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Employee Benefits Legislative Compliance
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Quick 1094/1095-C Filing Reminder:
File Form 1094-C and 1095-Cs (or 1094-B and 1095-Bs) with the IRS by June 30th, 2016, if filing electronically. (Due date extended from March 31, 2016, by IRS Notice 2016-04).

For more information, see:
https://www.irs.gov/instructions/i109495c/ar01.html

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LOS ANGELES, CALIFORNIA PASSES SICK LEAVE ORDINANCE

On June 2, 2016, the Los Angeles City Council passed the Los Angeles Minimum Wage Ordinance (Ordinance) which requires that employees working in the City receive paid sick time, in addition to an increased minimum wage rate. The Ordinance will take effect on July 1, 2016, just one month after its enactment. Employers must comply with both State law and the Los Angeles Ordinance—depending on which is more favorable to employees. This article only focuses on the paid sick leave portion of the Ordinance, and notes a few key differences between it and the California law.

Covered Employees

All employees who work at least two hours within the geographic boundaries of the City in any given week, and have worked for the same employer for at least 30 days, are entitled to accrue and use paid sick leave. Employees are entitled to accrue sick leave beginning July 1, 2016. New employees (hired after July 1, 2016) are entitled to accrue sick leave beginning on the date of hire, but cannot use sick leave until the 90th day of employment (under California law).

Covered Employers

The definition of "employer" includes any person (including a corporate officer or executive) who has direct or indirect control over the wages, hours or working conditions of any employee. This may also include a person who hires employees from a temporary staffing agency. Certain non-profit entities can apply for a deferral (i.e., ongoing exemption) from the paid sick leave provisions. Interestingly, it appears that corporate officers and executives may be held individually liable for a covered employer's failure to offer paid sick leave.

Paid Sick Time Wages

The minimum sick leave wages an employer must pay are based on an employer's size. The size of an employer is based on the average number of employees employed during the previous calendar year. For new employers, size shall be determined initially by the number of employees employed during its first pay period.

Employers with 26 or more employees must provide employees with paid sick time wages, at minimum, the following hourly rates: $10.50 starting July 1, 2016; $12.00 starting July 1, 2017; $13.25 starting July 1, 2018; $14.25 starting July 1, 2019; and $15.00 starting July 1, 2020. Employers with 25 or less employees follow the same rate increase schedule, but have an extra year to comply: $10.50 starting July 1, 2017; $12.00 starting July 1, 2018; $13.25 starting July 1, 2019; $14.25 starting July 1, 2020; and $15.00 starting July 1, 2021. Starting July 1, 2022, both groups will pay the same minimum rates.

Accrual of Leave Time

Employers may use either of two methods to provide paid sick time:

1. Lump-Sum Method: Employees are granted the full **48** hours of paid sick time at the beginning of each year (this can be any consecutive 12 month period);
2. Accrual Method: Employees accrue one hour of sick time for every 30 hours worked (including overtime hours) within the City. Employers may cap paid sick leave at **72** hours. For the accrual method, employers must provide the available sick time on employee paystubs.

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Los Angeles, California Passes Sick Leave Ordinance (Continued)

Accrued but unused sick leave may be carried over to the following year. **Note**: the Ordinance provides as much as two times the amount of paid sick time to an employee that is required by California law (which provides employees with 24 hours, or 3 days of sick leave per year under the lump-sum method, or up to 48 hours, or 6 days, under the accrual method).

Termination

Generally, accrued but unused paid sick leave is forfeited upon termination. However, if a terminated employee is rehired within one year, the employer must reinstate the employee's unused paid sick leave.

Permitted Uses of Leave Time

Employees may use sick leave time for themselves, or to take care of ill family members. Notably, the Ordinance significantly expands the definition of family member to "any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship." Employers should review their own policies to ensure it meets the expansive definition of "family relationship" set forth under the Ordinance.

In contrast to California state law, the Ordinance does not specify that employers may require sick time be taken in two-hour increments.

Notice

Employers must post notices regarding sick leave entitlement. Notices must be in English, plus any other language spoken by at least 5% of the employees at the workplace or job site. In addition, employers must provide written notice of any policy changes within 10 days of implementation.

Additional Protections for Employees

The Ordinance prohibits employers from taking retaliatory actions (e.g., reducing compensation, terminating an employee) or otherwise discriminating against employees for exercising their right to paid sick leave. In addition, employees cannot waive their rights to paid sick leave.

