WELLS FARGO INSURANCE

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Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice

In this issue — Page

- Trump Administration issues ACA Executive Order — 1
- Enforcement of ACA Section 1557 HHS nondiscrimination regulations partially enjoined — 2
- Departments issue ACA FAQs (Part 37), which include guidance on HRAs integrated with other employer plans — 3
- Notices and forms for wellness programs — 3
- HHS updates federal poverty level figures — 4
- Final rules issued for disability benefits claims and appeals procedures — 6
- Employer obligations to disclose "creditable" status of prescription drug coverage includes online reporting to CMS under Medicare Part D rules — 7
- Final rules for tribal employers participating in the Federal Employees Health Benefits Program — 8

Together we'll go far

Trump Administration issues ACA Executive Order

In brief:

- President Trump issues an Executive Order announcing it is the policy of his Administration to seek the prompt repeal of the ACA, and directs all federal agencies to minimize the economic burden of the law pending its repeal.
- While the issuance of the Order suggests that federal agencies will be more flexible in granting various waivers and exceptions, there are limits on how much action can be taken by administrative actions to unwind the ACA.
- Accordingly, it is important for employers to continue to comply with the ACA, including the ACA reporting requirements for the 2016 filing season, unless and until definitive action is taken by the applicable federal agencies or Congress.

As promised during his campaign, one of the first Executive Orders signed by President Trump on Friday, January 20, 2017, concerned the Affordable Care Act (ACA). In very broad sweeping language, the Executive Order directs all federal agencies to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the ACA that imposes a fiscal burden on any State or any cost, fee, penalty, or regulatory burden on any individual, families, health care providers, health insurers, purchasers of health insurance, and various other stakeholders in the health care industry.

The implementation of this order is left to the applicable federal agencies, but as the Order acknowledges any such actions are allowed only to the extent permitted by law (which, among other things, includes having to follow the Administrative Procedures Act to change any regulations previously issued through notice-and-comment rulemaking that are already effective). Nevertheless, once various senior policy level appointments are made at Department of Health & Human Services, Department of Labor, Treasury Department, Internal Revenue Service, and Centers for Medicare & Medicaid Services, the issuance of this order suggests the Administration's views on how the ACA should be implemented by the applicable federal agencies. States may be given greater flexibility to address their own health care issues by granting more approval waivers for certain state-based programs (such as ACA section 1332 waivers that allow states to design their own alternative coverage models within certain parameters, or Medicaid section 1115 waivers allowing states greater leeway to impose cost-sharing rules and various personal responsibility features to their state Medicaid programs).

Nevertheless, it appears that granting sweeping exemptions or implementing broad non-enforcement policies with respect to the individual and employer shared responsibility mandates (including their associated reporting requirements) may be more legally problematic because of the statutory structure of these ACA provisions and the fact that most of these ACA rules are already subject to regulations previously issued through notice-and-comment rulemaking. (Some of these potential legal limitations are discussed by the Congressional Reporting Service's report "Affordable Care Act Executive Order: Legal Considerations"). In addition, from a practical perspective, it is unclear whether taking such action prior to ACA replacement legislation coming into better focus will trigger the withdrawal of even more health insurers from the already fragile individual market.

Thus, it remains to be seen whether this Executive Order will be more directional or substantive in nature. Accordingly, it continues to be prudent for employers to comply with the ACA as currently enacted and implemented with final regulations (including ACA reporting for the 2016 filing season) unless and until action is actually and definitively taken by the applicable regulatory agencies.

Enforcement of ACA Section 1557 HHS nondiscrimination regulations partially enjoined

In brief:

- HHS is enjoined from enforcing ACA Section 1557 regulations against covered entities with respect to discrimination based on gender identity or termination of pregnancy.
- Nevertheless, covered and non-covered employers may want to proceed cautiously before reversing any plan design changes concerning gender transition services they have made to their group health plans.
- Depending on an employer's risk tolerance, eliminating categorical exclusions of all gender transition services still appears to be prudent, but providing less than full and comprehensive gender transition services may now be more attractive.

