Employee Benefits Update June 2016

POSTED:
Jun 10, 2016

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Select Compliance Deadlines and Reminders

1. **Forms 1095 B and 1095 C.** If filing electronically, self-funded health plan sponsors and Applicable Large Employers ("ALEs") must file Forms 1095 B and 1095 C with the Internal Revenue Service ("IRS") by June 30, 2016. Electronic filing is required for entities filing at least 250 information returns.

2. **Forms 1094 B and 1094 C.** If filing electronically, plan sponsors and ALEs must file the first Forms 1094-B and 1094-C with the IRS no later than June 30, 2016. These forms serve as transmittal forms for the Forms 1095-B and 1095-C.

3. **Summary of Description of Material Modifications for Calendar-Year Plans.** Plan administrators of employee pension and welfare benefit plans must provide to each participant covered under the plan and each beneficiary receiving benefits under the plan a summary description of any material modifications ("SMM") to the plan and changes to the summary plan description. Administrators must provide this summary no later than 210 days after the close of the plan year in which the modification or change was adopted, unless otherwise described in a timely summary plan description. For calendar year plans that made design changes in 2015, the deadline for providing an SMM is July 28, 2016. Please note that this SMM rule is separate from the rules imposed by the Affordable Care Act (the "ACA") for updating a group health plan's summery of benefits and coverage ("SBC").If a group health plan is modified during the year in a way that is not reflected in the most recently provided SBC, an updated SBC must be provided 60 days **in advance of** the effective date of the change. No advance notice is required for changes to the SBC that are effective in conjunction with benefit renewal. Plan sponsors that timely comply with the SBC 60-day advance notice requirement do not have to also send an SMM summarizing the changes disclosed in the 60-day advance notice.

1. **FBAR Filing for Certain Foreign Investments.** S. persons who have a financial interest in, or signature or other authority over, foreign financial accounts are generally required to report on the Treasury Department

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Form TD F 90 22.1 (the "FBAR") by June 30 of each year. While foreign hedge funds and private equity funds are not required to be reported on the FBAR, other accounts in foreign jurisdictions might be. Plan sponsors should consult with tax and legal counsel to determine if any FBAR filing is required.

Retirement Plan Developments

PBGC Nearly Doubles Penalties for Failure to Provide Certain Notices.

On May 13, 2016, the Pension Benefit Guaranty Corporation ("PBGC") issued an interim final rule that significantly increases the maximum daily penalty for failure to provide the notices required by ERISA section 4071 (Penalties for Failure to Provide Certain Notices or Other Material Information) and ERISA section 4302 (Penalties for Failure to Provide Certain Multiemployer Plan Notices).

According to the interim final rule:

- The maximum penalty amount under ERISA section 4071 increases from $1,100 per day to $2,063 per day.
- The maximum penalty amount under ERISA section 4302 increases from $110 per day to $275 per day.

These increases apply on and after August 1, 2016.

IRS Issues Final Regulations on Distributions from Designated Roth Accounts to Multiple Destinations.

The IRS issued final regulations eliminating the requirement that each distribution from a designated Roth account that is directly rolled over to an eligible retirement plan be treated as a separate distribution from any amount paid directly to the employee. Under the final regulations, if distributions are made from a taxpayer's designated Roth account to the taxpayer and also to the taxpayer's Roth IRA or designated Roth account in a direct rollover, then pretax amounts will be allocated first to the direct rollover rather than being allocated pro rata to each destination. Also, a taxpayer will be able to direct the allocation of pretax and after-tax amounts that are included in distributions from a designated Roth account that are directly rolled over to multiple destinations, applying the same allocation rules to distributions from designated Roth accounts

that apply to distributions from other types of accounts.

These regulations apply to distributions from designated Roth accounts made on or after January 1, 2016.

Health and Welfare Plan Developments

HHS Issues Final ACA Nondiscrimination Rule.

On May 13, 2016, the Department of Health and Human Services ("HHS") issued a final rule ("Final Rule") that implements ACA section 1557. ACA section 1557 provides that an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity provided or administered by a covered entity on the basis of race, color, national origin, sex, age or disability.