Employer Rights

Employers may require employees taking leave to provide reasonable documentation of an absence from work. However, "reasonable documentation" is left undefined in the Ordinance.

Employers that already have a paid time off policy permitting 48 hours of annual leave to the employee, or for use by the employee to care for the employee's family member or anyone of "close association similar to that of a family member," are not required to provide any additional paid sick leave.

Action Required

Employers with employees in the City of Los Angeles should review and revise their paid sick leave policies to ensure compliance with the Los Angeles Ordinance.

For the complete details, see:

Los Angeles Minimum Wage Ordinance No. 184320:

http://clkrep.lacity.org/onlinedocs/2014/14-1371_ORD_184320_6-2-16.pdf

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HHS ISSUES FINAL RULE ON ACA NONDISCRIMINATION IN HEALTH PROGRAMS AND ACTIVITIES

On May 13, 2016, the Department of Health and Human Services (HHS) released its final rules implementing Section 1557 of the Affordable Care Act (ACA), titled *Nondiscrimination in Health Programs and Activities*. The final rules are effective beginning July 18, 2016, except for provisions relating to health insurance plan benefit designs, which will take effect the first day of the first plan year beginning on or after January 1, 2017.

Section 1557 of the ACA prohibits "covered entities" from discriminating against individuals by excluding them from participation in, or denying them the benefits of health programs and activities based on race, color, national origin, sex, age, or disability. In September 2015, HHS released proposed regulations implementing Section 1557. The final rules confirm and clarify the proposed regulations, as well as provide additional guidance on consumers' rights and the obligations of covered entities. Highlights of the final rules are outlined below.

Covered Entities Defined

Section 1557 only applies to "covered entities" and their employee health benefit programs. Similar to the proposed rules, the final rules define a "covered entity" as:

- Any health program or activity that receives federal financial assistance through HHS (including Medicaid, most Medicare, and student health funds);
- Any health program or activity administered by an entity established under Title I of the ACA, including state-based marketplaces; and
- The HHS and the programs it administers, including the federally facilitated marketplace.

Prohibitions on Discrimination

The final rules include a general prohibition on discrimination based on race, color, national origin, sex, age, and disability, as well as rules against the specific forms of discrimination discussed below.

Sex, Gender Identity, and Sexual Orientation

The final rules prohibit discrimination based on sex, which includes the denial of health care or coverage based on pregnancy, false pregnancy, termination of pregnancy, childbirth, or sex stereotyping. The rules also prohibit discrimination based on gender identity, meaning a covered entity must treat transgender individuals consistently with their own gender identity.

The final rules do not clarify whether discrimination based on sexual orientation would be considered discrimination based on sex. Allegations of discrimination based on sexual orientation will be left up to the Office for Civil Rights (OCR) to evaluate.

Persons with Limited English Proficiency

The final rules require covered entities to take reasonable steps to provide individuals with limited English proficiency (LEP) access to health programs and activities. An individual with LEP is one whose primary language is not English, and who has limited ability to read, speak, write, or understand English. Failure to provide meaningful access to individuals with LEP who are eligible to be served or likely to be encountered in the health programs or activities is considered discrimination based on national origin.

In determining whether covered entities have provided meaningful access to individuals with LEP, the final rules delete the list of proposed relevant factors to consider, and instead focus on the nature and importance of the health program/activity, the particular communication, and "other relevant factors." To satisfy the meaningful access requirement, covered entitles are encouraged to have an effective and appropriate written language access plan.

Covered entities must also provide language assistance services for individuals with LEP (availability of these services must be included in significant notices and publications). Language assistance services must be provided in a timely manner, and covered entities must provide translators and interpreters who are "qualified bilingual/multilingual staff." Qualified translators and interpreters must be proficient in English and at least one other spoken language, including use of specialized vocabulary, and must be able to communicate effectively, accurately, and efficiently. The final regulations clarify that LEP individuals cannot be required to provide their own interpreters.

Persons with Disabilities

The final rules require covered entities to make all health programs and activities offered through electronic and information technology accessible to all consumers and other program beneficiaries, including those with disabilities.

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HHS Issues Final Rule on ACA Nondiscrimination in Health Programs and Activities (Continued)

Further, covered entities must provide auxiliary aids and services, free of charge and in a timely manner, when such aids/services are necessary to provide individuals with disabilities equal access to health program or activities benefits. Lastly, covered entities are prohibited from using marketing practices or benefit designs that discriminate based on disabilities (as well as other prohibited bases).

The final regulations also include physical accessibility standards for buildings and facilities, which are not addressed within this article. A link to the final rules detailing these standards is included at the end of this article.

