WELLS FARGO INSURANCE

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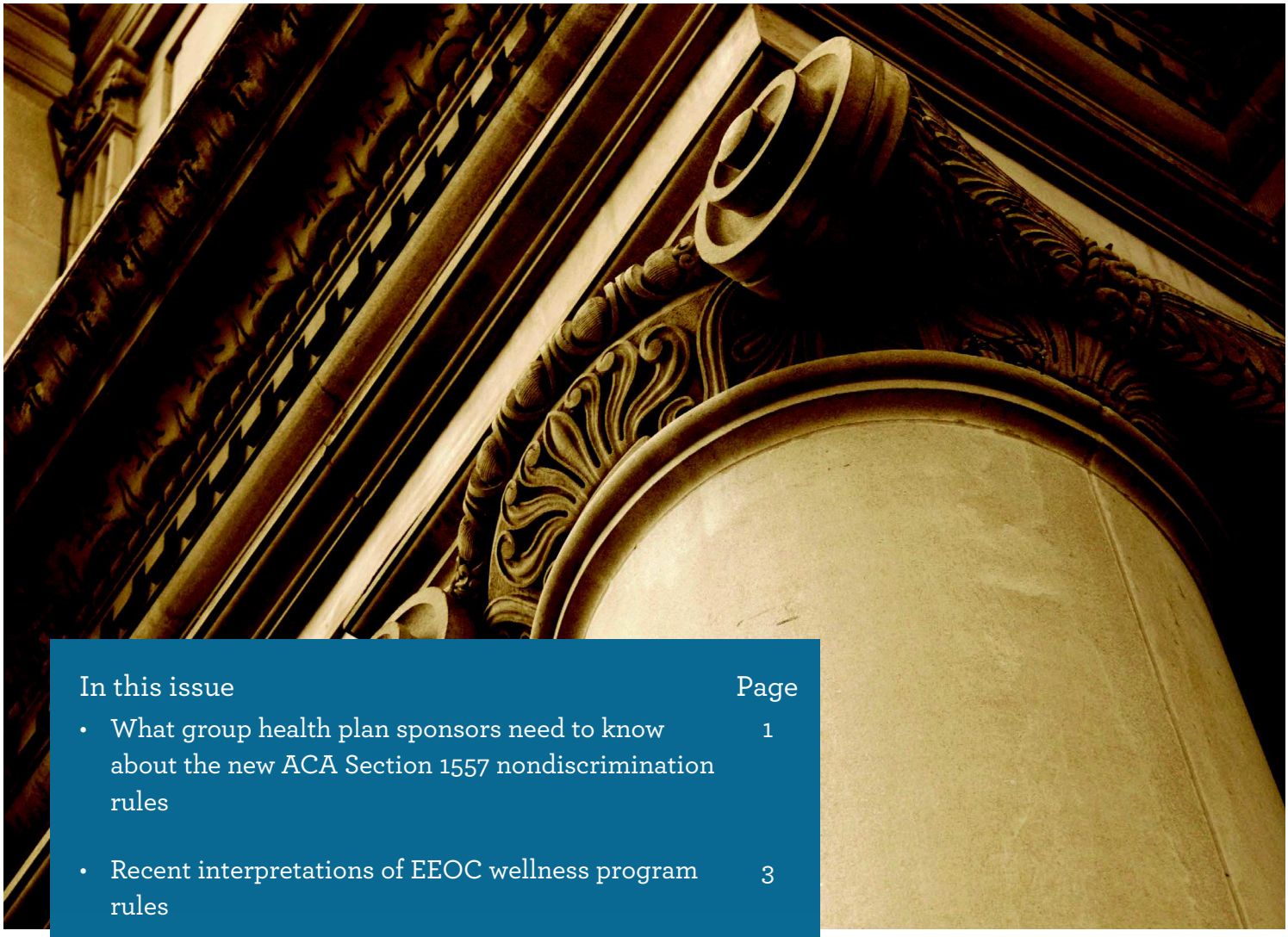
Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice



In this issue

Together we'll go far

What group health plan sponsors need to know about the new ACA Section 1557 nondiscrimination rules

In brief:

- The new ACA Section 1557 nondiscrimination rules require some employers to make sure their group health plans do not discriminate against certain federally protected classes of individuals, and to inform participants of these protections.
- It will be prudent for other non-covered employers to also comply with the nondiscrimination aspects of the rule in order to avoid possible regulatory enforcement and litigation under federal civil rights nondiscrimination laws.
- Thus, most group health plan sponsors will need to review their plan designs with respect to covering gender transition services. Some group health plan sponsors will also have to comply with certain additional disclosure requirements.
- While October 16, 2016, is the general deadline for covered entities to comply with the disclosure requirements, the deadline to incorporate nondiscrimination notices, statements, and taglines into summary plan descriptions for group health plans is deferred until the current stock of hard copies is exhausted and new copies are generated.

