are required to post a notice regarding the Act (notice has not yet been issued).

Employer Verification of Domestic Violence Leave

Employees must provide advanced written notice when such leave is foreseeable, as far in advance as is reasonable under the circumstances. Under certain circumstances, employers may require verification of leave under the Act; proof may include:

- Copies of restraining orders
- A letter from a prosecutor
- Proof of conviction
- Medical documentation
- Certification from an agency or professional involved in assisting the victim, including social, religious, or shelter workers

OREGON EXPANDS FAMILY LEAVE ACT TO INCLUDE BEREAVEMENT

Oregon recently passed House Bill 2950 (HB 2950) which expands the current Oregon Family Leave Act (OFLA) to include bereavement leave. HB 2950 goes into effect on Jan. 1, 2014.

Action Required

Employers should start preparing now by reviewing and updating employee handbooks and leave policies to be compliant by Jan. 1, 2014.

For complete details, see a copy of the bill at:

https://olis.leg.state.or.us/liz/2013R1/Measures/Text/HB2950/Enrolled

SUMMARY

Employers who are Subject to the Ordinance

Employers who fall under HB 2950 include:

- Any employer with 25 or more employees in the state of Oregon:
  - During each working day for 20 or more calendar work weeks in the calendar year in which the leave is to be taken; or
  - In the calendar year immediately preceding the year in which the leave is to be taken

Employees who are Eligible for Bereavement Leave

Employees who are eligible for leave under HB 2950 include:

- Any person employed in Oregon for a period of at least 180 days; and
- Any person that has averaged 25 hours per week during the 180 calendar days immediately preceding the date the leave begins

Employee Utilization of Bereavement Leave

Reasons for leave may be to:

- Attend the funeral or alternative to a funeral of a family member (e.g., spouse, parent, child, parent-in-law, grandparent, grandchild, same-gender domestic partner, or parent or child of same-gender domestic partner)
- Make arrangements necessary for the death of a family member
- Grieve the death of a family member

Once an employee is eligible for leave, the employee is entitled to two weeks of unpaid leave. The leave must be completed within 60 days of the date in which the employee receives notice of the death.

The leave does not run concurrently for multiple deaths (i.e., if a family has the misfortune of losing two family members, one after the other, the employer cannot require that the leave occur concurrently; therefore, the employee would be allowed four weeks of leave).

Employer Verification of Bereavement Leave

Employees must provide advanced written notice when such leave is foreseeable, as far in advance as is reasonable under the circumstances; however, an employer may not reduce the two week leave if an employee fails to provide a timely notice.

MINNESOTA EXPANDS SICK LEAVE

Minnesota recently passed a bill amending the Minnesota Parenting Leave Act (the Act), which expands the list of persons an employee may request leave for when they are caring for that individual. The Act is effective as of Aug. 1, 2013.

Action Required

Employers should review and update employee handbooks and leave policies due to the expanded sick leave, effective Aug.1, 2013.

For more information regarding the Act, go to:

https://www.revisor.mn.gov/laws/?id=87&doctype=Chapter&year=2013&type=

SUMMARY

Employers who are Subject to the Ordinance

Employers who fall under the Act include:

- Any employer with 21 or more employees in the state of Minnesota

Employees who are Eligible for Sick Leave

Employees who are eligible for leave under the Act include:

- Any person employed in Minnesota for a period of at least 12 months; and
- Any person that has averaged one-half the full-time equivalent position in the employee's job classification during those 12 months

Employee Utilization of Sick Leave

Reasons for leave may be based upon:

- An illness or injury to the employee's child, adult child, spouse, sibling, parent, grandparent, or step-parent

Once an employee is eligible for leave, the employee is entitled to at least 160 hours of leave (no requirement to be paid) to be used in any 12 month period.