No Specific Religious Exemption

The final rules declined to include a religious exemption to Section 1775, but stated that these rules do not displace existing statutory religious freedom protections.

Notice Requirements

The final regulations require covered entities to provide initial and continuing notification to beneficiaries, enrollees, applicants, and the public of individuals' rights provided under Section 1557. The notices should include the following information:

- That they do not discriminate on the basis of race, color, national origin, sex, age, or disability;
- That they will provide appropriate aids and services without charge and in a timely manner, including qualified interpreters, for people with disabilities;
- That they will provide language assistance including translated documents and oral interpretation free of charge and in a timely manner;
- How to obtain aids and services;
- How to contact the employee responsible for compliance;
- About the availability of a grievance procedure; and
- How to contact OCR to file a discrimination complaint.

Covered entities must include taglines in each notice and other significant publication in the top 15 non-English languages in the entity's state which informs individuals of the availability of language assistance services. For small-sized significant publications (e.g., postcards), covered entities must post taglines in at least the top two non-English languages in the state.

In response to comments regarding the length of the notice, the final regulations permit covered entities to combine the above-listed content with the content of other notices required under other Federal civil rights laws. However, if the notices are combined, the final notice must clearly convey the information listed above and inform individuals of their civil rights under Section 1557. The final rules permit small-sized significant communications to include a shorter non-discrimination statement.

The final rules also allow for some flexibility for covered entities to determine the size and location of the notices and taglines in their facilities. However, the final rules state that the content must be sufficiently conspicuous and visible, such that individuals participating in, or seeking services from, the health program or activity could reasonably be expected or see and be able to read the information within the communication.

OCR provides a sample notice and taglines on its website in 64 languages that covered entities may use for guidance.

Grievance Procedures

Covered entities with 15 or more employees must have a grievance procedure in place, as well as appoint a compliance coordinator. The final rules provide a model grievance procedure for guidance. A grievance procedure is not required for entities with less than 15 employees.

Action Required

Employers should be aware of these nondiscrimination provisions, and any employer qualifying as a covered entity should ensure compliance with these rules.

For the complete details, see:

HHS Final Rules: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-11458.pdf

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INTERNAL REVENUE SERVICE RELEASES MEMORANDUM ON WELLNESS PROGRAM CASH REWARDS AND PREMIUM REIMBURSEMENTS

The Internal Revenue Service (IRS) released a Memorandum (Memo) on May 27, 2016. As a reminder, IRS Memoranda do not act as binding authoritative writings, and therefore may not be treated as precedence, so employers should not rely on the contents of the Memo. However, IRS Memoranda are often used to guide employers in the area of tax compliance. The Memo addresses two specific scenarios:

- May employers provide cash rewards as part of a wellness program to employees, and have that amount excluded from employees' wages?
- May employers provide, as part of a wellness program, reimbursements to employees for employee contribution payments made towards insurance premiums, and can those amounts be excluded from employees' wages?

These scenarios are discussed separately below.

Wellness Program Cash Rewards

In general, an employer may exclude from an employee's wages the cost of any employer-provided coverage under an accident or health plan. Also, an employer may exclude from an employee's wages any reimbursement of expenses incurred by an employee for medical care. These provisions are both located in the Internal Revenue Code.

However, the question is whether employees who receive a cash reward for participation in a wellness program are considered to have received a reimbursement based upon "medical care," or if the employees should be taxed on this cash reward as income to the employees. The Memo resolves this issue by stating that "cash rewards" provided by employers to employees for participating in a wellness program are not considered to be employer-provided coverage nor for the reimbursement of expenses for "medical care." Therefore, any "cash rewards" offered by employers to employees as part of a wellness program would be considered wages to the employee, and subject to taxation. This also includes gym membership reimbursements, since they would also be considered "cash."

The Memo also discusses rewards that may not be cash, but are instead de minimus fringe benefits. Specifically, the IRS seems to consider a T-shirt a de minimum fringe benefit, and therefore, excluded from an employee's wages, even though it may not be considered a "reimbursement for medical care."

So for now, the value of cash rewards (or gym membership reimbursements) provided as part of a wellness program should be provided to employees as taxable income, but employers may be able to provide de minimus items such as T-shirts, without having to include the value of such items as taxable wages to employees.

