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BENEFITS BULLETIN

Regulatory Updates

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NONDISCRIMINATION REGULATIONS APPLY TO HEALTH PLANS

Section 1557 of the Affordable Care Act (ACA) prohibited discrimination by affected entities based on race, color, national origin, age, disability and sex. The final rules implementing this prohibition were released by the Office of Civil Rights (OCR) on May 18, 2016.

Affected Entities – The nondiscrimination regulations have an expansive scope since they apply to "every health program or activity" any part of which receives federal financial assistance. "Federal assistance" is also defined broadly and the consensus is that it includes Medicare Part D subsidies (RDS, EGWP and Medicare Advantage plans). There is no exemption for HIPAA-excepted benefit plans, such as retiree-only plans, or limited scope dental and vision plans.

Any health plan receiving a Retiree Drug Subsidy, or that has an Employer Group Waiver Plan or Medicare Advantage plan, will have to comply with the nondiscrimination mandates.

Summary - The major changes in the new guidance that affect health plans are:

- Expanded requirements to provide assistance to persons with limited English proficiency and disabilities;
- Required coverage for gender dysphoria; and
- New notice requirements.

Language Assistance - The final rule requires a covered entity to provide accurate and timely language assistance services free of charge to persons with limited English proficiency. This includes providing oral interpreters or written translations.

- Covered entities with 15 or more employees must designate at least one employee as their nondiscrimination coordinator. This person must, among other things, investigate any alleged grievances.
- All covered entities are "encouraged" to develop a "language access plan." The development of such a plan will be taken into account when enforcing the Final Rule and Section 1557.

The regulations specifically state that plans cannot require participants to provide their own interpreters/translators.

Accommodations for Persons With Disabilities - The regulations require reasonable accommodations that ensure effective communications to individuals with disabilities by providing access to auxiliary aids and services, including alternative formats and sign language interpreters.

The regulations also require that the parts of the buildings that are accessed by plan participants be accessible to persons with disabilities. The specifics vary based on the building's construction date.

Compliance with the language and disability accommodation provisions of Section 1557 could be very difficult – especially for small plans. The only option may be to contract with a vendor who can provide these services.

Benefits for Gender Dysphoria/Transitioning - Plans cannot have blanket exclusions for health services related to gender dysphoria and gender transitioning. (The commentary in the rules describes such exclusions as "outdated.") Transgender services cannot be subject to lower than normal limits or benefits.

Although plans can continue to exclude services and procedures that are cosmetic or not medically necessary, the preamble to the regulations indicates that medical necessity denials will be subject to careful scrutiny to assure that the reason for the denial is not a pretext for discrimination.

Sample Coverage Provision - Below is a sample coverage provision that we believe satisfies the new requirement to cover medically necessary gender reassignment procedures:

> The Plan will cover gender transitioning or reassignment services for a covered person age 18 years or older when the Plan's review organization has determined the services to be medically necessary, appropriate, and within the standard of care. Cosmetic procedures and treatments in connection with gender reassignment, including any complications arising from such services, are not covered. For example, the Plan will not cover abdominoplasty, breast augmentation, chin/nose implants, hair removal or transplantation or voice surgery/therapy.

Notice Requirements – The notice requirements in the Final Rules are very confusing. This is unfortunate since there is no delayed effective date or transition rule for the notice requirements.

The basic requirement is that the affected plan take "**appropriate initial and continuing steps to notify**" participants:

- Of its nondiscrimination policy;
- That it provides language assistant services;
- That it provides appropriate free auxiliary aids and services where necessary, and how to obtain these services;
- Of the identity of the person responsible for compliance (if the plan has 15 or more employees);
- About the availability of a grievance procedure (also for plans with 15 or more employees); and
- How to file a discrimination complaint with OCR.

These notifications must be "posted" and included in significant participant communications. Clarification is needed as to which communications are considered "significant," and whether or not an annual notice will suffice. In the meantime, we recommend that plans create a short notice that satisfies the basic requirements and includes the 15 non-English taglines (see below). To distribute the notice, we recommend:

- Mailing an initial notice by October 17, 2016;
- Adding it to the next edition of the SPD;
- Adding it to all SMMs starting October 17, 2016; and
- Posting it on the Plan's website.

Non-English Taglines - All "significant" communications must contain taglines (short statements) in other languages advising participants of the availability of assistance.

- The taglines in longer communications must be in the top 15 languages spoken in the entity's state. (It doesn't matter if there are any speakers of a particular language in the plan.) If the covered entity serves individuals in more than one state, it can aggregate them and determine the top 15 languages in all its states.
- Small-sized communications such as postcards and trifolds need to include the taglines in the top two languages. Note that this is very different than the criteria

used by ERISA and the SBC requirements.

Absent additional guidance, the most prudent course of action may be to distribute a compliant nondiscrimination notice by **October 17, 2016.** Please check with the fund's attorneys to see if they agree.

Grievance Procedure - Covered entities with 15 or more employees must adopt a grievance procedure.

Implementation Dates - The notice requirement must be implemented by October 17, 2016. The coverage mandate is effective for Plan years beginning on or after January 1, 2017.