CERTAIN EMPLOYEE BENEFITS IN MINNESOTA MAY REQUIRE ADDITIONAL TAX WITHHOLDING

Minnesota did not adopt certain extensions of the Federal Tax Code in 2013. Because of this, employers in Minnesota may need to increase or begin withholding taxes for certain employee fringe benefits. The following are those areas of benefits:

Employer Provided Educational Assistance

- Tax breaks for employer provided educational assistance of up to $5,250 a year not extended
  - Under a different section of the federal Internal Revenue Service Code (Code), an employee may still receive tax-free employer provided educational assistance, if the employer provides educational assistance, and so long as the educational assistance:
    - Maintains or improves skills needed for an employee's current job; or
    - Is required of the employer by law for the employee to retain present salary, status, or employment
  - Educational institutions may provide qualified tuition reductions for employees (as well as their children and spouses) who receive education at the educational institution where they are employed

Certain Employee Benefits in Minnesota may Require Additional Tax Withholding (Continued)

Transit Benefits

- No increase to transit pass / vanpool benefits limits
- The federal limit is now $245 per month, Minnesota's maximum contribution towards the employee transit pass/vanpool benefit is $125 per month
- Continues to allow the same maximum tax exemption as the federal Code for parking benefits, at $245 a month for 2013

Adoption Assistance

- Pretax adoption assistance benefits not extended
- Benefits offered by an employer will be taxable at the Minnesota state level, and treated as a pre-tax benefit at the federal level (in the amount of $12,970 in 2013)

Action Required

For employers who did not adjust for this change, and already provided these benefits pre-tax in 2013, Minnesota has provided guidance on its tax website, available at:

http://www.revenue.state.mn.us/Pages/FAQ.aspx?WebId=96eebbc5%2D823b%2D48d3%2Da102%2Db50a9bb72118&Owner=Withholding%20Tax&Topic=What%27s%20New&SubTopic=Employer%20provided%20education%20benefits

Employers should notify their employees that they may now be responsible for additional taxes for the benefits listed above.

For further information on the above listed benefits, and a link to the Minnesota Department of Revenue website, go to:

http://www.revenue.state.mn.us/Pages/2013_wh_fed_conformity.aspx

MASSACHUSETTS REPEALS STATE HEALTH CARE REFORM LAW & IMPLEMENTS EMPLOYER MEDICAL ASSISTANCE CONTRIBUTION

Previously, Massachusetts employers with 11 or more employees were required to make a "fair and reasonable contribution" to an employee's health insurance premium cost. If the employer failed to do so, the employer would be subject to a $295 per Full-Time Equivalent (FTE) employee penalty.

In addition, the law required employers to collect the Health Insurance Responsibility Disclosure (HIRD) form from every employee who waived employer sponsored health coverage, or waived out of the employer's cafeteria plan in order to utilize coverage through the Massachusetts Health Connector (i.e., Massachusetts State Exchange).

Massachusetts Repeals State Health Care Reform Law & Implements Employer Medical Assistance Contribution (Continued)

SUMMARY

Two Legislative Provisions Repealed

Massachusetts recently repealed two provisions of the Massachusetts 2006 health care reform legislation: the "fair and reasonable contribution" requirement for employers and the employer collection of HIRD forms from employees.

Effective July 1, 2013, employers no longer need to:

- Make a "fair share" contribution towards employee health insurance coverage; and
- Collect HIRD forms from employees

All other components of the Massachusetts law remain in effect, which include:

- The individual mandate; and
- The requirement that employers offer a cafeteria plan to eligible employees, to help those employees pay for the cost of individual health coverage on a pre-tax basis

If, however, an employer owes a penalty for failing to be in compliance with the "fair and reasonable contribution" prior to July 1, 2013, they will continue to owe the state of Massachusetts for that payment.

In addition, employers may still face an audit for times when the employer, prior to July 1, 2013, may not have been in compliance with the law or failed to file reporting forms for past years.

Employer Medical Assistance Contribution

Although the above requirements for employers were repealed, effective Jan. 1, 2014, Massachusetts will implement a new tax on employers with more than **five employees** in Massachusetts, called the Employer Medical Assistance Contribution (EMAC).

The payment of the fee is effective Jan. 1, 2014, and is 0.36% of all wages up to the Massachusetts unemployment taxable wage base, which currently is $14,000.00. This approximately equals $50 ($14,000 X .0036 = 50.40) per employee, per year. For a new employer or employer who has not done business in Massachusetts prior to Jan. 1, 2014, the assessment is reduced to 0.12% in the first year, and 0.24% in the second year.

