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EMPLOYEE BENEFITS UPDATE

September 23, 2016
A Roundup of Recent Legal Developments Impacting Your Health and Welfare Plans

Executive Summary

- The Federal Government has issued a series of new rules addressing gender identity discrimination and transgender rights, which may impact the benefits that you are required to offer under your health insurance plans.
- The IRS issued proposed regulations on the treatment of "opt-out" payments that employees may receive for waiving an employer's medical coverage, providing that properly structured payments will not be considered employee contributions for purposes of determining whether the coverage that is offered is affordable under the employer-shared responsibility provisions of the Affordable Care Act (the "ACA"). The proposed regulations will apply beginning with the first plan year beginning on or after January 1, 2017, although they can be relied on immediately.
- Employers have started to receive notices from the Health Insurance Marketplaces informing them that one of their employees has been found eligible for a premium subsidy (either a premium tax credit or cost-sharing reduction) to help pay for health care coverage through the Marketplace. Although employers are not required to appeal these notices, there may be strategic advantages in doing so.
- The IRS has announced the dollar limitations that will apply in 2017 for health savings accounts ("HSAs") and high deductible health plans ("HDHPs"), including a change to the HSA contribution limits for individual coverage.

What You Should Do

- Consult your broker or legal counsel to determine what changes, if any, are needed to your health plan for 2017 to comply with the new rules impacting gender identity and transgender benefits. The rules apply differently to fully-insured plans, self-insured plans, and plans sponsored by federal government contractors and, in some cases, require additional notices and procedures to be put into place, as detailed below.
- If you offer opt-out payments to your employees for waiving health coverage, determine how those opt-out payments are classified under the proposed IRS regulations. If they are currently structured as "unconditional payments", determine what changes may be needed to have your opt-out payments count as an employer contribution under the affordability calculation of the ACA's employer-shared responsibility provisions.
- If you receive a Marketplace notice, determine whether you want to respond.
- Update your health plan documents and other communications, including annual open enrollment materials, to incorporate the revised HSA contribution limits for 2017.
- Remember to distribute your Medicare Part D notice to employees by October 14th.

The summer was a busy one for government agencies, as evidenced by the issuance of guidance in the form of proposed and final regulations, as well as the increase in enforcement actions. As we head into open enrollment season, it's worth taking the time to assess whether any of the new legal developments described below may impact your health plan design and require changes.

I. NEW GUIDANCE MAY REQUIRE YOUR HEALTH PLAN TO COVER TRANSGENDER BENEFITS

Gender transition and transgender benefits are in the spotlight due to the new rules issued this summer by the U.S. Department of Health and Human Services ("HHS") and by the Office of Federal Contract Compliance Programs ("OFCCP"), as well as the EEOC's position under Title VII of the Civil Rights Act of 1964. Although these rules are wide-ranging and impact areas beyond employee benefit plans (e.g., compensation reviews, pay discrimination, pregnancy discrimination), this Employee Benefits Update is limited to some of the key provisions that may impact your health and welfare plan design.

A. Final Regulations under ACA Section 1557

On May 13, 2016, the Office of Civil Rights of HHS issued final regulations under Section 1557 of the ACA, which prohibit "covered entities" from discriminating based on race, color, national origin, sex, age or disability in health programs and activities receiving financial payments from the federal government. The final regulations became effective July 18, 2016, and apply to calendar-year health plans as of January 1, 2017.

- ***What is a "Covered Entity"?***

Generally, covered entities include health programs and activities that receive federal financial assistance ("FFA"), insurers participating in a state or federal exchange, and all health programs funded by HHS.

If you sponsor a fully insured plan, your insurance carrier must comply with the requirements under the new regulations.

If you sponsor a self-insured plan, you will be subject to these rules if your plan receives FFA. If you sponsor a self-insured health plan for retirees with prescription drug coverage that receives the retiree drug subsidy ("RDS"), the more cautious approach would be to consider the health plan a covered entity. However, because under the RDS program the employer (not the group health plan itself) receives the payments, further clarification from HHS about these rules would be welcome so that plan sponsors can fully understand their obligations.

- ***What do the Section 1557 Final Regulations Require of a Covered Entity?***

Covered health plans, programs and activities that are subject to the Section 1557 rules must:

- Provide equal treatment to men and women in providing health care coverage and services.
- Not discriminate based on childbirth, sex stereotyping, pregnancy, false pregnancy, termination of pregnancy or recovery from pregnancy.

- Not discriminate based on gender identity, which includes identity as "male, female, neither, or a combination of male and female." Covered entities must treat transgender individuals consistently with their gender identity. If, however, a health service is ordinarily and exclusively available to one gender, it must also be provided to someone with a different gender identity if the service is necessary or appropriate.