On December 31, 2016, a federal district court judge from Texas issued a nationwide injunction preventing the Department of Health and Human Services (HHS) from enforcing its regulations under Section 1557 of the Affordable Care Act (ACA) as they apply to "covered entities" with respect to discrimination based on gender identity or termination of pregnancy. Note that this injunction does not affect other aspects of the Section 1557 regulations, including its complicated notice requirements. See our October 2016 and June 2016 Employee Benefits Compliance Updates for background information concerning the Section 1557 regulations.

Background

While the Section 1557 regulations did not directly require covered entities to cover any specific types of gender transition services, they did provide that covered entities' group health plans should not discriminate based on gender identity and that a categorical exclusion of all gender transition services was discriminatory. In addition, even if they were not a covered entity directly subject to the 1557 regulations (which is generally limited to entities receiving federal funds from HHS), employers that generally receive any federal funding still have litigation exposure based on the statutory provision itself unless and until it is repealed. In addition, all employers (covered or non-covered) face litigation exposure directly by the Equal Employment Opportunity Commission (EEOC) based on its interpretation of the federal nondiscrimination laws that sex discrimination includes discrimination based on gender identity. As a result, most health carriers added gender transition coverage to their insured policies for plan years beginning on or after January 1, 2017. In addition, most third-party administrators requested self-insured employers to specifically identify whether they wanted to cover such services or not.

Potential response strategies

In light of the injunction, what should employers do? One approach is to continue with plan design decisions previously made and put into effect for the 2017 plan year. Amending a group health plan to eliminate gender transition services likely will not save the employer a significant amount of insurance or stop-loss premium expense due to the low utilization of such services, provided the services were subject to good medical management techniques and treatment protocols. Also, not providing comprehensive gender transition services could potentially cost the employer money in the long-run in terms of higher mental health claims and reduced employee productivity. In addition, the issue of whether sex discrimination includes discrimination based on gender identity and whether any federal regulations that adopt this interpretation violate the Religious Freedom Restoration Act or another federal law is likely going to be litigated for some time. Thus, all employers would still face some litigation exposure if they reverse course now.

On the other hand, non-covered employers with a self-insured group health plan that already decided not to expand their gender transition services policy, or any employer that has not yet finalized its non-calendar year plan, may have a little more flexibility to not provide comprehensive gender transition services at this point. In fact, in light of the injunction, we understand that at least one health issuer is considering modifying the terms of its insured health plans to only provide gender transition services through the counseling phase, which would not include surgery benefits. Depending on risk tolerance, employers with a self-insured group health plan could follow this alternative approach.

Departments issue ACA FAQs (Part 37), which include guidance on HRAs integrated with other employer plans

In brief:

- HRAs generally must be integrated with a non-HRA group health plan in order to meet the ACA's prohibition on annual dollar limits under PHS Act section 2711 and the ACA requirement to cover certain preventive services without cost sharing.
- HRAs of one employer can be integrated with group health plans of another employer, such as the employer of a spouse of an employee.
- ACA FAQs (Part 37) clarify that a family HRA can be integrated with a non-HRA group health plan of the employer of the employee's spouse if that other plan covers the same individuals as those covered under the family HRA.
- The FAQs further clarify that an employer's HRA coverage of employees and family members can be integrated with a combination of that employer's non-HRA group health plan and another employer's non-HRA group health plan.

On January 12, 2017, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, "Departments") released FAQs about Affordable Care Act (ACA) Implementation (Part 37). Of most importance to employers were the first two questions and answers relating to health reimbursement arrangements (HRAs) and the similar concept of "employer payment plans" (EPPs). Both HRAs and EPPs are typically arrangements where an employer reimburses employee (and, often family) medical expenses, usually also including premiums, up to a certain dollar amount. However, HRAs and EPPs are viewed as "group health plans" subject to certain ACA market reform mandates, particularly the prohibition on annual dollar limits and the requirement to provide certain preventive services without cost sharing. Guidance dating back to 2013 views such HRAs and EPPs as failing to comply with these mandates (although mandates do not apply to Qualified Small Employer Health Reimbursement Arrangements, which are discussed in our January 2017 Employee Benefits Compliance Update). However, HRAs and EPPs can comply if they are "integrated" with another group health plan that otherwise complies with such mandates. See our October 16, 2013 Legislative Alert for a thorough explanation of such integration.