Requirement to Offer a Cafeteria Plan to Eligible Employees & New Notice Requirement

Employers with 11 or more FTE employees were previously only required to offer a cafeteria plan to eligible employees. Now, in addition to offering cafeteria plan benefits coverage, an employer must notify employees of its compliance with the requirement (this does not mean that the employer must contribute towards the coverage, but rather coverage need only be offered to employees; employers should still be aware of the impending Federal Employer Mandate, which fines an employer for failing to provide affordable coverage to a full-time employee).

It is anticipated that the Connector will develop a model form and/or notice to distribute to employees; notice would indicate the employer's compliance with this statute.

To calculate the number of FTE employees an employer has in a 12 month period, an employer would:

- Add all hours of service for all employees in a 12 month period (except those who were employed less than one month) from July 1 through June 30; and divide by 2000

If an employer fails to provide a section 125 plan, and employees access medical care through the Health Safety Net (a state maintained fund that pays for care when uninsured people need care), an employer may be subject to a penalty of between 20% – 100% of the cost of the medical services that exceed $50,000.00 in a 12 month period. This is called the "Free Rider Surcharge."

Massachusetts Repeals State Health Care Reform Law & Implements Employer Medical Assistance Contribution (Continued)

Requirement to Offer a Cafeteria Plan to Eligible Employees & New Notice Requirement (Continued)

Employees who may be ineligible, and therefore need not be offered the ability to participate in a cafeteria plan, include the following:

- Employees less than 18 years of age
- Temporary employees
- Part-time employees working on average fewer than 64 hours a month
- Employees who are considered wait staff, service employees or service bartenders who, on average, earn less than $400 a month in wages
- Student employees who are employed as interns
- Seasonal employees who are international workers, who are enrolled in travel health insurance

It is important to note that plans in Massachusetts may not have a more than two month waiting period, and there is a filing requirement for employers to file their plan documents with the Connector.

Action Required

Employers doing business in Massachusetts should watch for future developments, and review their Fair Share Contribution (FSC) filing history to determine whether any filings were required / missed prior to July 1, 2013. Employers with more than five employees should be aware of the impending EMAC fee for each employee. Massachusetts employers should be aware of the requirement to offer a cafeteria plan to all benefits eligible employees (excluding those listed above as ineligible), and should watch for the cafeteria plan notice that will be released from the Connector for distribution to employees.

Fair Share Contribution (repeal):

https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=/FindInsurance/Employer/Obligations/Fair%20Share%20Contribution/&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=co

Defining Minimum Essential Coverage in Massachusetts (revised law):

http://www.lawlib.state.ma.us/source/mass/cmr/cmrtext/956CMR5.pdf

Free Rider Surcharge:

https://www.mahealthconnector.org/portal/site/connector/template.MAXIMIZE/menuitem.3ef8fb03b7fa1ae4a7ca7738e6468a0c/?javax.portlet.tpst=2fdfb140904d489c8781176033468a0c_ws_MX&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_viewID=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_docName=content&javax.portlet.prp_2fdfb140904d489c8781176033468a0c_folderPath=%2FFindInsurance%2FEmployer%2FObligations%2FFree%20Rider%20Surcharge%2F&javax.portlet.begCacheTok=com.vignette.cachetoken&javax.portlet.endCacheTok=com.vignette.cachetoken

Cafeteria Plan Offering Requirement:

https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/2007/Week%2520Beginning%2520March%252018%252C%25202007/Emergency%2520Section%2520125%2520Regulation.pdf

QUESTION OF THE MONTH

Q: Our company sponsors a calendar-year self-insured major medical plan subject to ERISA. Are we permitted to treat the new fees under health care reform (the Patient-Centered Outcomes Research (PCOR) fees and reinsurance contributions) as plan expenses?

A: The two new fees under health care reform that you have asked about – PCOR fees and reinsurance contributions – are treated differently in terms of whether they may be paid out of plan assets.

