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BENEFITS REPORT

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Internal Revenue Service Provides Guidance on the Scope of the New Determination Letter Program for Individually Designed Plans

T. KATURI KAYE

The IRS issued Revenue Procedure 2016-37 on June 29, 2016, which provides much anticipated guidance on the elimination of the determination letter program for individually designed retirement plans effective January 1, 2017. The following is a summary of Revenue Procedure 2016-37 in order to assist plan sponsors with making timely decisions with respect to their individually designed retirement plans and to alert them to the new compliance requirements.

Elimination of Staggered Five-Year Remedial Amendment Cycle

The staggered five-year remedial amendment cycle system for individually designed retirement plans is eliminated, meaning that a plan sponsor will not be permitted to apply for a determination letter once every five years. The last cycle permitted to file under the current system is the Cycle A submission period (for plan sponsors with employer identification numbers ending in

IN THIS ISSUE...

Super Lawyers Recognizes Ten Trucker ✦ Huss Attorneys in 2016

Trucker Huss is pleased to announce that Super Lawyers magazine has released its Northern and Southern California lists, and ten Trucker Huss attorneys were included. Brad Huss was also included in the distinguished list of Top 100 Northern California Attorneys.

Super Lawyers identifies the top five percent of attorneys in each state or region, as chosen by their peers and through independent research to receive this honor. In addition, each year no more than 2.5 percent of the lawyers in the state are selected by the research team at Super Lawyers to receive the honor of Rising Star.

Trucker Huss Super Lawyers — Northern California

- Barbara B. Creed
- R. Bradford Huss
- Clarissa A. Kang
- Robert F. Schwartz
- Benjamin F. Spater
- Charles A. Storke
- Lee A. Trucker

Trucker Huss Super Lawyers — Southern California

- Joseph C. Faucher

Trucker Huss Rising Stars:

- Angel L. Garrett
- Robert R. Gower

1 or 6) beginning February 1, 2016 and ending January 31, 2017. Controlled groups and affiliated service groups that maintain one or more plans may submit determination letter applications for such plans during Cycle A in accordance with prior Cycle A election(s).

Determination Letter Requests on or after January 1, 2017

Limited Access to Determination Letter Program

A plan sponsor of an individually designed retirement plan may submit a determination letter application to the IRS only in the following limited circumstances:

- **Initial Plan Qualification.** An application for initial plan qualification on a Form 5300 will be accepted by the IRS if a favorable determination letter has never been issued for the plan (including any favorable determination letter issued pursuant to Form 5307).
- **Qualification Upon Plan Termination.** A determination letter filed in connection with a plan termination on Form 5310 will be accepted by the IRS if the filing is made no later than the later of (i) one year from the effective date of the termination, or (ii) one year from the date on which the action terminating the plan is taken, but in any case not later than twelve months after the date that substantially all plan assets have been distributed in connection with the plan termination.
- **Other Circumstances.** The IRS will consider whether determination letter applications will be accepted

for individually designed retirement plans under circumstances other than initial qualification or plan termination. The IRS indicates that it will consider several factors when making this consideration including, for example, significant law changes, new approaches to plan design, the inability of certain plans to convert to a pre-approved plan document, and the IRS's case load and resources available to process determination letter applications. The IRS and Treasury intend to solicit comments on a periodic basis on the scope of these additional circumstances and will announce the additional circumstances in an annual Internal Revenue Bulletin. However, at this time, the IRS will only accept requests for determination letters for individually designed retirement plans in the case of Cycle A submissions (through January 31, 2017), initial plan qualification and qualification upon plan termination.

Scope of IRS Review of a Plan on Determination Letter Request

For an individually designed retirement plan for which a determination letter has been requested, the IRS's review will be based on the "Required Amendments List" (described below) issued during the second calendar year preceding the submission of the application. The IRS's review will also consider all previously issued Required Amendments Lists (and Cumulative Lists issued prior to 2016). In addition, a terminating plan will be reviewed for amendments required to be adopted in connection with plan termination (discussed below). Plans submitted for initial qualification in 2017 will be reviewed based on the 2015 Cumulative List. Individually designed retirement plans (except terminating plans) must be restated to incorporate all previously adopted amendments when a determination letter application is submitted.