One type of integration, which may be unusual, is between an employee's family HRA with one employer and a non-HRA group health plan with another employer, typically the employer of the employee's spouse. The first two FAQs address this type of integration. The first FAQ reiterates this is permissible, provided the other employer non-HRA group health plan covers all the individuals covered by the family HRA. An employer can rely on a reasonable representation from the employee that all such individuals have non-HRA coverage meeting integration requirements. The second FAQ adds that the non-HRA coverage can consist of coverage through a combination of coverages. One example would be an employee covered under self-only coverage under a non-HRA group health plan of the employee's employer, and a spouse and any dependent children's coverage under the non-HRA group health plan of the spouse's employer.

Notices and forms for wellness programs

In brief:

- Wellness programs may need to provide an ADA notice and/or obtain the spouse's signature on a GINA consent form, depending upon the healthcare information being requested by the wellness program.

As stated in our July 2016 Employee Benefits Compliance Update, the EEOC has issued a sample notice as well as guidance in the form of Q&As to assist employers in complying with the new wellness notice requirement. Depending upon the healthcare information being requested by a wellness program, the Americans with Disability Act (ADA) Notice and the Genetic Information Nondiscrimination Act (GINA) Consent Form may be required in the context of an employer sponsored wellness program.

EEOC sample notice

The EEOC sample notice must be distributed to employees and spouses participating in a wellness program that has inquiries or medical examinations as of the first day of the plan year that begins on or after January 1, 2017.

The EEOC sample notice is required if an employer wellness program asks disability related questions or has medical examinations. A "medical examination" is defined as "a procedure or test that seeks information about an individual's physical or mental impairments or health." The following factors are considered in determining whether or not there is a medical examination in the context of a wellness examination: (1) whether the test is administered by a health care professional; (2) whether the test is interpreted by a health care professional; (3) whether the test is designed to reveal an impairment or physical or mental health; (4) whether the test is invasive; (5) whether the test measures an employee's performance of a task or measures his/her physiological responses to performing the task; (6) whether the test normally is given in a medical setting; and (7) whether medical equipment is used. A "disability-related inquiry" is a question or series of questions "that is likely to elicit information about a disability." Prohibited questions include questions about disabilities, workers' compensation history, and prescription drug use.

The EEOC sample notice must include what type of medical information is being collected, how it will be used and how it will be protected. The EEOC sample notice can be included with other ERISA disclosures as long as it reaches the participant.

GINA sample notice

In the context of a wellness program, if a spouse conducts a health risk assessment (HRA) that includes family medical history, there is a notice requirement that takes the form of an authorization which must be signed by the spouse effective January 1, 2017.

GINA generally prohibits employers from requesting, requiring, or purchasing "genetic information" of an individual or family member of the individual. GINA defines genetic information as including family history. Wellness programs that ask family medical history questions on a health risk assessment for employees, and health risk assessments or biometric screenings for an employee's family members often contain genetic information. A GINA authorization is required if a group health plan provides an incentive to an employee whose spouse (i) is covered by the plan; (ii) receives health or genetic services, including as part of a wellness program; and (iii) provides information about current or past health status through an HRA. GINA requires that the spouse provide knowing, written and voluntary authorization prior to the spouse completing the HRA.

While there is no sample GINA authorization from the government, the ADA sample notice can be used to satisfy the GINA authorization requirement if a signature line is added. Generally, it is best practice that the GINA authorization is distributed apart from open enrollment materials to ensure that the spouse can sign the authorization.