As background, PCOR fees, which are designed to help fund a new nonprofit corporation to support clinical effectiveness research, are payable annually by sponsors of self-insured plans (and insurers, but we focus here on plan sponsors) beginning with plan years ending after Oct. 1, 2012 and before Oct. 1, 2019; for a calendar-year plan such as yours, the PCOR fees apply for plan years 2012 through 2018. The amount of this fee is $2 times the average number of covered lives under the plan (except the multiplier is $1 for plan years ending before Oct. 1, 2013). Plan sponsors have a choice of methods in determining the average number of lives covered under the plan during the plan year, with special treatment for sponsors of multiple self-insured arrangements. The DOL has indicated that PCOR fees generally are not permissible plan expenses under ERISA, since by law they are imposed on the plan sponsor and not the plan. This means that plan assets (e.g., trust assets or participant contributions) may not be used to pay the PCOR fees since ERISA's prohibited transaction rules prohibit plan assets from being used to offset employer obligations. However, an IRS legal memorandum states that plan sponsors may deduct these fees as ordinary and necessary business expenses.

Reinsurance contributions fund temporary payments to insurers that cover high risk individuals in the individual market (i.e., reinsurance is basically insurance for those insurers). These annual contributions are required of self-insured (and insured) plans during 2014, 2015, and 2016. HHS is required to establish a national reinsurance contribution rate each year – the annual contribution rate for 2014 is $63 times the average number of covered lives under the plan. Although self-insured plans are ultimately liable for reinsurance contributions, a TPA may be used to transfer the plans' contributions to HHS. Similar to PCOR fees, plan sponsors have a choice of methods for counting the average number of covered lives. In contrast to its position on PCOR fees, the DOL has stated that reinsurance contributions are permissible plan expenses under ERISA because these payments are required by the plan. (The IRS has indicated that reinsurance contributions are also deductible as ordinary and necessary business expenses, subject to any applicable disallowances or limitations.)

Contributing Editors: EBIA Staff.

IMPORTANT DATES

PLAN YEARS ON / AFTER 08/01/2012

- **Health Care Reform's Women's Preventive Services Mandate** with no cost sharing (for calendar year plans the effective date was 01/01/2013)

PLAN YEARS ON / AFTER 09/23/2012

- **Health Care Reform's Annual Dollar Limits** for "essential health benefits" restricted to no less than $2 million, absent a waiver (for calendar year plans the effective date was 01/01/2013)

PLAN YEARS ON / AFTER 09/23/2012

- **Summary of Benefits and Coverage (SBC)** must be provided to plan participants and prospective participants when marketing, 30 days prior to renewal, upon demand within 7 days, and upon special enrollment election (for calendar year plans the effective date was 01/01/2013

PLAN YEARS ENDING ON / AFTER 10/01/2012

- **Comparative Effectiveness Fee**. Fully-insured carriers and self-funded plan sponsors will be subject to a fee in the amount of $1 per covered life. The Fee is due 07/31 of each year using Form 720 "Quarterly Federal Excise Tax Return"

PLAN YEARS ON / AFTER 01/01/2013

- **Flexible Spending Accounts** limited to $2,500 for employee contributions

60 DAYS AFTER THE BEGINNING OF THE PLAN YEAR

- **Employer Creditable Coverage Reporting to CMS** due (e.g., if a plan effective date is 01/01, reporting must be completed by 03/01)

OCTOBER 2013

- **10/01/2013 – Notice of Exchange**. Ongoing employees must receive notice before 10/01/2013; for each new employee, notice must be provided upon hire beginning 10/01/2013
- **10/01/2013 –Exchange Initial Open Enrollment** begins
- **10/15/2013 – Medicare Part D Creditable and/or Non-Creditable Coverage Notice** to plan participants due (if not previously provided earlier in the year as part of the Benefits Information Guide or at open enrollment)

NOVEMBER 2013

- **11/14/2013 – Barney & Barney's Legislative Compliance 2014 Outlook Seminar** in San Diego, CA
- **11/15/2013 – Reinsurance Fee** reporting due for carriers and self-funded plans (including HRA plan sponsors where not integrated with a self-funded plan)

JANUARY 2015

- **01/01/2015 – Employer Mandate** effective for calendar year plans