According to the Final Rule, a "covered entity" is:

1. an entity that operates a health program or activity, any part of which receives federal financial assistance (*g.*, Medicare Parts A, C or D; student health plans);
2. an entity established under Title I of the ACA that administers a health program or activity; and
3. HHS and health programs it administers (the ACA marketplaces).

Some of the key provisions in the Final Rule include:

- The protection from discrimination based on sex applies not only to an individual's sex, but also to pregnancy, sex stereotyping, and gender identity. The Final Rule requires individuals be treated consistent with their gender identity. Additionally, the Final Rule prohibits categorical exclusions of all services related to gender transition as per se discriminatory.
- Covered entities are required to ensure that communications with individuals with disabilities are as effective as communications with individuals without disabilities. For example, such entities must provide any programs and activities delivered through electronic or information technology to these individuals. Such entities must also provide auxiliary aids and services, free of charge, in a timely manner, to individuals with disabilities.

- To provide meaningful access to individuals with limited English proficiency, covered entities must provide notices and "taglines" to those individuals explaining how they may obtain language services.

The Final Rule is effective as of July 18, 2016, except to the extent that provisions of the Final Rule require changes to health insurance or group health plan benefit design, such provisions will be effective on the first day of the first plan year beginning on or after January 1, 2017.

EEOC Issues Final Rules on Wellness Programs.

On May 17, 2016, the Equal Employment Opportunity Commission ("EEOC") issued final rules explaining how the Americans with Disabilities Act ("ADA") and the Genetic Information Nondiscrimination Act ("GINA") apply to employer-sponsored wellness programs.

Wellness Program

Under the final regulations, "wellness program" generally refers to health promotion and disease prevention programs and activities offered to employees, regardless of whether the program is part of an employer-sponsored group health plan.

ADA Final Rule

When Is a Wellness Program "Voluntary"?

The ADA allows employers to make medical inquiries and conduct examinations of employees if the inquiry or examination is (i) "job-related and consistent with business necessity" or (ii) "voluntary" as part of an employee health program. The ADA final rule clarifies what it means for a wellness program to be "voluntary." According to the final rule, the definition of "voluntary" includes the following factors:

- The employer does not require employees to participate.
- The employer does not deny coverage under any group health plan to employees for nonparticipation.
- The employer does not take any adverse action, retaliate against or coerce employees who choose not to participate.

- The employer provides a notice to employees clearly explaining what medical information will be obtained, how it will be used, who will receive it, and what methods will be applied to prevent improper disclosure of the medical information.

Limitation on Incentives.

Under the ADA final rule, an employer may offer incentives up to 30 percent of the total cost of self-only coverage (including both the employee's and employer's contribution), whether in the form of a reward or penalty, to promote an employee's participation in a voluntary wellness program that includes disability-related inquiries and/or medical examinations. The 30-percent limit applies to all workplace wellness programs, whether they are offered only to employees enrolled in an employer-sponsored group health plan, offered to all employees regardless of their enrollment in such a plan, or offered as a benefit of employment where an employer does not sponsor a group health plan or group health insurance coverage.

The ADA final rule confirms that a smoking cessation program that merely asks employees whether they use tobacco (or whether they ceased using tobacco upon completion of the program) is not an employee health program that includes disability-related inquiries and/or medical examinations; thus, the 30-percent incentive limit does not apply. Instead, a covered entity can offer a 50-percent incentive permitted by the Health Insurance Portability and Accountability Act ("HIPAA") regulations, as amended by the ACA.

Wellness programs that do not require disability-related inquiries and/or medical examinations, including attending nutrition and weight loss classes, are not subject to the 30-percent incentive limitation.

GINA Final Rule

GINA prohibits an employer from discriminating on the basis of genetic information, including acquiring genetic information about an employee. Under GINA, genetic information includes information about an individual's genetic tests and the genetic tests of an individual's family members, as well as information about the manifestation of a disease or disorder in an individual's family members (*i.e.*, family medical history).