Wellness Program Premium Reimbursements

In addition, the Memo addresses premium contribution reimbursements to employees for participation in a wellness program. Employees who receive employer cash reimbursements for participation in a wellness program must claim those reimbursements as taxable wages. However, the Memo does not address the issue of whether a **reduction** in premium costs (rather than **reimbursement** of those costs) to an employee for participation in a wellness program should be considered taxable income to the employee. Guidance on this issue from the IRS would be much appreciated.

For now, it seems that if an employer **reimburses** an employee a portion of his/her cost of the premium for health coverage or health costs as part of a wellness program, then this would need to be treated as taxable wages to the employee.

Action Required

Although this Memorandum is not binding, employers' legal counsel should use this Memorandum as potential guidance if they offer cash rewards or premium reimbursements for employees participating in a wellness program, or employees could face potential adverse tax consequences.

For the complete details, see:

Office of Chief Counsel, IRS Memorandum 201622031: https://www.irs.gov/pub/irs-wd/201622031.pdf

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ADA AND GINA FINAL RULES: UPDATES AND IMPACT ON EMPLOYER-SPONSORED WELLNESS PROGRAMS

On May 17, 2016, the U.S. Equal Employment Opportunity Commission (EEOC) released the Americans with Disabilities Act (ADA) Final Rule and the Genetic Information Nondiscrimination Act (GINA) Final Rule (collectively Final Rules). As outlined below, the Final Rules describe the extent to which employers can induce employees or dependents to undergo medical examinations (ADA), respond to disability related inquiries (ADA), or disclose their spouses' genetic information (GINA) in connection with a wellness program. The Final Rules apply to employer-sponsored wellness programs broadly, regardless of whether they are a stand-alone wellness program, or included as part of a group health plan. These Final Rules are effective as of the first day of the first plan year beginning on or after January 1, 2017.

ADA Final Rule on Wellness Programs

ADA Regulations Apply to Certain Wellness Programs

Generally, the ADA prohibits employers from discriminating on the basis of disability, and generally restricts an employer from inquiring into an employee's health, or requiring an employee to undergo a medical examination. However, in some instances under the ADA Final Rule, employers as part of a wellness program may inquire about an employee's disabilities and/or have employees undergo a medical examination.

Wellness Programs Must be "Reasonably Designed" To Promote Health or Prevent Disease

The ADA Final Rule holds that looking at all the relevant facts and circumstances, a wellness program must be reasonably designed to promote the health of and prevent disease in, employees who participate in such program. These employer-sponsored wellness programs must not be overly burdensome, require excessively intrusive or costly procedures, or be a ruse for violating the ADA, GINA, and/or other discrimination laws.

Wellness Programs Must be Voluntary

The final regulations confirm that wellness programs must be voluntary, and clarify the definition of voluntary. For a wellness program to be considered voluntary, the employer may **not** take any of the following actions in response to an employee's decision not to participate:

- Require the employee to participate despite the employee's wishes not to participate
- Deny or limit an employee the ability to access a health plan or particular benefits package within a group health plan
- Offer participating employees an incentive greater than 30% of the total cost of self-only-coverage; or
- Retaliate against, interfere with, coerce, intimidate, or threaten a non-participating employee.

In addition, the employer must provide a notice in language that is reasonably likely to be understood by the employee clearly explaining:

- The medical information that is being obtained
- How the medical information will be used
- Who will receive the medical information
- Restrictions on the disclosure of the medical information; and
- Methods used to ensure the medical information is not improperly disclosed.

If an employer's current notice does not meet these requirements, the employer must revise its existing notice or develop a new notice to comply with these requirements. The EEOC has provided a sample notice on their website that complies with these requirements.

Financial Incentive Requirement

Financial incentives for wellness programs under the ADA are limited for wellness programs that are part of a group health plan. Outcomes-based wellness programs are considered part of the health plan. Also any wellness that includes health questions and medical screenings would likely be considered part of a group health plan.

The maximum financial incentive is 30% of the cost of premiums for employee-only coverage. Financial incentives can be either rewards or penalties. This 30% applies to both participatory and health contingent wellness programs. For example, if the total premium paid by the employer and employee for single coverage is $5,000, rewards or penalties for participating in a wellness program cannot exceed $1,500.