Although the final regulations do not mandate any coverage of any specific itemized benefits, such as transgender surgery, the rules make clear that categorical coverage exclusions or limitations for health services related to gender transition will be considered discriminatory. However, appropriate medical management techniques to mitigate costs (such as requiring pre-authorization for any surgery) should continue to be appropriate.

Covered entities must also comply with new standards and processes involving equal access and language proficiency standards for people with disabilities. For covered entities with 15 or more employees, grievance procedures must be implemented, and a compliance coordinator must be appointed. There are also certain notice requirements and filing obligations with OCR that apply to covered entities regardless of size. Sample notice materials are available at: http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

B. Final OFCCP Regulations for Federal Government Contractors

On June 15, 2016, OFCCP released final regulations that set forth requirements for federal government contractors under Executive Order 11246, which prohibits employment discrimination on the basis of sex. The final OFCCP regulations became effective August 15, 2016, and apply to any company doing business with the federal government that meets the following threshold:

- Holds a single federal contract, subcontract, or federally assisted construction contract or subcontract in excess of $10,000; or
- Holds federal contracts or subcontracts that have a combined total in excess of $10,000 in any 12-month period.

The final OFCCP rules require employers to provide equal fringe benefits regardless of sex assigned at birth, gender identity, or recorded gender. For this purpose, fringe benefits include medical, hospital, accident, life insurance, and retirement benefits; profit-sharing and bonus plans; leave; and other terms and conditions of employment. Under these rules, an explicit, categorical exclusion of medical coverage for care related to an employee's gender dysphoria or gender transition are facially discriminatory.

Federal government contractors subject to the OFCCP rules will want to take immediate action to make any necessary changes to their health plan design as soon as possible. Importantly for employers, however, the OFCCP noted that it will consider a company's good faith progress in this area when deciding whether or not enforcement action is needed.

C. Title VII of the Civil Rights Act

Even if you are not directly impacted by the Section 1557 or OFCCP rules, plan sponsors should be aware that the EEOC takes the position that transgender status and identity are protected under Title VII of the Civil Rights Act, which prohibits sex discrimination.

Although the EEOC has not issued guidance that explicitly addresses the obligations of health plans to cover transgender benefits, it appears that the EEOC agrees with the premise that categorical exclusions of transgender benefits are discriminatory under Title VII. For example, the EEOC recently settled a discrimination case against an employer that categorically excluded transgender benefits from its health plan, and the consent decree provided that the "health benefits plan will not include any partial or categorical exclusion for otherwise medically necessary care based on transgender status."

Although the courts have not unanimously supported the EEOC's position, because Title VII applies to all employers with 15 or more employees, employers should be cautious about excluding transgender benefits from their health plans, even if the Section 1557 and the OFCCP final regulations do not apply. There are still many open issues, including the exact scope of benefits that need to be covered under an employer's health plan for transgender individuals, but the cautious approach would be for all employers to consider covering transgender benefits, subject to reasonable medical management techniques that could help to mitigate the costs of providing such benefits.

II. OPT-OUT PAYMENTS UNDER THE ACA'S SHARED RESPONSIBILITY PROVISIONS

The ACA's shared responsibility rules require applicable large employers (generally, employers with more than 50 full-time employees or full-time equivalent employees) to offer their full-time employees and their non-spousal dependents with minimum essential health care coverage that is both "affordable" and provides "minimum value", or else pay a tax penalty.

- **Determining Affordability of Medical Coverage with Opt-Out Payments**

Some employers provide opt-out payments for employees who forego the employer's medical coverage. Although guidance on these payments was previously issued in IRS Notice 2015-87, earlier this summer the IRS issued proposed regulations that expand on the treatment of these cash incentives.

Under the proposed regulations, so-called "unconditional opt-out payments" are payments that the employee receives for waiving medical coverage without having to satisfy any other conditions. The proposed regulations provide that these unconditional opt-out payments will be added to the amount that the employee is considered to contribute, for purposes of determining whether the coverage offered by the employer is "affordable". In contrast, "eligible opt-out payments" that require the employee to satisfy certain conditions in addition to waiving the coverage will not be treated as an employee contribution for purposes of determining whether the coverage is "affordable".

In order to be considered an "eligible opt-out payment", the following requirements must be met:

- The employee must provide reasonable evidence that the employee and the employee's tax family (those for whom the employee expects to claim a personal tax exemption) have minimum essential coverage from an alternate source;
- The alternate source may be any type of group plan such as a spouse's or parent's plan, a union plan, Medicare or Medicaid, but it may not be coverage under an individual policy;
- The employee must provide reasonable evidence of the alternate coverage annually, which may be an attestation by the employee; and
- No opt-out payments may be paid if the employer knows that the employee or a member of the employee's tax family does not have alternate coverage.

