Wells Fargo Insurance Services

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Legislative update

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Health care reform: Regulators issue FAQs on timing of automatic enrollment, status of full-time employee guidance, and waiting periods

On February 9, 2012, both the Internal Revenue Service (in IRS Notice 2012-17) and the U.S. Department of Labor (in Technical Release No. 2012-01) issued an identical set of frequently asked questions (FAQs) that provide further guidance on some key aspects of the Patient Protection and Affordable Care Act (ACA).

Automatic enrollment

The ACA amended the Fair Labor Standards Act to direct applicable employers with more than 200 full-time employees to automatically enroll full-time employees in the employer's health plan, including continuation of coverage of those already enrolled. The ACA further provided that the Secretary of Labor would issue regulations related to this new requirement. In an FAQ issued in December 2010, the agencies indicated that the requirement would not go into effect until regulations were issued and that the Department of Labor (DOL) would provide such regulations by 2014. However, in the new FAQs the agencies recognize that stakeholders need adequate time to implement the new requirement, including coordination with other upcoming ACA requirements. The DOL concluded that the automatic enrollment guidance would not be ready to take effect by 2014. Thus, at this stage it appears automatic enrollment will not be required before 2015 (possibly later), which delays some of the anticipated increases in employer plan costs that would result from complying with the automatic enrollment process.

Employer "play or pay" and "affordable" coverage

The ACA generally encourages "large" employers to offer coverage to all full-time employees. It further encourages that the coverage be "affordable," meaning that each employee's cost for the employer's lowest cost, single-only coverage plan will not exceed 9.5 percent of the employee's modified adjusted gross income (MAGI). However, in IRS Notice 2011-73, the Internal Revenue Service (IRS) previously recognized the complications that exist in determining household income and indicated that the IRS intended to permit employers to use an employee's Form W-2, Box 1 wages as a safe harbor in determining affordability. In a new FAQ, regulators reiterated their intent to issue proposed regulations or other guidance to such effect. Employers should feel reasonably comfortable in applying the safe harbor in projecting potential costs of employer "play or pay" starting in 2014.

Employer "play or pay" full-time employee determinations

In 2014, large employers (those with 50 employees or more in the prior calendar year) will face penalties under the "play or pay" mandate of the ACA if the employer does not offer coverage to full-time employees, or offers coverage that does not meet the minimum essential value (60 percent actuarial value), or is unaffordable. However, a new FAQ indicates that regulators will issue guidance on the applicability of the "play or pay" mandate on new employees. The guidance will state that the "play or pay" penalty will only apply to new employees after the employee satisfies a 90-day period counted from the employee's hire date, assuming all other plan eligibility criteria has been satisfied.

Employer "play or pay" rules only take into account full-time employees, which are generally defined as any "employee who is employed on average at least 30 hours of service per week." In IRS Notice 2011-36, the IRS indicated one possible "safe harbor" that would allow using a "look-back/stability period" method, which was discussed in detail in our May 2011 Legislative Update. In the new FAQ, regulators emphasized their intent to allow for such method to apply in 2014 and later years. However, that method will apply solely to existing employees (presumably those who work throughout the look-back period), as a separate FAQ addresses newly-hired employees.

As for newly-hired employees, the FAQ goes into detail describing the method to be used in determining if newly-hired employees satisfy the full-time employee status. This method, which will be addressed in upcoming guidance, allows an employer to use up to a six-month period to determine a newly-hired employee's full-time status. For new hires, regulators propose the following:

- **Full-time employees.** At the time the employee is hired, an employer must determine if 1) the employee is reasonably scheduled to work on average 30 or more hours per week annually, and 2) if the number of hours worked by the employee during the first three months of employment are deemed to be representative of the number of hours the employee is expected to work annually. If so, coverage must be offered to that employee at the end of the three-month period. This example clearly describes an employer who has hired an employee to work on a full-time basis throughout the year.
- **Seasonal employees.** If the employee worked on average 30 hours or more per week during the first three months of employment (the first three-month period), but the first three months of employment are not representative of the number of hours the employee is anticipated to work annually, the offer of coverage can be delayed for an additional three months. If at the end of the second three-month period, the employer determines the employee worked on average 30 or more hours per week, coverage must be offered to the employee at the end of the second three-month period.