As discussed in our June 2016 Benefits Compliance Update, the Department of Health and Human Services (HHS) issued final regulations under Section 1557 of the Affordable Care Act. Section 1557 prohibits discrimination in certain health programs or activities on the basis of race, color, national origin, sex, age, or disability. More specifically, these rules extend the application of certain long-standing federal civil rights nondiscrimination laws to the health programs and activities of "covered entities," including group health plans they sponsor.

These final regulations became effective on July 18, 2016; however, additional time is allowed to comply with certain health coverage plan design, notice, and language assistance requirements. As a result, issues regarding the scope and potential application of these rules are being raised and are confusing many employers that sponsor group health plans as they finalize their plan design and compliance plans for their 2017 plan year.

Definition of covered entity

A "covered entity" for purposes of these HHS regulations includes an entity that both operates a health program or activity and receives federal financial assistance from HHS. Simply stated, "covered entities" generally include:

- Healthcare providers receiving funding (such as Medicare or Medicaid payments) from HHS. This includes most hospitals, health clinics, physician practices, community health centers, nursing facilities, and laboratories.
- Carriers providing insured coverage through an ACA Health Insurance Marketplace, which includes most major health insurance carriers.
- Employers receiving Medicare Part D reimbursements.

A carrier serving as a third party administrator (TPA) to an employer's self-insured group health plan, where the carrier is a covered entity, is also subject to the Section 1557 regulations. However, the preamble to the final regulations clarify that the rules only extend to the administrative activities of a TPA as opposed to plan design decisions that the sponsor of the self-insured plan makes.

Scope of discrimination rules extends to gender transition services

Although the regulations prohibit discrimination with respect to various classes of employees protected under federal civil rights nondiscrimination laws, a point of emphasis under the new rules is that the federal government interprets discrimination on the basis of sex to include discrimination based on gender identity, which could impact the group health plans of covered entities with respect to gender transition services. While the

regulations do not specifically require covered entities to offer such services, they must not discriminate against an individual with respect to the services offered under their group health plan based on gender identity. In addition, group health plans of covered entities may not impose a categorical exclusion of coverage for all health services related to gender transition. Furthermore, HHS indicated that they will refer cases not involving covered entities that come to their attention (such as self-insured plans sponsored by non-covered entities) to the Equal Employment Opportunity Commission (EEOC) for direct enforcement under the applicable federal civil rights nondiscrimination laws.

Therefore, the application of Section 1557 nondiscrimination rules to group health plans will depend on the nature of the plan sponsor and how it funds its plan, as follows:

Type of Sponsor and Plan	Applicability of Nondiscrimination Rules
Covered entity sponsoring either an insured or self-insured group health plan	Employer and its group health plan are subject to the Section 1557 nondiscrimination rules
Non-covered entity sponsoring insured group health plan obtained from carrier that is a covered entity	Since the carrier is a covered entity, it must comply with the Section 1557 nondiscrimination rules and any group contract will likely include coverage for gender transition services
Non-covered entity sponsoring a self-insured group health plan or insured group health plan obtained from a non-covered carrier	Employer and its group health plan are not subject to the Section 1557 regulations, but the employer may be subject to discrimination claims by employees and the EEOC if plan excludes coverage for gender transition services

Essentially all group health plans have either direct or indirect exposure to the federal civil rights nondiscrimination laws, which includes discrimination based on gender identity. As a result, when the low cost of offering gender transition services (due to low utilization of these services and the ability to control costs with reasonable medical management techniques and treatment protocols) is compared to the risk of regulatory action, litigation, and adverse publicity, it is anticipated that most employers will offer gender transition services regardless of whether they are covered entities or not. However, employers with strong religious beliefs could look to the Religious Freedom Restoration Act to avoid offering these services if they are willing to accept the litigation risk of becoming a "test case."

Language assistance, notices, and taglines

In addition to the nondiscrimination requirements, the new rules also require covered entities to post by October 16, 2016, a nondiscrimination notice informing their employees and customers of the entities' obligation to comply with Section 1557, and telling consumers with disabilities and with limited English proficiency (LEP) about their right to receive communication assistance. Non-covered entities are not subject to the Section 1557 nondiscrimination notice and communication rules.

