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# Pension and Health Plans: 2015 Year-End Review

February 2016

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Over the past year, the U.S. Departments of Labor (the "DOL"), Treasury, and Health and Human Services ("HHS") (collectively, the "Departments"), as well as the Internal Revenue Service (the "IRS"), have issued a variety of rules and regulations applicable to both pension and welfare plans. Employers and other plan sponsors of ERISA-covered benefit plans (collectively, "plan sponsors") should be reviewing their plan documents, policies and procedures, and participant communications to make sure they are complying with the current rules and regulations. In this *2015 Year-End Review*, we provide an overview of these rules and regulations.

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The following are some action item highlights for plan sponsors of health plans. For more information on these, and other, updates for the 2016 plan year, please see page 2 of this *Review*.

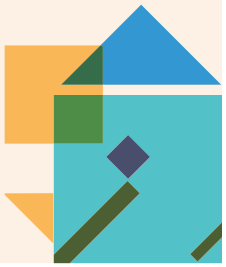
## Health Plan Action Items for Plan Sponsors

- ✔ **CONTINUE** to count employees and track hours to determine large employer status and potential liability for a 4980H penalty
- ✔ **TRACK** offers of health coverage to employees to aid compliance with required ACA reporting
- ✔ **REVIEW** cafeteria plan documents and timely adopt any discretionary plan amendments
- ✔ **PREPARE** and distribute updated SBCs
- ✔ **REVIEW** summary plan descriptions and plan documents to reflect health care reform changes being made under ACA
- ✔ **REMIT** transitional reinsurance fee and PCORI fee payments, as applicable
- ✔ **CONTINUE** to monitor whether, and when, the Cadillac Tax will apply (currently delayed to 2020)

The following are some action item highlights for plan sponsors of pension plans. For more information on these, and other, updates for the 2016 plan year, please see page 6 of this *Review*.

## Pension Plan Action Items for Plan Sponsors

- ✔ **REVIEW** plan documents to ensure compliance with *Windsor* and *Obergefell* decisions
- ✔ **PREPARE** to file determination letter applications for Cycle A (between Feb. 1, 2016 and Jan. 31, 2017)
- ✔ **ADOPT** any discretionary plan amendments in a timely manner
- ✔ **PREPARE** and distribute necessary participant communications, including automatic enrollment notices, Safe Harbor 401(k) notices, QACA notices and QDIA notices
- ✔ **UPDATE** SPD, if necessary (e.g., if changes have been made within the last five years that would be reflected in the SPD)
- ✔ **REVIEW** and distribute, as applicable, all necessary fee disclosures, including 408(b)(2) responses and 404(a)(5) participant disclosures
- ✔ **MONITOR** internal plan controls to ensure compliance with plan requirements



Employers that show a good faith effort to timely comply with the ACA's reporting requirements will not be assessed any penalties for failure to submit complete and accurate returns in 2016 that relate to offers of coverage during 2015

# Health Plans

## The 'Cadillac Tax'

In late December 2015 President Barack Obama signed a year-end spending package that included a two-year delay of the "Cadillac Tax" to 2020. The tax was originally set to take effect Jan. 1, 2018.

For more information on the Cadillac Tax, please see our recent *Alert* "Cadillac Tax Officially Delayed to 2020."

## Delayed ACA Reporting

On Dec. 28, 2015, the IRS issued Notice 2016-4, which extends the due dates for the 2015 information reporting requirements on Forms 1094-B, 1094-C, 1095-B and 1095-C. Specifically, insurers, self-insured large employers and other providers of minimum essential coverage now have until March 31, 2016 to provide individuals with the appropriate Form 1094 (the original deadline was Feb. 1, 2016), and they have until June 30, 2016 to file the applicable Form 1095 with the IRS if filing electronically (the original deadline was March 31, 2016). If not filed electronically, the Form 1095 is due by May 31, 2016 (the original deadline was Feb. 29, 2016).

We discussed 1095 reporting in our January 2015 publication "New Health Care Compliance Considerations for Employers in 2015."

The IRS has also clarified that employers that show a good faith effort to timely comply with the Affordable Care Act's ("ACA's") reporting requirements will not be assessed any penalties for failure to submit complete and accurate returns in 2016 that relate to offers of coverage during 2015.

## Legal Challenges to the ACA

***Zubik v. Burwell***. In early November 2015, the U.S. Supreme Court granted review of seven petitions it received, all of which challenged the Obama administration's accommodation for religious employers with respect to the ACA's "contraceptive mandate" and consolidated the requests in *Zubik v. Burwell*.