- **Seasonal employees.** If the employee worked on average 30 or more hours per week in the first three-month period, but averaged less than 30 hours per week in the second three-month period, the employer is not required to offer coverage to the employee for the next three-month period (third three-month period), as the employee failed to meet the full-time employee status.

Final guidance will be necessary to work through the new proposals, but an initial impression is that the new proposals will be welcome news for employers who hire extensive temporary and seasonal employees.

Ninety-day waiting period requirement

Beginning in 2014, the ACA will require plans to impose waiting periods of 90 days or less after an employee meets a health plan's eligibility conditions. A new FAQ addresses the regulators' intent on some aspects of this new requirement. First, it appears upcoming guidance will provide that for a new, immediately-eligible full-time employee, the waiting period cannot exceed 90 days from the employee's date of hire, which appears to prohibit commencement of coverage based on a first day of a month following the month in which a 90-day waiting period ends.

The 90-day waiting period FAQ goes on to clarify that eligibility conditions can be imposed, such as full-time status, a bona fide job category (an example indicates exclusion of computer programmers is permissible, though perhaps not if an employer wishes to avoid a "play or pay" penalty), or receipt of a license. Regulators further anticipate allowing an hours-of-service eligibility condition in some limited circumstances. One example indicates it might be permissible to make part-time employee meet a 750 cumulative hours eligibility condition, with the ability to apply a 90-day waiting period after the condition is met.

The IRS Notice and DOL Technical Release both appear to contain some welcome news. Both include a request for comments, to be provided by April 9, 2012.

Final regulations released on the Summary of Benefits Coverage notice requirement

On August 17, 2011, the Internal Revenue Service (IRS), Department of Labor (DOL), and the Department of Health and Human Services (HHS) (collectively, "the Departments") released proposed rules regarding group health plans' and health insurance issuers' obligations under the Patient Protection and Affordable Care Act (ACA) to provide a summary of benefits coverage (SBC) and uniform glossary of terms. (See our August 25, 2011, Legislative Alert.) This requirement applies to grandfathered and non-grandfathered benefit options. The SBC template released by the Departments with the draft regulations was a four-page double-sided document that contained information on cost-sharing provisions, including deductible, co-insurance, and co-payment obligations, exceptions, reductions, and limitations on coverage, and examples illustrating common benefits scenarios. Under the ACA and proposed regulations, SBCs and the uniform glossary were to be distributed for all enrollments on or after March 23, 2012. In response to numerous comments on the proposed regulations, the Departments, by way of ACA Implementation FAQ, delayed the date plans and issuers would be required to comply with the SBC requirement until final regulations were issued. On February 9, 2012, the Departments released final regulations, an updated SBC template, and a revised uniform glossary of terms.

Effective date

The new effective date for the SBC notice requirement was the most significant change in the final regulations. Under the final regulations, the requirements to provide an SBC, notice of modification to an SBC, and uniform glossary apply to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period (including re-enrollees and late enrollees) beginning on the first day of the first open enrollment period on or after September 23, 2012. For disclosures to participants and beneficiaries who enroll in group health plan coverage other than through an open enrollment period (including individuals who are newly eligible for coverage outside of open enrollment), the requirement will apply beginning on the first day of the first plan year that begins on or after September 23, 2012. This means that a calendar year plan with an open enrollment period beginning November 15 would need to begin complying on November 15, 2012, for regular enrollees and late enrollees and January 1, 2013, for new hires.

Issuer and plan distribution requirements

The final regulations require a health insurance issuer (insurance carrier) to provide an SBC to a plan upon a new application by the plan for coverage. The SBC must be provided as soon as practicable following receipt of the application, and not later than seven business days following receipt of the application. If renewing automatically with an existing issuer, the issuer must provide the SBC to the plan within 30 days of the beginning of the plan year. If renewing subject to an application requirement, the issuer must provide the plan with the SBC with the required application materials. An insurance issuer must also provide an SBC to a plan upon request as soon as practicable and not later than seven business days following receipt of the request.