Covered entities may combine the content of this notice with the content of other similar required nondiscrimination and Equal Employment Opportunity notices as long as the combined notice clearly informs individuals of the Section 1557 rules. The nondiscrimination notice also must be included in any significant publications and communications issued by the covered entity (which would seem to include summary plan descriptions of group health plans). However, the effective date with respect to this aspect of the rule is deferred until the current stock of hard copies of significant publications and communications is exhausted and new versions are generated. There also is an exception for certain small-sized significant publications and communications (which would seem to include a Summary of Benefits and Coverage (SBC) for a group health plan), which are just required to incorporate a simple nondiscrimination statement rather than the full nondiscrimination notice.

In addition to providing a nondiscrimination notice, covered entities are required to post taglines in the top 15 languages spoken by individuals with LEP in the states in which the covered entity operates, advising individuals of the availability of free language assistance services. When a nondiscrimination statement may be used, taglines in only the top two non-English languages are required. A tagline is a simple statement indicating the availability of language assistance that is written in the applicable non-English language.

While group health plan sponsors that are covered entities or obtained insured coverage from a covered carrier generally should look to their carrier or TPA for assistance in complying with these notice and communication rules, HHS created a webpage providing a robust number of materials to assist with Section 1557 understanding and compliance. Among other items, this webpage includes a copy of the final regulations, a summary of those rules, various fact sheets and FAQs on key provisions, a sample nondiscrimination notice and statement, and a sample tagline. Translated versions of the sample notice and statement of nondiscrimination, along with the taglines, are provided in over 60 different languages. HHS also provided a list of the top 15 languages in all 50 states, the District of Columbia, and the U.S. territories.

Action steps

In order to address the Section 1557 regulations, an employer sponsoring a group health plan should take the following key action steps:

1. Determine if it is a covered entity that is automatically subject to the Section 1557 rules. If so, then the covered entity should comply with the rules with respect to all of its health programs and activities, including its group health plan. This will include reviewing and possibly changing the plan design to make it nondiscriminatory (in particular with respect to sex discrimination-based gender identity), and satisfying the applicable nondiscrimination notice, statement, and tagline requirements.

2. If the employer is not a covered entity but maintains an insured group health plan, then determine if the carrier is a covered entity. If so, work with the carrier to make sure that the plan design is not discriminatory. The covered carrier likely will satisfy its obligation to comply with the nondiscrimination notice, statement, and tagline requirements by incorporating these items into the detailed description of benefits it prepares and forwards to the employer with respect to its policy.

3. If the employer is not a covered entity but maintains a self-insured group health plan (or obtains insured coverage from a non-covered carrier), then the employer should work with its TPA to make sure the plan design is not discriminatory. The TPA may require the employer to provide an indemnification if the employer decides not to cover gender transition services. Compliance with the nondiscrimination notice, statement, and tagline requirements is not required.

4. If further assistance is needed, reach out to your Wells Fargo Insurance consultant.

Recent interpretations of EEOC wellness program rules

In brief:

- The EEOC Office of Legal Counsel recently published an informal discussion letter stating that the maximum incentive for a given wellness plan is determined by the lowest cost self-only option, even if that option is not the one in which the employee is actually enrolled.
- In addition, a federal court recently ruled in EEOC v. Orion Energy Systems, Inc. that the ADA safe harbor provision does not apply to Orion's wellness program and retroactively applied the EEOC's final rules.
- Employers are advised to review their wellness programs to ensure that they are in compliance with the EEOC final rules under both the ADA and GINA.

On May 17, 2016, the U.S. Equal Employment Opportunity Commission (EEOC) issued final regulations concerning the impact that the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) have on employer wellness programs. These rules finalize two sets of proposed regulations that the EEOC previously issued enforcing Title I of the ADA and Title II of GINA. For more information on the EEOC final rules, see our May 20, 2016 Employee Benefits Compliance Alert, April 22, 2015 Employee Benefits Compliance Alert, and November 2015 Employee Benefits Compliance Update. Two recent developments provide clarification on the final rules and highlight the need for additional guidance on how these rules impact employer wellness programs.