The GINA final rule addresses the extent to which employers may offer incentives for spouses to provide health-related information as part of a wellness program.

Under the GINA final rule, an employer may offer a limited incentive (in the form of a reward or penalty) to an employee whose spouse (i) is covered under the employee's health plan; (ii) receives health or genetic services offered by the employer, including as part of a wellness program; and (iii) provides information about his or her current or past health status. An employer may not deny access to health insurance or any package of health insurance benefits to an employee and/or his or her family members, or retaliate against him or her based on a spouse's refusal to provide information about his or her manifestation of disease or disorder to an employer-sponsored wellness program.

The maximum incentive for a spouse to provide information about his or her medical history will be 30 percent of the total cost of employee self-only coverage. The GINA final rule applies to all employer-sponsored wellness programs that request genetic information whether they are offered only to spouses of employees enrolled in an employer-sponsored group health plan, offered to spouses of all employees regardless of whether the employee or spouse is enrolled in such a plan, or offered as a benefit of employment to spouses of employees of employers who do not sponsor a group health plan or group health insurance.

An employer-sponsored wellness program does not request genetic information when it asks the spouse of an employee whether he or she uses tobacco or ceased using tobacco upon completion of a wellness program, or when it requires a spouse to take a blood test to determine nicotine levels.

Effective Date

- ADA: The rules concerning notice and incentive limits become effective as of the first day of the first plan year beginning on or after January 1, 2017. All other portions of the rule take effect on July 18, 2016.
- GINA: The rules concerning incentives become effective as of the first day of the first plan year beginning on or after January 1, 2017. All other portions of the rule take effect on July, 18, 2016.

IRS Issues 2017 Limits for Health Savings Accounts ("HSAs").

The IRS issued Rev. Proc. 2016-28, which provides inflation adjusted amounts for HSAs. There is only one change from the 2016 amounts: the annual limitation on deductions for an individual with self-only coverage under a high deductible health plan is increased by $50.

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Accordingly, for 2017, the annual limitation on deductions for HSAs will be:

- Self-only coverage: $3,400
- Family coverage: $6,750

As a reminder, a "high deductible health plan" is a health plan with an annual deductible not less than $1,300 for self-only coverage ($2,600 for family coverage) and annual out-of-pocket expenses not exceeding $6,550 for self-only coverage ($13,100 for family coverage).

District Court Holds That ACA Reimbursements Are Improper.

On May 12, 2016, the federal district court for the District of Columbia ruled in *U.S. House of* Representatives *v. Burwell et al.* that the Obama administration had improperly reimbursed insurers to cover discounts to low-income consumers. The case involves two sections of the ACA: sections 1401 and 1402. Section 1401 provides tax credits intended to make insurance premiums more affordable, while section 1402 reduces deductibles, co-pays, and other means of cost-sharing by insurers. Section 1401 was funded by adding it to a preexisting list of permanently appropriated tax credits and refunds, but section 1402 was not added to that list. The court found that the ACA "unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers."

Since the court stayed the order pending a likely appeal, the decision will not result in an immediate suspension of cost-sharing reduction payments to insurers.

U.S. Supreme Court Remands ACA Contraceptive Mandate Cases.

The U.S. Supreme Court declined to rule on the merits in *Zubik v. Burwell*. In this case, nonprofit religious organizations contended that the opt-out process in the contraception mandate under the ACA substantially burdens the exercise of their religion in violation of the Religious Freedom Restoration Act of 1993 ("RFRA"). The ACA's contraception mandate generally requires providers of health insurance to cover contraceptives for women. Certain religious entities, such as churches, however, can opt out of the requirement if (i) they submit EBSA Form 700 and provide a copy of the certification to the plan's health insurance issuer or a third-party administrator for self-insured health plans, or (ii) submit a similar notice directly to the Secretary of Health and Human Services. *Zubik* is a

consolidation of seven cases in which seven circuit courts of appeals held that the ACA accommodation for nonprofit religious organizations from the contraceptive mandate did not violate the RFRA. The Supreme Court vacated and remanded these decisions back to lower courts.