SBCs must also be distributed to participants and beneficiaries. Although either the issuer or the plan can satisfy the obligation under the ACA to provide an SBC to participants and beneficiaries, the preamble of the final regulations makes clear that the plan administrator bears the ultimate responsibility for providing an SBC to participants and beneficiaries. The SBC may be provided electronically if the requirements of the DOL's electronic disclosure

safe harbor are met. A separate SBC must be provided to each participant and beneficiary for each benefit package offered by the plan as part of open enrollment materials. Beneficiaries, who often do not separately receive a plan's open enrollment materials, will need to receive separate SBCs if known to reside at a different address from the employee participant. If beneficiaries need to separately be provided with SBCs, electronic distribution would not satisfy the plan's notice obligation without the express consent of the beneficiary. Note that the DOL's ten-year-old electronic disclosure rules are currently under review.

If a plan does not have an established open enrollment period or annually distribute enrollment materials, then the SBCs must be distributed no later than the first date on which the participant is eligible to enroll. If participants are automatically reenrolled, then the SBC must generally be provided no later than 30 days prior to the first day of the new plan year. The regulations contain a special rule to prevent duplication providing that SBCs are not required to be provided automatically upon renewal for benefit options in which the participant or beneficiary is not enrolled unless a specific request is made. However, it is unclear what aspect of a plan's disclosure obligations this special rule would make unnecessary. For example, it does not appear that the special rule would eliminate the requirement for a plan to provide separate SBCs for all available benefit options at open enrollment.

If there is any change to the information required to be in the SBC before the first day of coverage, the issuer must provide a current SBC to the plan and the plan must provided the amended SBC to participants and beneficiaries no later than the first day of coverage. Although the content of the final SBC template does not differ significantly from the draft version, the final regulations eliminate the requirement to include premium or cost of coverage information in the SBC. The Departments believe that this change should limit potential changes between when the SBC is initially provided and the first day of coverage.

Another significant change in the final regulations is with respect to special enrollees. The plan must provide any SBCs to special enrollees no later than the date by which a summary plan description is required to be provided, which is 90 days from enrollment. Otherwise, a plan or insurance issuer must provide an SBC to participants or beneficiaries upon request as soon as practicable, and not later than seven business days following receipt of the request.

Language requirements

Under the final regulations, the SBC must be provided in writing and free of charge and must also be provided in a culturally and linguistically appropriate manner. This means that translated documents are required in counties where ten percent of the population is literate only in the same non-English language based on U.S. Census Bureau American Community Survey data. Summary census data that can be used by plans is available at http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=25131. HHS will provide written translations of the SBC template and uniform glossary in languages that meet this threshold, which at present include Spanish, Tagalog, Chinese, and Navajo (at http://cciio.cms.gov or www.dol.gov/ebsa/healthreform). In addition to translated documents, plans or issuers must also provide oral language services, such as a telephone customer assistance hotline that include answering questions in any applicable non-English language.

Excepted benefits and HSAs

The final regulations also confirm that an SBC need not be provided for excepted benefits like most stand-alone dental or vision plans (insured plans offered under a separate contract or self-funded plans where dental or vision can be declined and, if elected, require an additional employee premium) or most health flexible spending arrangements (health FSAs) (major medical is also offered and the maximum benefit does not exceed the greater of $500 or two times the employee salary reduction amount). For health FSAs that do not meet excepted benefit criteria and for health reimbursement accounts (HRAs) (which almost never meet the excepted benefit criteria) that are integrated with other major medical coverage, the effects of the health FSA or HRA can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. A standalone health FSA that is not an excepted benefit or standalone HRA must satisfy the SBC requirements independently. Although HSAs are generally not group health plans and are not subject to the SBC requirements, an SBC prepared for a high-deductible health plan associated with an HSA can also mention the effects of employer contributions to HSAs in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the high-deductible health plan. A separate SBC will not ever be required for an HSA.

Notice of modification

A group health plan or issuer must provide a new SBC 60 days in advance of any mid-year material modification that is not reflected in the most recently provided SBC. A material modification is defined as any enhancement or reduction in coverage that would be considered by an average plan participant to be an important change in covered benefits or other terms of coverage under the plan. The final regulations confirm that 60 days notice is not required for changes in connection with benefits renewal. Providing the new SBC will also satisfy the requirement to provide a summary of material modification (SMM) under the Employee Retirement Income Security Act (ERISA).

Uniform glossary

The ACA directs the Departments to develop standards for definitions for certain insurance and medical terms. The Departments, in connection with the National Association of Insurance Commissioners (NAIC), created a template that provides the required definitions. The final regulations require that the SBC

include an Internet address where an individual may review and obtain the uniform glossary, a contact phone number to obtain a paper copy of the uniform glossary, and a statement that paper copies are available upon request. A plan or issuer must still make a paper copy of the glossary available within seven business days.

