Waves of Guidance and Benefit Plan Developments Worth Watching

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Waves of Guidance and Other Benefit Plan Developments Worth Watching: Notices on Second Round of Privacy and Security Audits are Out, Expat Plans, OON Surgery Center Billing Issues, and New Nondiscrimination Rules for Federal Contractors, New ERISA Civil Monetary Penalties, COBRA Notices and SBCs

Second Round Selection Notices for OCR Audits are Out

The OCR announced that the notices to entities selected for the second round of HIPAA Privacy and Security audits were sent out by e-mail on Monday July 11, 2016. Employers sponsoring group health plans should monitor their e-mail spam filtering software and junk mail folders for e-mails from OSOCRAudit@hhs.gov. There are two e-mails to watch for:

- One e-mail includes a notification letter providing instructions for responding to the desk audit document request, the timeline for response, and a unique link for each organization to submit documents via OCR's secure online portal.
- A second e-mail contains an additional request to provide a listing of the entity's business associates and also provides information about an upcoming webinar, where OCR will explain the desk audit process for auditees and take their questions.

Entities have 10 business days, until July 22, 2016, to respond to the document requests. Desk audits of business associates will follow this fall. The e-mail notification included the list of areas on which the desk audits will focus.

New Nondiscrimination Rules for Federal Contractors Related to Gender Identity

In May we received the Affordable Care Act ("ACA") regulations on nondiscrimination based on sex, including gender identity, issued by the Department of Health and Human Services which are effective for those plans of employers receiving certain "federal financial assistance" from the U.S. Department of Health and Human Services effective for plan years beginning on or after January 1, 2017.

June brought us the further extension of the prohibition on discrimination based on sex, including gender Identity and transgender status, applicable to certain federal contractors and which is effective on and after August 16, 2016 with no delayed effective date for those regulations in the regulation for plan years.

The federal contractors covered by this new non-discrimination requirement applicable to employment, compensation and benefits includes an entity that has a single federal contract worth $10,000 or more, or an entity that has federal contracts which in total exceed $10,000 in a 12 month period, or if your entity holds government bills of lading, serves as a depository of federal funds, or is an issuing and paying agency for U.S. Savings bonds and notes in any amount.

An individual employed by or seeing to work for such a federal contractor is protected from discrimination. An individual who does not work on a federal contract is still protected if they work for a company that holds a covered federal contract or subcontract (FAQ, Coverage Questions 1 and 2).

The OFCCP nondiscrimination rules for federal contractors preclude discrimination based on sex (which includes gender identity and transgender status) in hiring, firing, disciplining, compensation and benefits. This means your benefit plans should be reviewed to determine if there are exclusions from coverage or actuarial assumptions or benefit calculations that may be gender based that may require immediate consideration if your employer is a federal contractor subject to these new requirements.

The FAQs on the OFCCP website provide some guidance regarding how these regulations impact benefit plans recognizing that the regulation effective date may occur mid-plan year. In FAQ Sexual Orientation and Gender Identity Discrimination, Numbers 3 and 4, clarify that discrimination on the basis of gender identity in the provision of fringe benefits falls within the scope of the regulations; however, the OFCCP's concept of fringe benefits is more like the Davis-Bacon Act concept and not the tax concept of fringe benefits because it includes health benefits. It clarifies that coverage for health care services that are medically appropriate, regardless of sex assigned at birth must be covered as well as

coverage for treatment of gender dysphoria and gender transition, provided the nondiscriminatory terms of the plan are satisfied. Any denial will be reviewed to determine if there is a legitimate, nondiscriminatory reason for such denial or limitation of coverage.

The FAQs recognized that some plans cannot be updated and the benefit change may not be one that can be implemented immediately to comply by the August 16, 2016 regulation effective date. The FAQ indicates that the OFCCP will consider good faith progress to take steps to change benefits policies and practices in determining whether it will take enforcement efforts. This means that companies potentially subject to this rule need to:

1. determine first if they are subject to this rule as a federal contractor or otherwise,
2. determine if their plans, compensation practices or employment practices require revision,
3. determine if they are bound by any restrictions that may limit their ability to make changes to the benefit plans etc. unilaterally, such as collective bargaining agreements (recently an employer changing a flexible benefit plan unilaterally without negotiation resulted in it losing an unfair labor practice charge at the NLRB),or other contractual obligations,
4. determine what steps it must take to become compliant,
5. document the steps it takes and its action plan to become compliant, remembering the effective date of the new requirements.