Reliance on a Favorable Determination Letter

Effective January 4, 2016, favorable determination letters issued by the IRS to sponsors of individually designed retirement plans will no longer contain expiration dates, and expiration dates in determination letters issued prior to January 4, 2016 are no longer operative. A plan sponsor maintaining an individually designed plan for which a favorable determination letter has been issued and that is otherwise entitled to rely on the determination letter may not continue to rely on the determination letter with respect to any plan provision that is subsequently amended or is subsequently affected by a change in the law. However, the plan sponsor may continue to rely on such determination letter for plan provisions that are not amended or affected by a change in the law.

Plan Amendments Guidance

Elimination of Interim Amendments

Plan sponsors of individually designed retirement plans are no longer required to adopt interim plan amendments as described in Revenue Procedure 2007-44 with adoption deadlines on or after January 1, 2017.

Extension of Remedial Amendment Period

A "disqualifying provision" generally is a provision, or the absence of a provision, in a new plan or an amendment to an existing plan that causes a plan to fail to satisfy the requirements of the Code as of the date the plan or amendment is first effective. Additionally, a disqualifying provision includes a plan provision that has been designated by the IRS as a disqualifying provision by reason of a change in those requirements. Effective for any disqualifying provision that is first effective on or after January 1, 2016, the remedial amendment period for an individually designed plan (excluding a governmental plan) is extended as, follows:

- **New Plan.** The remedial amendment period is extended to the later of (i) the fifteenth day of the tenth calendar month after the end of the plan's initial plan year or (ii) the "modified Code Section 401(b) expiration date," defined below.
    - **Plan Not Maintained by a Tax-Exempt Employer:** The modified Code Section 401(b) expiration date generally is the due date for the employer's income tax return or partnership return of income, determined as if the extension applies.
    - **Plan Maintained by a Tax-Exempt Employer:** The modified Code Section 401(b) expiration date generally is the due date for the Form 990 series, determined as if the extension applies or,

if no Form 990 series filing is required, the fifteenth day of the tenth month after the end of the employer's tax year (treating the calendar year as the tax year if the employer has no tax year).

- **Existing Plan.** The remedial amendment period for a disqualifying provision related to an amendment to an existing plan which is not on the Required Amendments List generally ends on the last day of the second calendar year following the calendar year in which the amendment is adopted or effective, whichever is later.
- **Change in Qualification Requirements.** The remedial amendment period for a disqualifying provision related to a change in qualification requirements which is on the Required Amendments List generally ends on the last day of the second calendar year following the year the list is issued.

Remedial Amendment Period Transition Rule

The remedial amendment period for disqualifying provisions identified in Revenue Procedure 2007-44 that was set to expire on December 31, 2016, is extended to December 31, 2017, except for a disqualifying provision that is on the 2016 Required Amendments List. The remedial amendment period for a disqualifying provision on the 2016 Required Amendments Lists ends on the last day of the second calendar year that begins after the issuance of the Required Amendments List.

Disqualifying Provisions

The deadline for a plan sponsor to adopt an amendment to an individually designed retirement plan (excluding a governmental plan) with respect to any disqualifying provision is generally the date on which the remedial amendment period (described above) expires, unless otherwise provided by statute, regulations or other guidance.

Discretionary Amendments

The deadline for a plan sponsor to adopt a discretionary amendment (generally, any amendment not related to a disqualifying provision) to an individually designed retirement plan (excluding a governmental plan) is the end of the plan year in which the amendment is operationally put into effect, unless otherwise provided by statute, regulations or other guidance. An amendment is operationally put into effect when the plan is administered in a manner consistent with the intended plan amendment (rather than existing plan terms). This generally is the current rule applicable to the deadline for discretionary amendments under Code Section 401(b) except in the case of amendments that reduce or eliminate benefits.