IMPORTANT
Plan administrators should consult with Fund Counsel as soon as possible regarding Section 1557's effect on their plans.

Resources

Final Nondiscrimination Rules: *https://www.federalregister.gov/articles/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities?utm_campaign=subscription+mailing+list&utm_medium=email&utm_source=federalregister.gov*

Sample Nondiscrimination Notice: *http://www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf.*

Top 15 non-English languages by state: *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf*

Taglines in various languages: *http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/*

MAJOR CHANGES PROPOSED FOR FORM 5500

On July 21, 2016 the DOL, the IRS and the PBGC jointly issued proposed revisions to the Form 5500 annual reporting form. The proposed changes would completely restructure the Form 5500 and its related schedules, and significantly increase the time required for information gathering and form completion.

Much More Data Will Be Required - Under the proposed rules, a health or pension plan would be required to disclose:

- More information on the fees it pays;
- The number and type of investment alternatives offered (for self-directed retirement plans);
- Schedule C information for additional services providers;
- More detailed Schedule H information;
- Plan design, funding, categories and benefit offerings for various participant categories;
- Numbers of COBRA offers and elections;
- Information on TPAs, utilization review managers, prescription benefit managers, wellness program managers, etc.;
- Claims information, including the numbers and dollar amounts of claims approved, denied, pended, etc.;
- Claims and appeals timing; and
- Compliance information

Compliance Date - The revised Form 5500 will apply to plan years beginning on or after January 1, 2019. Comments on the proposed revisions are due by October 4, 2016. The complete text of the proposals are posted on the DOL's website: *https://www.dol.gov/ebsa/.*

CHANGES TO FORMS 1094-C and 1095-C

In August 2016 the IRS issued draft versions of the forms employers must use to satisfy their ACA reporting requirements for calendar year 2016. The changes are meant to clarify some of the confusing instructions, and to remove information about expired transition rules.

The draft instructions for Lines 14 and 16 on Form 1095-C, two lines of special interest to employers contributing to multiemployer plans, are slightly expanded, but are essentially the same as last year. Also like last year, the instructions warn that changes are coming in the reporting requirements for employers in multiemployer plans.

EEOC/ADA FINAL WELLNESS RULES

On May 17, 2016 the Equal Employment Opportunity Commission (EEOC), which regulates the Americans with Disabilities Act (ADA), issued final ADA rules governing wellness programs. **Any wellness program that involves a disability-related inquiry or requires a medical exam are subject to the new ADA rules.** The EEOC/ADA wellness program rules were issued May 17, 2016. Wellness programs must also comply with HIPAA rules, which are regulated by HHS, DOL and IRS.

The ADA's basic requirements for wellness programs are similar to HIPAA's rules, although the EEOC's focus is on keeping wellness programs voluntary and not burdensome. The ADA rules allow monetary incentives/penalties of up to 30% of the cost of coverage. HIPAA also permits a 30% incentive, but the ADA and HIPAA define the cost of coverage differently. HIPAA uses the cost of coverage in which the participant is enrolled, while the ADA bases the cost on employee-only coverage.

- Smoking-cessation programs that screen for tobacco usage through biometrics or an exam are "disability-related" and are limited to the 30% incentive limit. (HIPAA rules allow a 50% incentive.) Programs that determine smoking behavior based on self-reporting, however, are not disability-related and can provide the higher incentive.
- In related regulations governing GINA (the Genetic Information Nondiscrimination Act), the EEOC's final rules also limit the incentive for spousal participation in an ADA-governed wellness program to 30% of the cost of self-only coverage. This doubles the permissible incentive amount for a husband-and-wife program.
- The ADA rules do not permit plans to provide incentives in exchange for health information (which includes health questionnaires) about an employee's biological and non-biological children.

Required Notices - Plans must provide participants with understandable notices that describe the type of medical information that will be collected and how it will be used. The notice should explain with whom the person's medical information will be shared, and how it will be protected.

Compliance Date - The EEOC/ADA wellness program rules apply to plan years on or after January 1, 2017.

Resources

The rules are available at: *https://www.federalregister.gov/articles/2016/05/17/2016-11558/regulations-under-the-americans-with-disabilities-act*

The sample notice is posted at: *https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm*

REMINDER - TRANSITIONAL REINSURANCE

Plans that are required to pay ACA's transitional reinsurance fees should register to pay by November 15, 2016. This is the third and final year for the fees, and the amount due is $27 per covered person. Self-insured and self-administered plans are not required to pay the fees for the second and third years. COBRA participants are included, but Medicare-primary participants are excluded.

BENEFIT ISSUES

Robotic Assisted Surgery - Some surgeons are using robotic systems to assist them during certain surgical procedures. Note that there should be no additional charge for using this new technology. Providers should bill for the primary surgical procedure without listing or billing extra for the robotic assist.

Replacement Dental Implants - If a dental plan covers tooth implants, it may need a policy for replacement implants. Implants, which are usually permanent, have been known to fracture, especially if they were placed using older techniques. Implant manufacturers usually warranty their products for ten years, and some dentists guarantee them for the patient's lifetime. The majority of dental insurers cover necessary replacements every five (5) years, but some plans limit to every seven (7) years. We recommend that plans adopt one of these two frequency limitations.