Penalties for non-compliance

A penalty of up to $1,000 per failure can be assessed on insurers and plans that willfully fail to provide the SBC as required under the final regulations. Failure to comply could also trigger an Internal Revenue Code Chapter 100 excise tax of $100 per day per effected individual to whom the failure relates.

The final SBC regulations, in addition to the revised SBC template, an SBC compliance guide, and a copy of the uniform glossary of terms are available at http://www.dol.gov/ebsa/. Please contact your Wells Fargo Insurance Services representative if you have questions regarding this issue.

Disclosure to CMS regarding Medicare Part D coverage

Employers with group health plans (whether insured or self-insured) that provide prescription drug benefits must annually disclose to the Centers for Medicare & Medicaid Services (CMS) whether these benefits are creditable or non-creditable for purposes of Medicare Part D. A creditable prescription drug plan is one with coverage that is expected to pay on average as much as the standard Medicare prescription drug plan (Medicare Part D). This determination is typically made by an actuary employed by the insurance company, administrator, or plan, or by satisfying the safe harbor approach. The disclosure to CMS is in addition to the annual notices that must be provided to Medicare eligible participants (active employees and their dependents, COBRA qualified beneficiaries, and retirees and their dependents) stating whether their prescription drug coverage is creditable coverage or non-creditable. All employers with group health plans are subject to the disclosure obligation, including churches and federal, state, and local governments.

A disclosure to CMS regarding the status of Medicare Part D coverage is required:

- **Sixty days after the beginning of the plan year.** The "plan year" can be the Employee Retirement Income Security Act (ERISA) plan year set forth on Form 5500 (if applicable), or the insurance policy year, or the insurance policy renewal year. Whichever definition is used must be followed consistently. For example, if the plan year for ERISA purposes is the calendar year, and the employer decides to adopt the ERISA plan year as the "plan year" for disclosure purposes, then the deadline for making the disclosure to CMS is March 2 (that is, 60 days after the first day of the plan year).
- **Thirty days after any change in the creditable-coverage status of the prescription drug plan.** If the group health plan provides non-creditable prescription drug benefits, and the plan is changed so that prescription drug benefits are now creditable, or vice versa, disclosure of the change must be made within 30 days of the change.
- **Thirty days after termination of prescription drug benefits under the plan.** If the group health plan is terminated, or if the plan is changed so that it no longer provides prescription drug benefits, the termination or change must be disclosed to CMS within 30 days.

Disclosure is made via the Internet at https://www.cms.gov/CreditableCoverage/45_CCDisclosureForm.asp.

Step by step instructions, including screen shots, are available at https://www.cms.gov/CreditableCoverage/Downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf.

HHS issues final rule on preventive services

In August 2011, the Department of Health and Human Services (HHS) released an interim final rule providing guidance on no-cost preventive services for women to include contraception. In this interim final rule, HHS included an exemption for non-profit religious employers, who satisfied certain criteria, to exclude contraceptive services. For more information on the interim final rule and the religious employer exemption requirements, you can view our August 2011 Legislative Update.

The rule is set to take effect on all non-grandfathered plans on the first plan year beginning on or after August 1, 2012 (that is, January 1, 2013, for calendar year plans).

On January 20, 2012, HHS released the final rule on preventive health services, and kept the exemption for those employers who meet the definition of a non-profit religious employer. The final rule did include an additional one-year exemption for non-profit employers who, based on religious beliefs, do not currently provide contraceptive coverage in their group health plan. These groups will have to include no-cost contraceptive coverage in their group health plan on the first plan year beginning on or after August 1, 2013 (January 1, 2014, for calendar year plans). Employers who will take advantage of the one-year exemption must certify that they qualify to delay the implementation.

In addition, employers who do not offer contraceptive coverage will be required to provide a notice to their employees. The notice will be designed to inform the employee that such contraceptive coverage, including income-based support of the coverage, is available to the employee at various locations, such as community health centers, public clinics, and hospitals.

The Conference of Catholic Bishops announced that it will legally challenge the requirement to include contraceptive coverage as a preventive service as it is considered to be a violation of Catholic religious beliefs. In addition, it will challenge the definition of a "non-profit religious employer" as defined by HHS, on the basis that the definition is too narrow and excludes a wide range of religious universities, hospitals, and schools that do not currently offer contraceptive coverage.