EEOC Office of Legal Counsel informal discussion letter

On July 1, 2016, the EEOC Office of Legal Counsel published an informal discussion letter (not an official opinion) to clarify how to calculate compliant incentive limits for employer wellness programs in accordance with the EEOC final rules. The EEOC final rules explain that an employer may offer limited incentives for employees and their spouses as part of a wellness program. The final rules clarify that under the ADA, incentives are limited under an employer wellness program that asks employees disability-related inquiries and/or requires medical examinations. Under GINA, incentives are limited when the employer wellness program asks the employees for genetic information about their spouses' current or past health status.

The informal discussion letter describes a fact pattern in which an employee must be enrolled in one of an employer's three major medical health plan options in order to be eligible for incentives under the employer's wellness program. The letter states that under the ADA and GINA final rules, "when an employer has more than one group health plan and enrollment in a particular plan is not required to participate in a wellness program that collects health information, the incentive limit is calculated using the total cost of the lowest cost self-only coverage under a major medical group health plan." In other words, in calculating the wellness incentive under both rules, the maximum incentive is determined by the lowest cost self-only option, even if that option is not the one in which the employee is actually enrolled.

EEOC v. Orion Energy Systems, Inc.

On September 19, 2016, the U.S. District Court for the Eastern District of Wisconsin ruled on the EEOC challenge to a wellness program sponsored by Orion Energy Systems, Inc. (Orion). In the original 2014 case, the EEOC claimed that Orion's wellness program was not "voluntary" and violated the ADA because employees who enrolled in the health plan were required to either complete a health risk assessment (HRA) or pay 100 percent of their monthly premium amount. (An employee who completed the HRA paid no monthly premium, whereas an employee who did not complete the HRA paid $413.43 a month for single coverage, $744.16 a month for limited family coverage, and $1,139.83 a month for family coverage.) The HRA consisted of a health history questionnaire and a biometrics screening that included health tests and a blood draw analysis. Orion argued that the wellness program was protected under the ADA's insurance "safe harbor" provision, and alternatively that its wellness program was "voluntary" under the ADA.

ADA safe harbor

The court ruled that the ADA safe harbor provision does not apply to Orion's wellness program and retroactively applied the EEOC's final rules. The court stated that there is not an exemption under ADA for activities related to a health insurance plan that includes activities based on underwriting, classification, or administering risk. The court clarified that the EEOC has the authority to determine that the safe harbor provision does not apply to wellness programs that require involuntary medical examinations and inquiries.

This decision is at odds with decisions made in two prior cases, Seff and Flambeau, where the courts broadly interpreted the ADA safe harbor to defend employer wellness programs. The Seff and Flambeau courts concluded that the ADA safe harbor protections enabled employers to design insurance benefit plans that require otherwise prohibited medical examination and inquiries as a condition of enrollment in an insurance plan.

ADA voluntary requirement

Under the EEOC final rules, an employer generally cannot ask an employee to answer medical inquiries or undergo a medical examination, but there is an exception if this information is provided on a "voluntary" basis as part of a health program. A voluntary wellness program cannot require an employee to participate in the plan. Additionally, a voluntary wellness program cannot deny health coverage to an employee who does not participate in the wellness program. Finally, the employer must comply with incentive limits and provide notice and avoid retaliatory conduct for a wellness program to be voluntary.

The Orion court ruled that Orion's wellness program was voluntary even though employees who chose not to complete the HRA had to pay 100 percent of the health plan premium. The court explained that "Orion's wellness initiative is voluntary in the sense that it is optional . . . There may be strong reasons to comply with an employer's wellness initiative, and the employee must balance the considerations in deciding whether to participate or not. But a 'hard choice is not the same as no choice'." The court did not retroactively apply the EEOC final rule incentive limits, which the Orion design would not meet.

Next steps

It is likely that additional guidance and court cases will provide insight as to how the EEOC final rules impact employer wellness programs. In the interim, employers that sponsor wellness plans should review these arrangements to ensure that they are in compliance with the EEOC final rules under both the ADA and GINA. Wellness programs that are a part of a group health plan must also be reviewed for compliance with the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA).

2016 transitional reinsurance fee reporting due soon

In brief:

- The reinsurance fee for the 2016 benefit year is $27 per covered life.
- The number of covered lives must be reported no later than November 15, 2016.

Background

The ACA established the transitional reinsurance program to provide payments to health insurance issuers that cover high-risk individuals, and to more evenly spread the financial risk of issuers. The reinsurance program is funded by contributions collected from health insurance issuers and certain self-insured group health plans to cover costs for high-cost individuals enrolled in non-grandfathered reinsurance-eligible individual market plans. Contributions are required for the 2014, 2015, and 2016 benefit years, and fees are deductible as an ordinary and necessary business expense.