Under the ACA, contraceptive drugs, devices and services are considered "preventive services" that certain plans must offer. After numerous nonprofit organizations objected to the mandate on religious grounds, the Obama administration granted an "accommodation" to these religious nonprofit organizations by permitting them to opt out of providing contraceptive drugs, devices and services free of charge if they completed and filed a government-prescribed form that details their objections to the mandate and confirms that their objections are religious in nature and that they are nonprofit organizations.

In a 2013 challenge to the contraceptive mandate, the Supreme Court modified the accommodation in *Little Sisters of the Poor v. Sebelius* and ruled that such organizations only have to file a written notice with HHS stating that their religious beliefs precluded them from providing contraceptive drugs, devices and services. The effect of the written notice permits the insurer, HHS or the plan administrator to contract directly with the affected employees for contraceptive coverage.

Religiously affiliated nonprofit organizations have continued to argue that the written notice requirement substantially burdens their right to exercise their religion. They argue that submitting a written notice to HHS forces them to participate in an action that is against their religious beliefs because they are helping their employees obtain access to contraceptive drugs, devices and services, even if they are not providing the contraceptive coverage directly. Nonprofits that fail to submit a written notice are required to comply with the contraceptive mandate or face steep fines.

The Supreme Court is expected to hear the consolidated case in March 2016 and rule on whether the modified accommodation substantially burdens religiously affiliated nonprofit organizations' right to free exercise of religion, and whether the accommodation is the least restrictive means of carrying out the ACA's intent with the contraceptive mandate.

***United States House of Representatives v. Burwell***. The House of Representatives has filed a lawsuit against various departments, and named officials, within the executive branch on the grounds that certain subsidies granted to health insurance companies for lowering out-of-pocket health care costs for low-income individuals were never properly appropriated by Congress.

If the case were to proceed on its merits, and the subsidies were found to be misappropriated, affected individuals could see an increase in their health insurance costs, which may render health insurance unaffordable. This, in turn, could cause such individuals to be exempt from the ACA's individual mandate.

***King v. Burwell***. The Supreme Court announced its second decision to uphold the ACA, ruling that the premium tax credits created by the ACA are available to all qualifying individuals who purchase coverage on an Exchange, regardless of whether the Exchange was created by a state or the federal government.

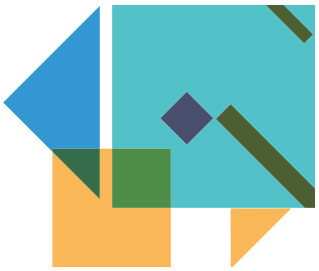
We analyzed the *King v. Burwell* decision in our *Alert* "U.S. Supreme Court Holds Premium Tax Credits Available on All Exchanges – Key Group Health Plan Action Items."

## Repeal of Automatic Enrollment

In late October 2015, the Senate, the House of Representatives and the White House all agreed to repeal a provision of the ACA that would have required employers subject to the Fair Labor Standards Act with 200 or more full-time employees to automatically enroll new full-time employees in one of the plans offered. The ACA's automatic enrollment provision was initially expected to take effect in 2014, but had been "suspended indefinitely" given the lack of regulations.

## Expanded Preventive Care Services

The ACA requires non-grandfathered group health plans, and health insurance coverage offered in the individual or group market, to provide preventive health care and screenings without cost-sharing. The list of preventive care services changes depending on different factors, including the current recommendations of the U.S. Preventive Services Task Force. Recently, the DOL issued a set of frequently asked questions (FAQs) clarifying certain additions to the list of required preventive services. These additions to the list of required preventative services include: lactation counselors, coverage of breastfeeding equipment for the duration of breastfeeding, screening for obesity in adults, services issued



A provision of the ACA has been repealed that would have required employers subject to the Fair Labor Standards Act with 200 or more full-time employees to automatically enroll new full-time employees in one of the plans offered

Large plans must provide 'substantial coverage of both inpatient hospital services and physician services'

in conjunction with colonoscopies (e.g., specialist consultations prior to the colonoscopy and pathology exams on polyp biopsies after the colonoscopy, if applicable) and BRCA testing for women found to be at an increased risk for breast cancer.