Required Amendments at Plan Termination

A plan sponsor's termination of an individually designed retirement plan generally ends the plan's remedial amendment period. As a result, retroactive remedial plan amendments or other required plan amendments for a terminating plan must be adopted in connection with the plan termination even if such amendments are not on the Required Amendments List. This means that a plan sponsor should include all required amendments with its Form 5310 filing.

New Annual IRS Lists

Annual Required Amendments List

The IRS and Treasury intend to publish an annual Required Amendments List beginning with changes in qualification requirements that become effective on or after January 1, 2016. The Required Amendments List will establish the date that the remedial amendment period (described above) expires for changes in qualification requirements contained on the list. In general, an item will appear on a Required Amendments List after guidance with respect to that item (including any model amendments) has been provided in regulations or in other guidance published in the Internal Revenue Bulletin, except as otherwise determined at the discretion of the IRS.

Annual Operational Compliance List

Although the deadline for amending an individually designed plan retroactively to comply with a change in plan qualification requirements is the last day of the remedial amendment period (described above), a plan must be operated in compliance with a change in qualification requirements as of the effective date of the change. To assist plan sponsors in achieving operational compliance, the IRS intends to issue an annual Operational Compliance List to identify changes in qualification requirements that are effective during a calendar year. Plan sponsors remain

responsible for complying with all relevant qualification requirements, even if the requirement is not included on an Operational Compliance List.

Next Steps for Plan Sponsors of Individually Designed Retirement Plans

In light of the changes made by Revenue Procedure 2016-37, plan sponsors who continue to maintain individually designed retirement plan documents should consider taking the following steps:

- Conduct annual reviews of their plan documents for compliance with the current (and any applicable prior) Required Amendments List and determine whether plan amendments are required, and if so, the applicable remedial amendment period.
- Conduct annual compliance reviews to evaluate compliance with the current (and any applicable prior) Operational Compliance List and determine if any failures need to be corrected in accordance with IRS guidelines.
- If applicable, evaluate the need for and timing of a determination letter request for a new or terminating individually designed retirement plan.
- Update their administrative procedures to monitor compliance with plan document and other qualification requirements in the absence of a favorable determination letter and consider the impact on the representations made in mergers and acquisitions, in the annual benefit plan audit, and in correcting errors under the IRS's Employee Plans Compliance Resolutions System ("EPCRS") (the IRS should issue guidance on the impact of these changes on EPCRS in the future).

We will continue to monitor and provide our clients with updates on future guidance from the IRS and the Treasury relating to the determination letter program. If you have questions or need assistance, please contact the author of this article or the Trucker Huss attorney with whom you normally work.

JULY 2016

Form 5500 as a Compliance Tool: Changes Today, Changes Tomorrow

ROBERT R. GOWER

Sponsors of calendar-year qualified plans working to complete the 2015 Form 5500 (Annual Return / Report of Employee Benefit Plan) by the extended filing deadline of October 15, 2016 may have noticed a handful of revisions to the Form 5500 for the 2015 plan year. These "compliance-focused" revisions indicate areas in which the Department of Labor ("DOL") and Internal Revenue Service ("IRS") are ramping up qualified plan compliance monitoring efforts and warrant special attention by plan sponsors.

The first, and most significant change for 2015 appears in an update to the instructions for a longstanding question on Line 4l to Schedule H (Financial Information for Large Plans) — *Has the plan failed to provide any benefit when due under the plan?*

The Form 5500 instructions in place prior to the 2015 reporting year were not clear on the intent or scope of the question, but practitioners generally understood Line 4l to focus on ascertaining whether a plan had sufficient assets available to timely pay benefits when due. The 2015 instructions were revised to provide that the failure

to provide any benefit when due includes the failure to pay required minimum distributions under section 401(a)(9) of the Internal Revenue Code (the "Code"). Generally, this means a plan sponsor must report the failure to pay required minimum distributions to 5% company owners who have attained age 70 1/2, and to all other participants who have reached age 70 1/2 and retired or separated from service, including the total dollar amount of the minimum distributions. Arguably, these expanded instructions also require reporting the failure to timely commence mandatory benefit payments for plans that have mandatory commencement dates prior to age 70 1/2 (*e.g.*, upon attainment of normal retirement age under the plan).