HHS updates federal poverty level figures

In brief:

- HHS recently updated federal poverty level (FPL) guidelines for 2017.
- These guidelines are important under the ACA for many individuals with respect to their eligibility for federal subsidies when purchasing Marketplace coverage and for Medicaid eligibility.
- Employees' eligibility for subsidies and Medicaid can also be important for employers under the "play or pay" mandate.
- New FPL guidelines increase the 2017 dollar amount for employers using the 100% of FPL "affordability" safe harbor to $97.38 per month (though just $95.93 for plans on a calendar plan year).

The U.S. Department of Health and Human Services published its annual update of poverty guidelines in the January 31, 2017 Federal Register. These guidelines are important to many aspects of the Affordable Care Act (ACA).

Individual eligibility for federal subsidies for Marketplace coverage

Individuals must meet several requirements to qualify for federal subsidies when purchasing Marketplace coverage. One such requirement is that their household size and household income places them between 100% and 400% of the federal poverty level (FPL), which is generally determined based on information provided through their federal income tax return for a given calendar year. Ideally, individuals falling below 100% of FPL will otherwise qualify for Medicaid (as discussed in the following section) or perhaps other assistance, while those above 400% of FPL are considered too high-income to qualify for federal assistance.

Individual eligibility for Medicaid in states approving ACA expanded Medicaid

In states that have elected to expand Medicaid pursuant to the ACA, individuals generally are eligible for Medicaid if they live in a household in which the household size and income places them at or below 138% of the FPL. States that have not expanded Medicaid generally have separate schedules for eligibility based on a percentage of the FPL. In some, there are separate criteria with respect to eligibility for children compared to adults, with thresholds typically being easier to meet for children. Especially for employees who are residents in Medicaid-expansion states, employers may want to keep employees informed of these thresholds. Employees enrolled in Medicaid typically will have no need for employer coverage and will not trigger penalties on employers under the ACA.

100% of FPL "affordability safe harbor" for employers subject to the "play or pay" mandate

For 2017, all "applicable large employers" (ALEs) may be at risk of employer "play or pay" penalties if they fail to offer full-time employees health coverage that meets "minimum value" and is "affordable." Regulations provide three affordability "safe harbor" methods for employers to be assured that coverage is affordable. One such method requires an employee's contribution for a calendar month for the lowest cost self-only coverage that provides 60% minimum value does not exceed 9.5% (indexed) of a monthly amount determined at the FPL for a single individual for the applicable calendar year, divided by 12. The applicable 9.5% (indexed) percentage for 2017 is 9.69%. For 2017, the FPL for a single individual in all states, including the District of Columbia (though excluding Alaska and Hawaii, which have slightly higher thresholds), is $12,060. Based on that amount, the monthly safe harbor premium for 2017 is $97.38. Thus, an ALE offering an employee self-only coverage that provides 60% minimum value at or below $97.38 per month (with slightly higher amounts for employees resident in Alaska or Hawaii) can rely on this employee not triggering an employer play or pay penalty for each such month.

Note that the final regulations on the FPL safe harbor provide that employers can use any FPL threshold in effect within six months "before the first day of the plan year." Thus, it appears that plans with a plan year beginning January 1, 2017, must use the 2016 100% FPL threshold in assessing the affordability of employee only coverage, which would equate to a maximum monthly employee contribution amount of $95.93. For plans with a plan year beginning on or after February 1, 2017, the employer may choose to use the 2017 amount of $97.38 or a lesser amount and still meet the FPL safe harbor.

The 2017 FPL guideline numbers

Persons in family/ household	Poverty guideline	400% of FPL	138% of FPL (Medicaid Threshold)
1	$12,060	$48,240	$16,394
2	$16,240	$64,960	$22,108
3	$20,420	$81,680	$27,821
4	$24,600	$98,400	$33,534
5	$28,780	$115,120	$39,247
6	$32,960	$131,840	$44,960
7	$37,140	$148,560	$50,687
8	$41,320	$165,280	$56,428
Each additional member	$4,180	$16,720	$5,741

Final rules issued for disability benefits claims and appeals procedures

In brief:

- The DOL has finalized changes to the rules governing disability benefits claims and appeals.
- The final rules largely mirror the ACA updates to claims and appeals procedures for group health plans, and provide greater protections to claimants.
- The final rules generally apply to disability benefit claims filed on and after January 1, 2018.