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ADA and GINA Final Rules: Updates and Impact On Employer-Sponsored Wellness Programs (Continued)

It is important to note the differences between the HIPAA rules and the ADA. The ADA rules do not change the HIPAA rules. But many employers need to comply with both. The following summarizes the differences:

- The 30% maximum would apply to the total wellness program, regardless of whether it is participatory, health-contingent, or both. Currently, under HIPAA, the 30% maximum applies only to health-contingent programs. Rewards for participatory programs would be included in the 30% maximum **if the participatory program asks a participant to provide medical information**, such as completing a Health Risk Assessment.
- The 50% maximum incentive that currently applies to tobacco cessation programs may continue to be allowed. It depends on how the employer manages the plan. The 50% incentive would only apply to programs that ask employees if they use tobacco. The 50% incentive **would not be permitted** if an employer requires an employee to participate in a biometric screening that tests for the presence of nicotine or tobacco. This testing would be considered a medical examination, and the 30% maximum would then apply.
- The proposed regulations do not address family member participation in wellness incentives. Currently under HIPAA, the 30% maximum can be applied to the family premium when an employee's family members can participate in the wellness program. This will need to be clarified in the final regulations.

Incentives May Be Financial or In-Kind

An employer's offer of limited financial or in-kind incentives (e.g., recognition, use of parking spot) to promote employee participation in wellness programs that include disability-related inquiries and medical examination will not render the program involuntary, so long as the total allowable incentive available under both programs do not exceed 30% of the total cost of self-only coverage. Employers may use a reasonable method to determine the value of in-kind incentives.

Confidentiality of Medical Information

The ADA final regulations added two new requirements. First, a wellness program administrator may only collect employee information in aggregate form that does not disclose or is not reasonably likely to disclose the identity of the employee, except as necessary to administer the plan. Second, employers may not require an employee to "agree to the sale, exchange, sharing, transfer, or other disclosure of medical information, or waive confidentiality protections, as a condition for participating in the wellness program or for receiving a wellness program incentive."

GINA Final Rule on Wellness Programs

GINA Final Rule Applies to Certain Employer-Sponsored Wellness Programs

Generally, GINA restricts employers from acquiring and disclosing the genetic information of its employees, and prohibits employers from the use of genetic information in making employment decisions. Genetic information includes genetic information about an individual's genetic tests, information about an individual's family members' genetic tests, and information about the individual and individual's family members' past or current health status. This broad definition prevents employers from obtaining and using information about the individual's family members to make conclusions about the individual's health, and discriminate against that individual.

In fact, employers and other entities can only request, require, or purchase genetic information when one or more of six narrow exceptions applies. One exception allows employers offering health or genetic services in connection with voluntary wellness programs to request genetic information.

Limited Scope of Final Rule

The GINA Final Rule addresses the extent to which employers can offer inducements to an employee for information on the employee's spouse's past or current health status pursuant to a wellness program (generally provided as part of a health risk assessment (HRA)). GINA applies to an employer-sponsored wellness program only when an employee's spouse is required to answer questions about his or her current or past health status, or to undergo a medical examination, in exchange for an inducement to participate in such wellness program. This includes wellness programs that are:

- Offered only to spouses of employees enrolled in an employer-sponsored health plan

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ADA and GINA Final Rules: Updates and Impact On Employer-Sponsored Wellness Programs (Continued)

- Offered to spouses of all employees regardless of the employee or spouse's enrollment in such plan; and
- Offered as a benefit of employment to spouses of employees of employers who do not sponsor group health plans or group health insurance.

GINA does not allow wellness plans to offer employee incentives for the genetic information (e.g., genetic tests) of their spouses or children. Further, employers are prohibited from using inducements to seek information about the past or current health status of an employee's children (including adult children). The Final Rule notes that employers are not prevented from offering health or genetic services, including participation in employer-sponsored wellness programs to an employee's children, but cannot offer incentives in order to obtain the children's genetic information.

Participation in Wellness Program Must Be Voluntary

The GINA Final Rule clarifies that the participation in a wellness program that requests information about an employee's spouse's past or current health status must be voluntary. In other words, inducements cannot be so substantial as to effectively coerce employees into participating and providing genetic information. These inducements may be rewards or penalties, including both financial and in-kind inducements, and are capped at 30% of the total cost of the plan (permissible incentive limit). When both an employee and the employee's spouse can enroll in the employer-sponsored wellness program, the inducement available to each individual cannot exceed 30% of the total cost of the plan in which the employee and any dependents are enrolled. Calculation of this 30% permissible incentive limit is the same as set forth in the ADA Final Rule.

Wellness Program Must be "Reasonably Designed" To Promote Health or Prevent Disease

This threshold is identical to the one set in the ADA Final Rule, and holds that any wellness program that offers incentives to employees to provide information relating to their spouses' past or current health status must be "reasonably designed" to promote health or prevent disease.