The revised instructions for Line 4l follow an uptick in investigations by the DOL of qualified plans with unpaid benefits. These investigations focus on a significant challenge for plan sponsors — locating missing participants in order to provide them with benefits when due. It is the view of the DOL that plan fiduciaries must maintain and follow procedures for ensuring payment of benefits to participants (including those participants who are "missing"). At a minimum, ERISA requires employers to maintain records with respect to employees sufficient to determine the benefits that are due or may be due to such employees. This means employers must work to maintain up-to-date and accurate records of their active and inactive participants, including current address and contact information. Failure to extend efforts to maintain such accurate records may result in penalties from the DOL of up to $10 per day, per impacted participant. When benefits come due, and a plan sponsor does not have current contact information, DOL guidance supports a plan sponsor exercising the following steps:

- Checking the records of related plans and employers
- Contacting the participant's designated beneficiary
- Using electronic/internet search tools
- Using a commercial locator
- Contacting credit reporting agencies

Responses to the revised Line 4l will require acknowledging any failure to timely distribute benefits when due, and potentially highlight weaknesses in maintaining up-to-date contact information for participants. As a result, Plan sponsors should examine their procedures for maintaining participant records, and consider whether additional efforts should be extended to locate current missing participants. If required minimum distributions (or other benefits) are not paid when due on account of an administrative error, then a plan sponsor will need to respond Yes to Line 4l. However, following guidance from the IRS published on July 29, 2016, it is appropriate to respond No if the delay solely is caused by the plan sponsor's inability to locate the participant or beneficiary after undertaking the steps described above.

Beyond the changes seen in Line 4l, the IRS added a significant series of new compliance questions to Schedule H, Schedule I (Financial Information for Small Plans), Schedule R (Retirement Plan Information), and Form 5500-SF (Short Form 5500 for Small Plans). The questions show the potential for new IRS compliance enforcement initiatives, and an attempt to gather much of the information previously obtained by the IRS through the now mostly closed determination letter application program. These compliance questions include the following:

- Whether the plan trust incurred any unrelated business taxable income ("UBTI") during the year.
- Whether there were any in-service distributions for the year.
- How a section 401(k) plan satisfies nondis–crimination requirements for employee deferrals and employer matching contributions, and whether the plan uses the "current year" or "prior year" testing methodology for the ADP and ACP tests.
- Whether the plan applies the ratio percentage test or average benefit test to satisfy coverage testing.
- Whether the plan is permissively aggregated with any other plans for purposes of satisfying coverage and nondiscrimination testing.

- Whether the plan has been timely amended for all required tax law changes, and the last date the plan received a favorable determination letter or opinion letter from the IRS.

These questions were originally *optional* for 2015. However, earlier this year, the IRS issued a statement providing that plan sponsors should ignore these new questions for 2015 reporting, largely the result of the IRS needing to review the questions with the Office of Management and Budget. Nevertheless, plan sponsors should anticipate these questions becoming mandatory in future reporting. Responses to these questions will require careful review between plan sponsors, administrators, and legal counsel in order to ensure accuracy, and where necessary, enhance plan compliance efforts.

Finally, on July 12, 2016, the DOL issued a Proposed Rule to overhaul the Form 5500 and its governing regulations. The proposal aims to modernize Form 5500 reporting by gathering greater information (including significant new information regarding group health plans), enhancing data mineability by making the 5500 more computer-friendly, improving and streamlining the reporting of service provider fees to align with ERISA section 408(b)(2), and enhancing compliance questions in order to better gather information on plan operations to protect participants' and beneficiaries' benefits, and educate and discipline plan fiduciaries. These changes, which the DOL hopes to implement beginning with the 2019 reporting year, promise to continue the expansion of enforcement efforts and reiterate the need for plan sponsors to carefully monitor and review their plans.

If you have questions or need assistance, please contact the author of this article or the Trucker Huss attorney with whom you normally work.