For more information about the transitional reinsurance program, please see our Benefits Compliance Updates from October 2015, March 2015, December 2014, November 2014, August 2014, June 2014, and January 2014, as well as our Benefits Compliance Alert issued on November 17, 2014.

2016 fees and deadlines

For the 2016 year, the number of covered lives must be reported to the Department no later than November 15, 2016. The Department will then notify reporting organizations no later than December 15, 2016, of the amount of the fee that will be due and payable.

The reinsurance fee for the 2016 benefit year is equal to $27 per covered life. The fee can be paid in full by January 17, 2017, or in two parts; $21.60 towards reinsurance payments and administrative expenses payable by January 17, 2017, and $5.40 towards payments to the U.S. Treasury payable by November 15, 2017. 2016 is the third and final year of the transitional reinsurance program.

Important information

- If a contributing entity registered on Pay.gov in 2014 or 2015, it will need to confirm its password but will not need to register again. Multiple Pay.gov accounts per Legal Business Name (LBN) or Tax Identification Number (TIN) should NOT be created.
- The Centers for Medicare & Medicaid Services (CMS) released the 2016 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form on the Pay.gov website on October 3, 2016. Please make sure to use the 2016 form. The form for 2015 is also available on the Pay.gov website, but there is a separate form for each benefit year.
- Self-insured, self-administered group health plans that do not use a third party administrator (TPA) in connection with claims processing or claims adjudication or plan enrollment are NOT Contributing Entities and are not required to make contributions. Exceptions permit the use of TPAs for (a) pharmacy benefits and/or excepted benefits; (b) de minimis administrative services for medical benefits; and/or (c) leasing of provider networks and related services.
- Supporting documentation is only required for Form submissions with four (4) or more Contributing Entities. If supporting documentation is required, the 2016 Supporting Documentation Job Aid is a macro-enabled Excel file on which Reporting Entity and Contributing Entity information is reported and the tool

creates the necessary .csv file. There is an associated 2016 Supporting Documentation Job Aid Manual for guidance on the process of using the Job Aid. Both are available to download on REGTA P and the CCIIO webpage.

- Payment of contributions may only be made on Pay.gov using an Automated Clearing House (ACH) debit. Many banks require prior approval for ACH transactions. A Contributing Entity should contact its bank to see if it needs to add the ALC+2 value to its allowed list. For 2016, the ALC+2 value for reinsurance contributions is 7505008016 and the Company ID is USDEPTHHSCMS. The bank approval process can take two to three weeks so, if necessary, should be commenced well in advance of the scheduled payment date.
- Make sure to check the scheduled payment date. Pay.gov will default to the next business day for payments, but this date can be changed. No refunds will be given if the next business day pay date is not changed.

Summary of reinsurance payment process

1. Calculate the Annual Enrollment Count using an approved method (CMS provided guidance with counting method examples in a July 17, 2014 release).
2. Register on Pay.gov, or confirm password if registered in 2014 or 2015.
3. Access the 2016 ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form.
4. Complete the Form. This includes providing Contributing Entity information when reporting for three or fewer Contributing Entities and entering the Annual Enrollment Count.
5. Upload Supporting Documentation if reporting for four (4) or more Contributing Entities.
6. Schedule payment for calculated contributions on the payment page.

San Francisco Health Care Security Ordinance update

In brief:

- As of January 1, 2017, the health care expenditure rates will increase under the San Francisco Health Care Security Ordinance.
- Employers required to satisfy the employer spending requirement should review their records to determine if they are in compliance for 2017.

Under the San Francisco Health Care Security Ordinance (SFHCSO), covered employers must satisfy the employer spending requirement by making required health care expenditures on behalf of covered employees. A covered employer is one who meets the following three conditions for any calendar quarter:

1. Employs one or more workers within the geographic boundaries of San Francisco;
2. Is required to obtain a valid San Francisco business registration certificate; and
3. Is a for profit business with 20 or more persons performing work, or a nonprofit organization with 50 or more persons performing work.

For purposes of counting employer size, employees are counted regardless of whether they live in San Francisco or not.

As of January 1, 2017, the health care expenditure rate will be $2.64 per hour for large businesses (100 or more employees total), and $1.76 per hour for medium-sized businesses (20-99 employees total). Covered employers are advised to make health care expenditures in accordance with the 2017 amounts on behalf of employees who have employed for more than 90 days and regularly work at least 8 hours per week in San Francisco.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.