Confidentiality of Medical Information

The GINA Final Rule explains that employers' requests for medical information are subject to confidentiality and antidiscrimination requirements previously set forth under the original GINA regulations.

Action Required

Employers with wellness programs subject to the ADA or GINA Final Rules should review their existing program terms, and update them as necessary to ensure compliance with the Final Rules by the first day of the first plan year beginning on or after January 1, 2017. In addition, employers who sponsor a wellness program should begin distributing notices in relation to their wellness programs to employees, in a manner that the employee from whom medical information is obtained is reasonably likely to understand it.

For the ADA Final Rule, see:

https://federalregister.gov/a/2016-11558

For a Sample ADA Wellness Program Notice, see:

https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm

For the GINA Final Rule, see:

https://federalregister.gov/a/2016-11557

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MINNEAPOLIS, MINNESOTA ENACTS SICK AND SAFE TIME ORDINANCE

On May 27, 2016, the Minneapolis City Council passed the Sick and Safe Time Ordinance (Ordinance), making Minneapolis (City) the first city in the Midwest to mandate sick leave for employees. Highlights of the Ordinance, which takes effect on July 1, 2017, are outlined below.

Covered Employees

Any individual employed by an employer (including temporary and part-time employees) who perform work within the geographic boundaries of the City for 80 or more hours per year, is eligible to accrue sick and safe leave. Independent contractors and government employees (except for City government employees) are not eligible for benefits under the Ordinance.

Paid Sick and Safe Time Wages

Employees under the Ordinance earn the same hourly rate and are entitled to the same benefits as they would have been entitled to as an active employee. However, employees are not entitled to compensation for lost tips or commissions while using sick and safe leave.

Construction industry employees must be paid at least the prevailing wage defined under Minnesota law, or the required rate established in a registered apprenticeship agreement with the Minnesota Department of Labor and Industry.

Accrual of Leave Time

Employees earn 1 hour of sick and safe leave time per 30 hours worked, beginning immediately upon employment, or the Ordinance's effective date, whichever is later. New employees are entitled to use accrued sick and safe leave 90 days after employment begins. Employers may cap the accrual of paid sick and safe leave to 48 hours in one calendar or fiscal year. Accrued but unused leave may be rolled over to the following year, but the total amount of accrued but unused sick and safe leave is capped at 80 hours (unless the employer agrees to a higher cap). Employees may use paid leave in increments consistent with current payroll practices as defined by the industry standard, or existing employer policy, provided such increment is not more than four hours.

Employers are not required to pay out accrued and unused sick and safe leave time upon termination. However, if employees are rehired within 90 days of separation, employers must reinstate the accrued and unused leave time of that employee.

Employers that already provide employees with sick leave under paid leave policies that meet or exceed the minimum requirements set forth by the Ordinance are not required to provide additional leave time.

Permitted Uses of Leave Time

Employees can use accrued sick and safe leave for the following reasons:

1. For the diagnosis, care, or treatment of mental or physical illness, for themselves or their family members
2. For victims of domestic abuse, sexual assault, stalking, and their family members to receive medical treatment, participate in civil or criminal legal proceeding relating to, or resulting from domestic abuse, sexual assault, or stalking, or receive other necessary services
3. For childcare or care of family members, whose school or care facility has been closed due to public health emergencies, inclement weather, or other unexpected reasons; and
4. For employees to close their place of businesses, by order of a public official, in connection with a public health emergency.

Notably, the Ordinance defines "family member" broadly as an employee's child, stepchild, adopted child, foster child, adult child, spouse, sibling, parent, stepparent, mother-in-law, father-in-law, grandchild, grandparent, guardian, ward, members of the employee's household, or registered domestic partner.

Grace Period Date for Certain Employers

The Ordinance contains certain allowances for new employers, and small employers. For the first five years after the Ordinance takes effect, newly-formed businesses other than chain establishments (i.e., a new establishment using the same trade name as two or more establishments, or under the same ownership, and doing the same business) can opt to provide employees with unpaid, rather than paid, sick and safe time during the first twelve months they are in business.

In addition, employers with five or less employees (determined by the average number of employees per week during the previous year, regardless of location) may opt to allow covered employees to accrue and use unpaid, rather than paid, sick and safe time.

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Minneapolis, Minnesota Enacts Sick and Safe Time Ordinance (Continued)

Notice and Record Keeping Requirements

Employers are required to display a poster by the Minneapolis Department of Civil Rights (Department) in a conspicuous place accessible by all employees. Posters must be in English, and any other language spoken by five percent or more of the employees at the Minneapolis worksite, if the Department has made such notice available.