JULY 2016

A Grab Bag of Recent Health Plan Guidance

TIFFANY N. SANTOS
and
SHANNON OLIVER

IRS Issues Early Affordable Care Act ("ACA") Draft Forms 1094 and 1095-C for 2016 Coverage and New Proposed Rules for Section 6055 Reporting by Providers of Coverage

In early July 2016, the IRS issued early drafts of the forms that applicable large employers must provide to employees in early 2017 and file with the IRS to report coverage offered to their full-time employees in calendar year 2016, draft Forms 1094 and 1095-C. While the drafts are substantially similar to the forms relating to 2015 coverage, the final forms will likely be different as the IRS has invited comments about the drafts and has not yet issued any instructions, draft or final, for the 2016 forms.

Section 6055 Reporting Proposed Rules

On August 1, 2016, the IRS issued new proposed regulations relating to the reporting of "minimum essential coverage" ("MEC") provided to individuals under Section 6055 of the Internal Revenue Code (the "Code") by health insurers, certain employers and other providers of coverage (for example, multiemployer plans that provide self-insured health plan coverage). Such reporting is accomplished via Forms 1094 and 1095-B. The proposed rules invite comments from the public and include guidance on the following items of relevance to plan sponsors:

- **Reporting of catastrophic plans**
  Insurers and the Exchanges were not required to report coverage provided under a catastrophic plan in 2015. The proposed rules provide for voluntary reporting in 2017 of such coverage provided in 2016 and mandate reporting in 2018 for coverage provided in 2017.

- **Solicitation of "taxpayer identification numbers" ("TINs")**
  The proposed regulations state:

  - Reporting entities may rely on the proposed rules and Notice 2015-68 regarding the timing of requests for TINs to avoid penalties for failing to report a TIN for an individual on the Form 1095-B (according to the prior guidance, the initial solicitation must be made at an individual's first enrollment, the second solicitation at a reasonable time thereafter, and the third by December 31 of the year following the initial solicitation).
    The proposed regulations provide:
    - The initial solicitation may be made as part of the application for coverage (including an application to add an individual to existing coverage);
    - The first annual solicitation for missing TINs (*i.e.*, the second solicitation overall) must be made no later than 75 days after the date the plan receives the individual's substantially complete application for coverage (or, in the case of retroactive coverage, within 75 days after the determination of retroactive coverage is made);
    - The second annual solicitation (the third solicitation overall) must be made December 31 of the year following the year the "account" was opened (***i.e.***, the date the plan received a substantially complete application for coverage).
  - The proposed regulations clarify that a plan may make TIN solicitations to the responsible individual for a plan (a plan is not required to make separate solicitations from the responsible individual for each covered individual nor must it contact each covered individual directly).

- **Clarification of plans that are NOT subject to reporting**
  The proposed regulations clarify:

  - If an individual is enrolled in a self-insured group health plan and self-insured health reimbursement arrangement ("HRA") provided by the same employer, the employer is required to report only one type of coverage for that individual. If such individual retires or otherwise drops coverage under the non-HRA group health plan mid-year and is covered only under the HRA for the remainder of the year, the employer must report coverage under the HRA for the months after the individual's retirement or dropping of non-HRA coverage;
  - An employer MUST report the supplemental coverage it offers (for example, self-insured HRA coverage) if it is only offered to individuals who are also covered by other MEC, including Medicare, TRICARE, Medicaid or certain employer-sponsored coverage (for example, a non-HRA group health plan provided by the employer of the employee's spouse), for which reporting is required under Section 6055.

2017 Health Savings Accounts and Interplay with 2017 ACA Maximum Out-of-Pocket Limits

In Revenue Procedure 2016-28, the IRS announced the inflation-adjusted amounts for health savings accounts ("HSAs") for the 2017 calendar year. The following chart provides the amounts for 2017 and how they compare to the 2016 limits:

	For 2017	For 2016
HSA contribution limit (employer + employee)	Individual: $3,400 Family: $6,750	Individual: $3,350 Family: $6,750
HSA catch-up contributions (age 55 or older)	$1,000	$1,000
High Deductible Health Plan ("HDHP") minimum deductibles	Individual: $1,300 Family: $2,600	Individual: $1,300 Family: $2,600
HDHP maximum out-of-pocket amounts (deductibles, co-payments and other amounts, but not premiums)	**Individual: $6,550 Family: $13,100**	**Individual: $6,550 Family: $13,100**