On December 19, 2016, the Department of Labor (DOL) published final changes to the claims and appeals procedures for disability benefits found at 29 CFR §2560.503-1, which are substantially similar to the proposed changes previously published on November 18, 2015 (see our December 2015 Employee Benefits Compliance Update). These final rules apply to any claim for benefits filed on and after January 1, 2018 under a welfare or retirement plan that is conditioned upon a showing of disability where the disability determination is made by the plan. The rules provide greater procedural protections to claimants, and impose additional responsibilities on plan administrators.

Following are some of the highlights of the new guidance.

Requirements for written benefit denial notices – A notice of adverse benefit determination must contain:

- A complete discussion of why the claim was denied and, if applicable, include the reasons for disagreeing with findings by health care professionals, vocational professionals, or the Social Security Administration.
- The specific internal rules, guidelines or standards of the plan that were relied upon in making the decision (not just a statement that those rules will be provided upon request), or a statement that none were used.
- If the denial is based on a plan exclusion or limit such as medical necessity or experimental treatment, either (1) an explanation of any scientific or clinical judgment, applying the plan terms to the claimant's medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.
- A statement that the claimant is entitled to receive copies of the claim file and other relevant documents, upon request and free of charge.
- A statement of the claimant's right to bring an action under §502(a) of ERISA, and any applicable plan-imposed contractual deadline for bringing an action, including the specific calendar date of such deadline.

Notices written in a culturally and linguistically appropriate manner - If a claimant lives in a county where 10% or more of the population is literate in only a non-English language, all notices must include a prominent statement in the non-English language explaining how to access oral and written language services provided by the plan. The plan must provide oral language services (such as a telephone customer assistance hotline) in the applicable non-English language to answer questions and assist with filing claims and appeals. The plan must also provide a notice written in the applicable non-English language upon the claimant's request.

Claimant's right to review and respond to new information before final decision – The plan's claims procedures must provide that the plan cannot deny a claim on appeal without first having given the claimant notice of any new or additional evidence or rationale the decision maker is considering that was not part of the initial benefit denial, nor without having allowed the claimant a reasonable opportunity to respond to the new information.

Avoiding conflicts of interest - The plan must take steps to ensure the impartiality and independence of individuals involved in making the disability determination (e.g., an internal or third party claims adjudicator or medical or vocational expert), including not basing hiring, promoting, or compensation decisions on the likelihood that the person will support denying benefits.

Deemed exhaustion of claims and appeal processes - If a plan does not establish and follow compliant claims procedures, a claimant will be deemed to have exhausted the administrative remedies available under the plan and is free to pursue an action in court, where the claim will be considered denied without the exercise of discretion by a fiduciary and decided by the court de novo. There are limited exceptions where the violation was the result of a minor error and other specified conditions are met.

Certain coverage rescissions are adverse benefit determinations - A retroactive cancellation of disability coverage is considered to be an adverse benefit determination that triggers the claims procedure protections (even if there is no adverse effect on any benefit at that time), unless the cancellation is due to the claimant's failure to timely pay required contributions toward the cost of coverage.

Employer obligations to disclose "creditable" status of prescription drug coverage includes online reporting to CMS under Medicare Part D rules

In brief:

- Medicare Part D requires employers to disclose the "creditable" status of prescription drug coverage to all plan enrollees (and those seeking to enroll) who are eligible for Medicare Part D at least once per year and also to CMS.
- The disclosure to CMS is completed online and is due within 60 days of the beginning of plan year, within 30 days of termination of coverage, and within 30 days of a change in creditable coverage status.

With very limited exception, all employers sponsoring group health plans providing prescription drug coverage, whether insured or self-insured ("Rx Plan Sponsors"), must meet two Medicare Part D disclosure requirements. The first is the requirement to disclose the "creditable" status of the prescription drug coverage to all plan enrollees (and those seeking to enroll) who are eligible for Medicare Part D at least once per year. While many Rx Plan Sponsors may be aware of the annual enrollee disclosures, they may not be aware of the second requirement, which is to disclose such status, along with some additional information, to the Centers for Medicare & Medicaid Services (CMS).