If you provide opt-out payments, you will want to assess whether you want to continue providing such payments in light of the proposed regulations, or if you want to restrict them so that they will be counted as an employer contribution for purposes of determining affordability under the ACA's shared responsibility provisions.

III. ACA MARKETPLACE NOTICES ISSUED TO EMPLOYERS

Earlier this summer, employers started to receive notices from the Health Insurance Marketplaces, informing them that one or more of their employees had been found eligible for a premium subsidy (either a premium tax credit or cost-sharing reduction) to help pay for the health care coverage being provided through the Marketplace. The notices were sent because the employee represented either that he was not eligible for, or was not offered, health coverage through the employer, or that the coverage that was offered was not "affordable" or did not provide "minimum value".

Although the receipt of the Marketplace notice does not mean that the employer has been assessed a shared responsibility tax penalty (because that is a separate process that will be handled by the IRS and will have its own appeals process), nevertheless, employers who receive the Marketplace notices are permitted to appeal these notices. There are strategic advantages for filing such an appeal, including correcting misinformation provided to HHS, such as the following:

- The individual claiming the premium subsidy may have been offered (and waived) the affordable, minimum value coverage offered by the employer;
- The individual claiming the premium subsidy may have been a former employee who was not employed by the employer during the period stated in the notice; or
- The individual claiming the premium subsidy may have been a part-time employee or independent contractor ineligible for coverage under the employer's health plan.

In addition, an appeal decided in the employer's favor may be helpful for the employer if the IRS attempts to impose a shared responsibility tax penalty at a future date, because it will establish the employer's consistent position that the individual was not eligible for a subsidy.

On the flip side, if an employer receives a Marketplace notice and determines that it has not made the required offer of coverage to a full-time employee, the employer can use the information to correct its oversight on a going forward basis, in order to limit its exposure to any further potential penalties.

If an employer decides to appeal a Marketplace notice for an actively employed individual, then for employee-relations purposes, the employer should consider notifying the employee about its appeal. If the employer's appeal is successful, the employee will need to repay any subsidies he or she has erroneously received.

IV. IRS ANNOUNCES 2017 DOLLAR LIMITS ON HSAs AND HDHPs

The IRS has announced the dollar limitations that will apply in 2017 for HSA contribution limits and the minimum annual deductible and maximum out-of-pocket expense limit for HDHPs. The only change is a modest increase to the HSA contribution limits for individual coverage.

The table below shows the limits that will apply for 2017, as well as the limits that continue to be in place for the remainder of 2016. These revised limits should be incorporated into your plan documents and other communications, including annual open enrollment materials for 2017 benefits.

Dollar Limits on Health Savings Accounts and High Deductible Health Plans			
Code Section	**Limit**	**2017**	**2016**
	Health Savings Account Annual Contribution Limits		
§223(b)(2)(A)	HSA Contributions for Individual Coverage	$3,400	$3,350
§223(b)(2)(B)	HSA Contributions for Family Coverage	$6,750	$6,750
	High Deductible Health Plan Annual Deductible Limits		
§223(c)(2)(A)	HDHP Maximum Deductible for Individual Coverage	$1,300	$1,300
§223(c)(2)(A)	HDHP Maximum Deductible for Family Coverage	$2,600	$2,600
	High Deductible Health Plan Annual Out-of-Pocket Expense Limits		
§223(c)(2)(A)	HDHP Out-of-Pocket Expense Limits for Individual Coverage	$6,550	$6,550
§223(c)(2)(A)	HDHP Out-of-Pocket Expense Limits for Family Coverage	$13,100	$13,100

V. REMINDER: MEDICARE PART D NOTICES MUST BE DISTRIBUTED BEFORE OCTOBER 15th

Although the list of required annual notices that must be provided to your employees seems to keep growing—and you can satisfy most of these notices through your open enrollment materials—it's important to keep in mind that the Medicare Part D Notice must be distributed no later than October 14th, which may be earlier than the date you otherwise distribute your open enrollment materials.

The Medicare Part D Notice advises your employees whether or not the prescription drug coverage offered under your health plan is considered to be as good as ("creditable") as that offered under the Medicare Part D prescription drug program. Because the Medicare open enrollment window runs from October 15th through December 7th each year, this notice must be distributed no later than October 14th. As you may not always know whether your employees or dependent are eligible for Medicare (because Medicare is available for reasons other than turning 65), it is recommended that you send out this notice to all of your employees who are eligible for coverage under your health plans. Model notices can be found at the following link: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html.

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If you would like assistance in determining whether these latest developments may impact the design of your health plans, or if you'd like to discuss your health and welfare plans generally, please feel free to contact the members of our Employee Benefits group below.

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