Interplay with Affordable Care Act ("ACA") Maximum Out-of-Pocket Limits

For the plan year beginning in calendar year 2017, the maximum out-of-pocket limits on cost-sharing for non-grandfathered health plans are $7,150 for self-only coverage and $14,300 for other than self-only coverage. To help ensure enrollees can contribute to their respective HSAs in 2017, a sponsor of a non-grandfathered high deductible health plan must apply the lower HSA/HDHP out-of-pocket limits referenced above to its plan as opposed to the 2017 ACA limits.

ACA Guidance — FAQs Part 31

The following tidbits from recently issued FAQs about ACA implementation prepared jointly by the Department of Labor ("DOL"), Internal Revenue Service ("IRS") and Department of Health and Human Services ("HHS") may be of interest to plan sponsors, in particular those with self-insured plans:

- **Coverage of Preventive Care Services**
  - Coverage of Preventive Care Colonoscopies — The FAQs clarify that preparation services that are integral to a preventive screening colonoscopy pursuant to the USPSTF recommendations, such as bowel preparation medications, must be covered by a non-grandfathered health plan without any cost sharing, provided the service or medication is medically appropriate and prescribed by a health care provider.
  - Coverage of FDA-Approved Contraceptives — In previous FAQs issued on May 11, 2015, the Departments stated that a plan may use reasonable medical management techniques within a specified method of contraception to determine which one form of contraception it must cover without any cost-sharing for any of 18 FDA-approved methods of preventive care contraception that a plan must cover. The Departments also stated that a plan must implement an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome for participants or providers to use so that a particular service or FDA-item that a provider recommends because of medical necessity can be covered without cost sharing (medical necessity considerations include side effects, differences in permanence and reversibility, and ability to adhere to the appropriate use of the item or service). The recent FAQs clarify that a plan may develop a standard form with instructions for providers and state that the Medicare Part D Coverage Determination Request Form may serve as a model for such a form.

- **Coverage of Out-of-Network Emergency Services**

  The ACA prohibits non-grandfathered health plans from imposing cost-sharing on out-of-network emergency services in amounts that are greater than what is imposed for in-network emergency services. A plan can satisfy this requirement if it provides benefits in an amount at least equal to the greatest amount determined under the following "minimum payment standards" (adjusted for in-network cost sharing): (i) the median amount negotiated with in-network providers for emergency services; (ii) the amount for emergency services calculated using the same method the plan generally uses to determine payments for out-of-network providers (for example, the usual, customary and reasonable [UCR] amount); or (iii) the amount that would be paid under Medicare for the emergency service. The FAQs clarify that the documentation and data used to calculate each of the above minimum payment standards are considered "instruments under which a plan is established or operated" and, therefore, must be furnished to a plan participant within 30 days of a request made under ERISA Section 104(b) and Labor Regulations Section 2520.104b-1. Such information must also be provided to a participant free of charge upon such participant's request for documents, records and other information relevant to her claim in accordance with the DOL's claims regulations and internal and external review requirements under the ACA (Public Health Service Act Section 2719).

- **Coverage for Routine Costs Furnished in Connection with Participation in a Clinical Trial**

  Under the ACA, non-grandfathered plans must cover the routine patient costs for items and services that are furnished in connection with an individual's participation in an approved clinical trial that relates to the prevention, detection, or treatment of cancer or another life-threatening disease or condition. The FAQs clarify that if a plan generally covers chemotherapy to treat cancer, the plan may not limit coverage for chemotherapy for an individual if it is provided in connection with the individual's participation in an approved clinical trial (for example, for a new anti-nausea drug). "Routine patient costs" also includes costs related to items and services to diagnose or treat complications or adverse events arising from an individual's participation in an approved clinical trial, provided the costs are otherwise covered under the plan for individuals who are not participating in approved clinical trials.