Employers that provide employee handbooks must include a notice of the employees' rights and remedies under the Ordinance in the handbooks.

Employers are required to keep records for each employee detailing the accrued and used leave time for each day of the workweek. These records must be retained for at least three calendar years, in addition to the current year. Upon request by an employee, an employer must provide in writing or electronically, the current amount of used and available sick and safe time. In addition, employers must make these records available to Department employees for inspection.

Employer Rights

Employers may request reasonable documentation supporting the need for illnesses or absences lasting longer than three consecutive days. Employers may require employees to provide up to seven days advance notice when the use of sick or safe time is foreseeable.

Penalties for Noncompliance

For the first twelve months following the effective date, the Department of Civil Rights Director (Director) will only issue warnings and notices to correct violations, after which, penalties may be assessed.

The Director may order relief including the following:

1. A $50 per day fine for failing to comply with notice requirements, and failing to remedy this violation within five business days;
2. Reinstatement and back pay;
3. Up to $1,500 administrative penalty payable to the employee; or
4. Crediting the employee with the accrued, but withheld leave, plus the dollar value of the withheld leave multiplied by 2 or $250, whichever is greater.

Action Required

Employers subject to the new Ordinance should review their existing policies and handbook, and update them as necessary to ensure compliance with the Ordinance before July 1, 2017. In addition, employers must obtain the workplace posters once available by the City, and post in an accessible location.

For the Minneapolis Sick and Safe Time Ordinance, see:

http://www.ci.minneapolis.mn.us/www/groups/public/@clerk/documents/webcontent/wcmsp-180691.pdf

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WISCONSIN ADOPTS UNPAID LEAVE LAW FOR DONORS

Effective July 1, 2016, Wisconsin, through the Wisconsin Donation Leave Act (WDLA), will require covered employers (i.e. employers who employ at least 50 individuals on a permanent basis) to provide eligible employees with up to 6 weeks of unpaid leave in a 12-month period if an employee undergoes either bone marrow or organ donation procedures.

The WDLA (which is codified at section 103.11 of Wisconsin Statutes) built its foundation from the rules surrounding the Wisconsin Family and Medical Leave Act (WFMLA), including its employer scope, employee eligibility requirements, and enforcement standards and procedures. The WDLA allows employers to require medical certification and advance notice from employees who are seeking leave pursuant to the WDLA's terms. A donor employee must also make a reasonable effort to schedule his or her procedure so that it does not unduly disrupt the employer's operations, which is conditional on the donee's healthcare provider's approval.

The new law will be enforced by the Wisconsin Department of Workforce Development, which is currently creating a mandatory workplace poster to be displayed once released.

Action Required

It is recommended that covered employers consider adopting policy language regarding the new leave requirement, either by creating a completely new policy or adding an amendment to existing policies. In addition, employers should be prepared to display the mandatory workplace poster once it is created by the Wisconsin Department of Workforce Development.

For the Wisconsin Senate Bill No. 517, see:

http://docs.legis.wisconsin.gov/2015/related/proposals/sb517

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COMPLIANCE REMINDER: PCORI FEE DUE TO IRS BY AUGUST 1ST

The health reform law imposes a number of fees, taxes, and other assessments on health insurance companies and sponsors of self-funded health plans to help subsidize a number of endeavors. One such fee funds the Patient-Centered Outcomes Research Institute (PCORI).

The **PCORI fee is $2.17 per covered life for plan years ending on or after Oct. 1, 2015**, and must be reported on (and remitted with) IRS Form 720 by August 1, 2016 (the deadline is July 31st, but since July 31st falls on a weekend, the form is due by the next business day, August 1st). For **self-funded plans**, the **employer/plan sponsor** will be responsible for submitting the fee and accompanying paperwork to the IRS. Third-party reporting and payment of the fee is not permitted for self-funded plans.

The process for remitting payment by sponsors of self-funded plans is described in more detail below.

PCORI Fee Reporting and Payment

The IRS will collect the fee from the insurer or, in the case of self-funded plans, the plan sponsor, in the same way many other excise taxes are collected. The fees are reported and paid annually on IRS Form 720 by July 31st of the year following the last day of the plan year. This year, the fee is due by August 1, 2016.

The fee due on August 1, 2016 is $2.17 per covered life for plan years ending before October 1, 2016, and on or after October 1, 2015. For plan years ending before October 1, 2015, the fee due on August 1, 2016, is $2.08 per covered life under the plan. IRS regulations provide three options for determining the average number of covered lives (actual count, snapshot, and Form 5500 method).