## Substantial Hospital Inpatient Services and Minimum Value

Under the ACA, large employers must offer their full-time employees and their dependents affordable coverage that provides minimum value, subject to certain limitations, or else potentially face a "large employer penalty" under Section 4980H of the Internal Revenue Code. To provide minimum value, the plan must pay at least 60 percent of the total cost of benefits under the plan. The Centers for Medicare and Medicaid Services published a "minimum value calculator" that plan sponsors can use to determine whether their plans provide minimum value. The calculator takes certain plan design aspects into consideration, including coinsurance and copayment levels for various benefits, but does not take into account any quantitative limits on benefits offered.

Because the minimum value calculator determines whether a plan covers 60 percent of the total allowed costs of benefits provided under the plan but does not determine whether a plan is offering the benefits it is required to offer under the ACA (e.g., if applicable, the essential health benefits package), HHS realized that group health plans could be designed in such a way as to provide no coverage for inpatient hospital services and yet still technically meet the ACA's definition of "minimum value." To remedy this inconsistency, HHS issued a final rule clarifying that even though certain plans have flexibility in designing their benefits packages, they must offer a minimum level of benefits in order to meet the minimum value standard. This minimum level of benefits includes "substantial coverage for inpatient hospital and physician services." The IRS and Treasury Department issued similar proposed regulations.

Based on this rule, large plans must provide a benefit package that meets a minimum standard of benefits in addition to the requirement that they cover at least 60 percent of the total cost of benefits provided under the plan, in order to meet the minimum value standard. More specifically, these plans must provide "substantial coverage of both inpatient hospital services and physician services." HHS declined to issue a clear standard as to what coverage constitutes "substantial coverage" for purposes of the final rule (including a "good faith compliance" standard), stating instead that it "intend[s] to provide further clarity on the requirement to provide 'substantial coverage' as circumstances warrant."

Recently, employer groups have questioned the ability of the government to require certain plans to cover inpatient hospital and physician services in order to satisfy the ACA's definition of minimum value. For example, the U.S. Chamber of Commerce criticized the rule in a comment letter to the proposed regulations, saying that the ACA does give authority to any department to require that plans offer inpatient hospital and physician services. Conversely, the AFL-CIO supports the rule, saying that it is consistent with the ACA's statutory language and employer mandate provisions. Many employer groups have requested clarification as to what "substantial" means.

## Pace Act

Under a bill recently signed by President Obama, employers with 51 to 100 employees will continue to be eligible to purchase large group health plans for their employees. The Protecting Affordable Coverage for Employees Act ("PACE Act") amends a provision of the ACA that would have required employers with 51 to 100 employees to be classified as small employers effective January 2016. Under the ACA, small employers are required to offer the essential health benefits package, among other requirements and restrictions. Under the PACE Act, states have the option of treating employers with 51 to 100 employees as small employers. Under New York law, effective Jan. 1, 2016, employers with 1 to 100 employees will be treated as "small employers."

## ACA Fees and Penalties

*Reduced Transitional Reinsurance Fee for 2016.* Certain health plans will be required to submit their next transitional reinsurance fee payment for the 2015 plan year in January of 2016. The 2015 fee will be $44 per covered life, and the 2016 fee will be reduced to $27 per covered life. The transitional reinsurance program is currently scheduled to end after the 2016 plan year.

*Increased Patient-Centered Outcomes Research Trust Fund (PCORI) Fee for 2016.* The ACA requires issuers of health insurance policies and sponsors of applicable self-insured health plans, including plans that provide retiree coverage and retiree-only plans, to pay PCORI fees since the first plan year beginning after Sept. 30, 2012. The amount of the PCORI fee equals the average number of lives covered during the plan or policy year, multiplied by the applicable dollar amount for the year. For policy and plan years ending after Sept. 30, 2014 and before Oct. 1, 2015, the applicable dollar amount was $2.08. For policy and plan years ending after Sept. 30, 2015 and before Oct. 1, 2016, the applicable dollar amount was increased to $2.17.

*Updated Employer Penalty Amounts for 2016.* The ACA requires that the employer penalty amounts be indexed for inflation. The original penalty amounts were 1/12 of $2,000 per full-time employee employed during each month by an employer that failed to offer coverage, or 1/12 of $3,000 per full-time employee that received a premium tax credit for employers that failed to offer coverage that was affordable or provided minimum value.

In recently issued guidance, the IRS confirmed that for the 2015 calendar year the $2,000 amount is indexed to $2,080 and the $3,000 amount is indexed to $3,120. For the 2016 calendar year, the $2,000 amount is indexed to $2,160 and the $3,000 amount is indexed to $3,240.