- The FAQs also provide guidance on the items that a provider of coverage or participant may wish to request from a plan to determine if the health plan has complied with the Mental Health Parity and Addiction Equity Act of 2008 (*i.e.*, summary plan description; specific underlying processes, strategies, evidentiary standards and other factors considered by the plan for determining whether to apply a "nonquantitative treatment limitation" [for example, a prior authorization requirement that applies to mental health treatment, but not to a medical treatment]; how the limitation has been applied to any medical/surgical benefits; and any analyses performed by the plan as to how the limitation applies with the law).

New Proposed Regulations Revising Annual Form Information Returns (Form 5500)

On July 21, 2016, the DOL, IRS and PBGC jointly issued proposed rules that significantly revise the annual information returns filed by employee benefits plans via the Form 5500. Of note to health and welfare plans, proposal eliminates the current exemption from annual filing for small insured and self-insured unfunded welfare benefit plans (*i.e.*, plans of employers with fewer than 100 employees). The intent is to provide the above referenced agencies with critical information regarding such "small plans" and facilitate their oversight of such plans.

ACA Nondiscrimination Final Rules — Section 1557

On May 18, 2016, the Department of Health and Human Services ("HHS") issued final rules implementing the Section 1557 of the Affordable Care Act which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities.

The nondiscrimination rule applies to the programs administered by the Federally-facilitated Marketplaces/Exchanges or a State-based Marketplace/Exchange and to all health programs and activities, any part of which receives Federal financial assistance administered by HHS. This means that if an employer or plan sponsor receives a subsidy from the Federal government, for example, a Medicare Part D prescription drug subsidy, its plan is subject to the nondiscrimination rules implementing Section 1557. Of note to employers and other plan sponsors, the final rules require the following among other provisions:

- The provision of language assistance services, free of charge, to facilitate meaningful access to individuals with limited English proficiency who are eligible to be served or likely to be encountered by the health plan. This includes offering a qualified interpreter for oral interpretations and translation by qualified translators of written documents (this would include the summary plan description);
- The taking of appropriate steps to ensure communications with individuals with disabilities are as effective as communications with others in health programs and activities;
- Ensuring that any health programs and activities that are provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or fundamental alteration in the nature of the health programs or activities;
- Prohibiting sex discrimination in health care by various measures, including:
  - Requiring that women must be treated equally with men in the health care they receive;
  - Prohibiting the denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping;
  - Prohibiting a plan from denying or limiting health services that are ordinarily or exclusively available to individuals of one sex, to a transgendered individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;
- Prohibiting any categorical coverage exclusion or limitation for all health services related to gender transition or the denial or limitation of coverage of a claim or the imposition of additional cost sharing for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual; and
- The provision of a notice that the plan complies with the nondiscrimination law and makes available accessibility assistance, language assistance services, how to obtain such aids, and how to file a grievance or complaint with HHS or the plan. Such notice must be provided within 90 days of the effective date of the final rules and include taglines describing the availability of language assistance in the top 15 languages spoken by individuals with limited English proficiency of the State(s) where the plan's participants are located. The notice must be included in "significant publications and significant communications targeted to beneficiaries, enrollees, applicants and members of the public" — these likely include the summary plan description, summary of material modifications, and initial and annual enrollment materials. The final rules include a sample notice that includes these taglines.

If you have any questions regarding the foregoing, please contact the author of this article.

JULY 2016

FIRM NEWS

On July 14, **Elizabeth Loh** co-presented an ABD Office Hours Webinar entitled: *Final Wellness Program Regulations Clarify Compliance Requirements.* She provided guidance on main compliance requirements for wellness programs following the recent final ADA and GINA regulations.

Nick White served as Co-Chair of the 2016 Western Benefits Conference in Seattle July 19–22. Nick also spoke on *401(k) Plan Internal Controls and Related IRS and DOL Enforcement Issues* at a "Lunch and Learn: 401(k) Strategy" seminar in Monterey on July 15.

On July 27, **Mary Powell**, **Marc Fosse** and **Eric Schillinger** co-presented a webinar entitled, *Compensation Planning for Non-Profits and Governmental Entities — Newly Issued Code Section 457(f) Proposed Regulations Offer Clarity and New Opportunities in Designing Executive Compensation.*

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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