On Friday, February 10, 2012, the White House revised its position on requiring non-profit religious employers to provide contraceptive coverage. Under the new proposal, non-profit religious employers will not have to provide contraceptive coverage or provide the notices to their employees regarding local organizations that provide contraception. In addition, they will not be required to subsidize the cost of contraception. However, this new accommodation will require the contraceptive coverage be offered to women by their employers' insurance companies directly at no cost.

We will continue to monitor developments in this area. Please contact your Wells Fargo Insurance Services representative for additional information on this and other health care reform provisions.

DOL proposes regulations on FMLA military leave and other provisions

On January 30, 2012, the Department of Labor (DOL) released proposed regulations implementing and interpreting provisions under the Family and Medical Leave Act (FMLA) that expand leave entitlement for military families. In addition, the proposed regulations address calculating increments of FMLA leave, anticipated revisions to the model FMLA forms, compliance with the Genetic Information Nondiscrimination Act (GINA), and airline flight crew FMLA eligibility.

FMLA military leave provisions background

The FMLA entitles eligible employees to take unpaid, job-protected leave for specified family and medical reasons. Eligible employees may take up to 12 weeks of FMLA leave in a 12-month period for the birth, adoption, or placement of a child, to care for a family member with a serious health condition, or because they are unable to work due to their own serious health condition. The National Defense Authorization Act for Fiscal Year 2008 (FY 2008 NDAA) expanded the FMLA to allow the following two types of military family leave:

- **Qualifying exigency leave.** Up to 12 weeks of leave in a 12-month period for any qualifying exigency arising out of the fact that a family member is on covered active duty (or has been notified of an impending call or order to covered active duty) in the United States Armed Forces.
- **Military caregiver leave.** Up to 26 weeks in a single 12-month period to care for a covered service member with a serious injury or illness.

In November 2008, the DOL issued Final Regulations on these military leave provisions. These regulations were effective January 16, 2009.

The National Defense Authorization Act for Fiscal Year 2010 (FY 2010 NDAA) further amended the FMLA to extend the military caregiver leave entitlement to veterans' family members and extended qualifying exigency leave to eligible family members of the Regular Armed Forces.

New proposed regulations on the military leave provisions

The proposed regulations implement and interpret the FY 2010 NDAA amendments. Prior to those amendments, qualifying exigency leave provided leave for family members of the National Guard and Reserves, but not for regular members of the Armed Forces. The latter group was specifically excluded in the statute under the rationale that the lives of regular service members were not disrupted to the same extent as those called to active duty as reservists or National Guard members. The new rule extends qualifying exigency leave to include family members of the Regular Armed Forces. In addition, under FY 2010 NDAA, in order for family members to be eligible for qualifying exigency leave, the covered service member must be deployed to a foreign country. The rest and recuperation component of the qualifying exigency leave, which allows employees to spend time with a covered service member on short-term rest and recuperation leave during deployment, is extended from five to 15 days under the proposed regulations.

Prior to the FY 2010 NDAA, military caregiver leave permitted employees to take up to 26 weeks to care for current service members. The proposed regulations expand the military caregiver leave provision to include care for eligible veterans discharged within five years before the treatment for which leave is requested. Under this rule, eligible employees may be begin taking military caregiver leave up to five years after their family member is discharged from the military and may continue to take such leave throughout the single 12-month period, even if that leave extends beyond the five-year date.

In addition, the proposed regulations revise the definition of serious injury or illness to include conditions that existed before the covered service member or veteran's active duty that were aggravated by service in the line of active duty. With respect to the certification process for military caregiver leave, the proposed regulations provide that health care providers not affiliated with the military are now eligible to provide a medical certification for this type of leave.

Calculating increments of FMLA leave

Prior to the 2009 Final Regulations, employers were required to track intermittent or reduced schedule leave in the smallest increment used by their payroll systems. For example, an employer that tracked employee time in eight-minute increments was required to track FMLA leave time in that same manner. The 2009 Final Regulations provided that employers could use any increment to track FMLA leave so long as it was consistent with the way they tracked other absences and was not greater than one hour, regardless of the way the employer tracked time through its payroll system. The new proposed regulations emphasize repeatedly that an employer may not require an employee to take more leave than is necessary to address the circumstances, and propose that employers must track FMLA leave in the shortest increment of leave available at any time. An example included in the proposed regulations provides that if an employer tracks sick time in half-hour increments and annual leave time in one-hour increments, the employer must track FMLA leave in the smaller, half-hour increments.