The CMS disclosure is done online. An Rx Plan Sponsor can make a single disclosure covering multiple plan options, even if some options are creditable and others are not. Other items needed in the disclosure include:

- Plan year beginning and end date (this cannot exceed 365/366 days).
- Number of Part D-eligible individuals expected to be covered – presumably this is just a "best guess" number due to the difficulty in specifically identifying Part D-eligible individuals, though some attempt should be made to obtain an accurate number, perhaps with assistance of an insurance carrier, third party administrator, or pharmacy benefits manager.
- Date the creditable coverage notice was provided to Part D-eligible individuals.

Due date

1. Within 60 days of the beginning of plan year;
2. Within 30 days of termination of coverage; and
3. Within 30 days of a change in creditable coverage status.

For most Rx Plan Sponsors, the key due date is the requirement to disclose within 60 days of the beginning of a plan year. For calendar year plans in 2017, this means completing the online disclosure no later than March 1, 2017. Thus, it is important for prescription drug plan sponsors to identify the status of their coverage as either creditable or non-creditable as soon as possible after the prescription drug coverage features are finalized for the plan year.

For more detailed information and frequently asked questions and answers, please see our Legislative Alert on this issue.

Final rules for tribal employers participating in the Federal Employees Health Benefits Program

In brief:

- Tribal employers that have an ISDEAA or IHCIA contract with the Federal government can participate in the Federal Employees Health Benefits Program by complying with final regulations recently published by the Office of Personnel Management.
- Eligible employees who enroll in the FEHB Program will choose among the same nationwide and local FEHB plans that are available to Federal employees.

On December 28, 2016, the Office of Personnel Management (OPM) published final regulations regarding access to the Federal Employees Health Benefits (FEHB) Program for employees of certain Indian tribal employers. The final regulations, which are effective February 27, 2017, contain the following rules:

Topic	Discussion
What tribal employers are eligible to participate in the FEHB Program?	• An Indian tribe or tribal organization carrying out at least one program under the Indian Self-Determination and Education Assistance Act (ISDEAA) • An urban Indian organization carrying out at least one program under Title V of the Indian Health Care Improvement Act (IHCIA)
Who is eligible for FEHB coverage within the tribal employer?	Full-time and part-time common-law employees of the tribal employer (if they are not excluded under rules set forth below), but only if the tribal employer has elected to purchase FEHB coverage for that employee's billing unit; family members are also eligible for coverage
Who is not eligible for FEHB coverage within the tribal employer?	Retirees and annuitants; volunteers; recipients of the Federal workers' disability programs in the past 365 days; individuals who are not common-law employees; and certain other employees
If the tribal employer has multiple billing units, which ones are eligible for FEHB coverage?	As long as the tribal employer purchases FEHB coverage for at least one billing unit carrying out programs or activities under the tribal employer's ISDEAA or IHCIA contract, the tribal employer may (but is not required) to purchase FEHB coverage for its other billing units
What is the minimum contribution from the tribal employer for employees enrolled in FEHB coverage?	The tribal employer is required to contribute to the premium for tribal employees at least the same as the Federal government does for its own employees, which currently averages out to 70% of the premium on a program-wide basis
What benefits are available under the FEHB Program?	Employees who enroll in the FEHB Program will choose among the same nationwide and local FEHB plans that are available to Federal employees
Can the tribal employer offer the FEHB Program as one option, along with other medical plan options offered by the employer?	No, the tribal employer cannot offer FEHB coverage to employees of a billing unit if those employees are offered an alternative employer-sponsored health insurance plan (with the exception of a collectively-bargained alternative plan); a stand-alone dental, vision, or disability plan is not considered alternative health insurance
How does the tribal employer make an initial election to purchase FEHB coverage?	The initial election can be made at any time, by contacting OPM

For more information, refer to the OPM website.

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.

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