> **Example:** The Form 720 must be filed by July 31st (August 1st in 2016) of the calendar year immediately following the last day of the plan year. Calendar year plans will owe a fee of $2.17 per covered life by August 1, 2016. Plans that operate on years that begin the first day of any month from February through October will be paying a $2.08 per covered life fee with the August 1, 2016 filing.

The **PCORI fee must be paid by the plan sponsor**; it is not permissible to pay this fee in whole or in part through participant contributions. The PCORI expense should not be included in the plan's cost when computing the plan's COBRA premium. The IRS has indicated the fee is, however, a tax-deductible business expense for employers with self-funded plans.

How to File IRS Form 720

The filing and remittance process to the IRS is straightforward and is largely unchanged from last year. On page two of Form 720, under Part II, the employer needs to designate the average number of covered lives under its "applicable self-insured plan". The number of covered lives is multiplied by $2.17 (for plan years ending on or after October 1, 2015) to determine the total fee owed to the IRS.

Patient - Centered Outcomes Research Fee (see instructions)	(a) Avg. number of lives covered (see inst.)	(b) Rate for avg. covered life	(c) Fee (see instructions)
Specified health insurance policies			
(a) With a policy year ending before October 1, 2015		$ 2.08	
(b) With a policy year ending on or after October 1, 2015, and before October 1, 2016		$ 2.17	
Applicable self - insured health plans			
(c) With a plan year ending before October 1, 2015		$ 2.08	
(d) With a plan year ending on or after October 1, 2015, and before October 1, 2016		$ 2.17	

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Compliance Reminder: PCORI Fee Due to IRS by August 1st (Continued)

How to File IRS Form 720 (continued)

The **Payment Voucher** (720-V) should indicate the tax period for the fee is "2nd Quarter".

720-V Department of the Treasury Internal Revenue Service	Payment Voucher ▶ Do not staple or attach this voucher to your payment.		OMB No. 1545-0023 2016
1 Enter your employer identification number (EIN) (see instructions).	2 Enter the amount of your payment. ▶ Make your check or money order payable to "United States Treasury."	Dollars	Cents
3 Tax Period	4 Enter your business name (individual name if sole proprietor).		
○ 1st Quarter / ○ 3rd Quarter	Enter your address.		
● 2nd Quarter / ○ 4th Quarter	City or town, state or province, country, and ZIP or foreign postal code		

Please Note: Failure to properly designate "2nd Quarter" on the voucher will result in the IRS's software generating a tardy filing notice, with all the incumbent aggravation on the employer to correct the matter with IRS.

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QUESTION OF THE MONTH

Q: Our company sponsors a group health plan under which full-time employees are eligible for coverage after a 90-day waiting period. We are a small company (under 20 employees) and not subject to employer shared responsibility. Due to business needs, we occasionally rehire employees who previously terminated employment with our company. Are we permitted to impose the plan's waiting period on rehired employees?

A: In general, former employees who are terminated and rehired may be treated as newly eligible for coverage upon rehire—meaning that your plan may require such individuals to meet the plan's eligibility criteria and satisfy the plan's waiting period anew. However, regulations specify that imposition of the waiting period must be reasonable under the circumstances (e.g., the termination and rehire cannot be a subterfuge to avoid compliance with the 90-day waiting period limitation).

The regulations do not elaborate on what is required for a new waiting period upon rehire to be "reasonable under the circumstances" and not a "subterfuge," but they include an example in which the terminating employee had "no expectation of providing further services" and the gap between the termination date and the rehire date was approximately three months. In that scenario, the regulations permit the employee to be treated as newly eligible for coverage under the plan upon rehire, allowing the imposition of the plan's waiting period. This suggests that there should not be a prearranged understanding that the terminating employee will return to employment. In addition, there should be a sufficient period of time between the termination date and the rehire date. For example, applying a new waiting period to an employee who terminates on a Friday and is rehired on the following Monday likely would not be considered reasonable under the circumstances.

For applicable large employers subject to employer shared responsibility under Code § 4980H, keep in mind that those rules differ from the waiting period rules, requiring some returning employees (including rehires) to be deemed continuing employees even after relatively lengthy absences. Thus, even though the waiting period rules may allow a new waiting period for a rehired employee, applying a waiting period to an employee who must be treated as a continuing full-time employee under Code § 4980H could expose an applicable large employer to penalties.

Source: EBIA Staff

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