Model FMLA forms

In conjunction with the 2009 Final Regulations, the DOL issued model FMLA forms that employers can use to administer FMLA. Those forms are available at http://www.dol.gov/whd/fmla/index.htm. The proposed regulations indicate that the DOL intends to update those forms to accurately reflect the changes included in the proposed regulations, but the forms will remain available online in the interim. Until such time as the DOL issues new model FMLA forms, we recommend employers continue to use the existing model forms. Employers should also continue to adhere to all applicable notice and certification process timelines set forth in the 2009 regulations.

GINA compliance

The Genetic Information and Nondiscrimination Act of 2008 (GINA) generally prohibits employers from discriminating against any employee with respect to the compensation, terms, conditions, or privileges of employment on the basis of genetic information. The employment nondiscrimination requirements prohibit the use of genetic information in employment decision making, restrict employers from requesting, requiring, or purchasing genetic information, require that genetic information be maintained as a confidential medical record, and place strict limits on the disclosure of genetic information. For purposes of GINA, genetic information includes family medical history. See our October 2009 Legislative Update for a full discussion of the requirements under GINA.

The proposed regulations add a recordkeeping standard under the FMLA that requires employers to comply with the confidentiality requirements of GINA. To the extent that records and documents created for FMLA purposes (that is, medical certifications and physician's notes) contain genetic information, including family medical history, employers must maintain those records in accordance with GINA's confidentiality requirements.

Airline flight crew eligibility

On December 21, 2009, the Airline Flight Crew Technical Corrections Act (the Act) amended the FMLA, establishing a special service eligibility requirement for airline flight crew members. The Act ensured that more airline employees would be eligible for FMLA by addressing the hours worked requirements for airline pilots and flight attendants whose schedules are unique and often fell short of the 1,250 hours in the previous 12-month period required to qualify for FMLA leave. Under the proposed regulation, airline flight crew members will be eligible for FMLA leave if they have worked or been paid at least 60 percent of the applicable total monthly guarantee (the 1,250 hours in a 12-month period equates to 60 percent of a typical 40-hour workweek) and have worked or been paid for not less than 504 hours during the previous 12 months. This calculation does not include personal commute time, or time spent on vacation, medical, or sick leave.

Effective date

The proposed regulatory changes noted here will not take effect until the DOL issues a final rule. However, most of the FY 2010 NDAA amendments to the FMLA took effect on October 28, 2009, the date the law was signed. Under these statutory provisions, eligible employees are already entitled to take FMLA leave for qualifying exigencies related to their spouse, parent, or child's deployment to a foreign country with the Regular Armed Forces. The foreign deployment requirement is also in effect for eligible employees taking qualifying exigency leave due to the call-up of their family member in the National Guard or Reserves. Additionally, eligible employees are entitled to take military caregiver leave to care for a current service member whose serious injury or illness is caused by the aggravation in the line of duty of a preexisting condition. The only statutory provision not yet in effect is the extension of military caregiver leave to family members of veterans with serious injuries or illnesses. In the meantime, eligible employees can take up to 12 weeks of FMLA leave to care for a family member who is veteran with a serious health condition.

Ninth U.S. Circuit Court in San Francisco declares California's same-sex marriage ban to be unconstitutional

On February 7, 2012, a three-judge panel of the 9th U.S. Circuit Court of Appeals in San Francisco ruled two to one in favor of a lower district court's decision that the ban on same-sex marriage, also known as Proposition 8, was a violation of the civil rights of gays and lesbians.

In November 2008, California voters approved Proposition 8, which amended the California Constitution to provide that "only marriage between a man and a woman is recognized and valid in California." Prior to the adoption of Proposition 8, California issued same-sex marriage licenses from June 16, 2008, through November 5, 2008, and ceased to issue licenses after the passage of Proposition 8.

This most recent ruling from the 9th U.S. Circuit is an additional step in the legal process that will lead to consideration by the U.S. Supreme Court. Proposition 8 supporters have said they would appeal the decision before the U.S. Supreme Court.

We will continue to monitor developments and provide comments in future Legislative Updates.