## Health FSA Contribution Limit Remains the Same for 2016

Effective Jan. 1, 2016, the maximum amount that employees who participate in Health Flexible Spending Accounts ("FSAs") remains at $2,550, the same level as for the 2015 plan year.

## Nondiscrimination for Fully Insured Health Plans

The ACA extends the current requirement that self-insured plans not discriminate in favor of highly compensated individuals to fully insured plans. This requirement, however, has been delayed pending further regulations from the IRS that will detail the specifics of the rule. The rule is expected to become effective beginning the first plan year after such regulations are issued. To date, no such guidance has been issued.

The ACA's current requirement that self-insured plans not discriminate in favor of highly compensated individuals to fully insured plans has been delayed pending further regulations from the IRS

# Pension Plans

## Same-Sex Spouses

The IRS recently issued Notice 2015-86 to provide guidance on how retirement plans can implement the Supreme Court's decision in *Obergefell v. Hodges*. In *Obergefell*, the Supreme Court ruled that state laws that prohibit same-sex couples from getting married are invalid, and that states cannot refuse to recognize a same-sex marriage that was validly performed in another jurisdiction. The decision followed the Court's 2013 ruling in *United States v. Windsor*, which struck down a key part of the Defense of Marriage Act ("DOMA").

For more information about how the *Windsor* case affected employee benefits, please see our *Alert* "Supreme Court's DOMA Decision Sparks Changes in Employee Benefits."

The IRS's recent Notice confirms that qualified retirement plans are not required to make additional changes after *Obergefell*. Retirement plans are not required to adopt any additional amendments because all required amendments were already required to become effective after the retirement-plan-focused guidance the IRS released in 2013 following the *Windsor* decision.

We analyzed the effects of the guidance in our Fall 2013 newsletter "2013 Year-End Action Items for Pension Plan Sponsors."

Notice 2015-86 clarifies that even though no additional amendments are required after *Obergefell*, plan sponsors of qualified requirement plans can still make discretionary amendments to their plans that affect same-sex spouses. For example, plan sponsors can amend their plans to permit a participant with a same-sex spouse who began receiving benefits as a single life annuity prior to June 26, 2013 (the date of the *Windsor* decision) to change the participant's form of benefit to a qualified joint and survivor annuity with a new annuity starting date.

Even though no additional amendments are required after *Obergefell*, plan sponsors of qualified requirement plans can still make discretionary amendments to their plans that affect same-sex spouses

## IRS Determination Letter Program

Early in 2016, the IRS announced that it would be discontinuing the current staggered determination letter program for individually designed plans, effective Jan. 1, 2017. Cycle A plans may file their applications between Feb. 1, 2016 and Jan. 31, 2017. The IRS is limiting its determination letter program for individually designed plans to initial plan qualification and qualification upon plan termination.

For more information about the IRS's action, see the article "IRS Eliminates Determination Letter Expiration Dates for Employee Benefit Plan Sponsors."

### Form 5500 Filing Deadlines Remain the Same

Recently, the President signed into law the Fixing America's Surface Transportation Act. Though the act funds certain domestic infrastructure projects, such as plans for highways and mass transit, it contains a provision repealing an automatic three-and-a-half month extension for filing the Form 5500 that was included in the "Surface Transportation and Veterans Health Care Choice Improvement Act" that was enacted in July. As a result, plan sponsors must continue to file Form 5500 by the end of the seventh month following the end of the plan year, with a permissible two-and-a-half-month extension. For calendar year plans, this means that the due date for filing Form 5500 continues to be July 31 (plus an extension to October 15).

## NYC Commuter Benefits Law

Effective Jan. 1, 2016, non-government employers (including temporary help firms) with 20 or more full-time non-union employees in New York City must offer their full-time employees the ability to buy qualified transportation fringe benefits with pre-tax dollars. Enforced by the Department of Consumer Affairs ("DCA"), the law has a six-month grace period through July 1, 2016 before DCA will seek penalties from employers for noncompliance. Employers who do not comply with the law by July 1, 2016 will have a 90-day window to cure their failures before penalties may be imposed.

The law imposes additional recordkeeping requirements on affected employers. Employers must now give their full-time employees a written offer notifying them of their ability to use pre-tax dollars to purchase qualified transportation fringe benefits. In addition, employers are required to maintain a record of the written offers and employees' responses. DCA has created a form that employers can use for this purpose. The Commuter Benefits Law requires that these records must be kept for two years (in addition to any other record-keeping requirement that may apply under federal and/or state law).

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