While the regulations issued under the ACA in May and the OFCCP's regulations issued in June deal with a similar type of discrimination, they each address different entities and they are effective at different times. Employers should carefully review whether either of these applies to its business because once either regulation applies to any portion of its business, the entire business is subject to the new requirements.

New Proposed Expat Plan Regulations under the ACA

The New Proposed Expat Plan regulations ("Expat Proposed Rules") can be relied upon by plans until final regulations are issued. The Expat Propose Rules implement the Expatriate Health Coverage Clarification Act of 2014 and clarify which rules apply to which individuals working abroad. The Expat Proposed Rules applicable to employer sponsored group health plans vary by the status of the individual employee. Employees or students/charitable workers are broken into essentially three basic groups. First these are the rules for plan that qualify as "expatriate plans" and that are primarily limited to covering individual s who reside outside of their home country for at least six months of the plan year and any covered dependents and meet a number of additional requirements as a plan and that its insurer or TPA also satisfy the applicable requirements. It is important to remember in the analysis that all workers who are working outside of their country of origin while commonly referred to as expats are not necessarily all treated the same under the various rules. Each employee working outside their country of origin/citizenship must have their situation reviewed to determine what categories they may fall into under the guidance. A chart is being developed to outline the general rules for the different categories under this guidance and for the application of the ACA requirements.

Out of Network Surgery Center Billing

Group health plan sponsors have been responding to many appeal requests from and on behalf of out-of-network surgical centers and some other providers. While pinning out of network reimbursement to a set percentage of a set data base, such as Medicare avoids the dispute regarding what is reasonable and customary, that is only one of the avenues being pursued. These appeal requests often include requests for numerous documents that also must be addressed in the response. **It is important to remember that those document requests must be responded to within 30 days particularly since the penalty for not complying will be increasing for failures to produce such documents under section 104 of ERISA occurring after August 1, 2016 when the penalties increase to $147 per day and up to $1,472 per request as catch up Civil Monetary penalties under the Department of Labor's final regulations under the Federal Civil Penalties Inflation Adjustment Improvements Act of 2015**. This is an increase from the amount for failures to produce documents after March 24, 2003 and prior to August 1, 2016 those penalties were $110 per day up to $1100 per request. **Please note that this is just one of a number of federal civil monetary penalties that have been adjusted to new levels as of August 1, 2016 that will impact plans. The penalties for late filed annual returns have also been increased as well as the penalties for a number of late notices that are required to be provided.**

Some of the out of network providers have engaged in practices of waiving the participant's financial responsibilities under the plan to provide an incentive for an individual to utilize that provider and some third party administrators have been denying the claims from those providers because the participant is not required to pay for the claim. This claim practice and adjudication dispute has been fought in a number of District Courts and in the Fifth Circuit and it has caught the eye of several federal regulators who are now investigating this practice. In addition to the federal regulators, the bankruptcy trustees of some bankrupt surgery centers are requesting authority of the bankruptcy court to be authorized issue document requests to certain health plans and third party administrators as part of their search to recover funds for the bankrupt surgical centers. So the out of network provider reimbursement claims may continue to be additional work for health plans.

Summary of Benefit and Coverage Revisions

The revised summary of benefits and coverage template for 2017 is required to be used for an **annual open enrollment** that begins on or after April 1, 2017. If the plan does not offer an annual open enrollment period, then the new template for the summary of benefits and coverage must be used for the first day of the first plan year that begins on or after April 1, 2017 per the Center for Medicare and Medicaid Services Questions and Answers on the Summary of Benefits & Coverage released this month. This guidance also clarified that until further notice is provided, Issuers should enter default values of "$0" for template validation requirements on the field for the coverage example of "Treatment of a Simple Fracture" and health plans and issuers may continue to use the Coverage example calculator approved for the plan year 2016 to calculate the coverage estimates on the form for "Having a Baby" and "Managing Diabetes."

COBRA and the ACA FAQ

The FAQ reinforced that the COBRA model notice is on the DoL's website and it includes information about coverage that can be obtained through the Marketplace created by the ACA. The FAQ clarifies that an employer may provide additional information about the Marketplace and how individuals can obtain assistance with enrollment and about the special enrollment period available on the Marketplace following certain losses of coverage as well as contact information and information about particular products on the Marketplace and other information that may help a qualified beneficiary choose between COBRA and Marketplace coverage options. COBRA notices can be tailored to particular groups, but they are all required to be "easily understood by the average plan participant" and should not be too lengthy or difficult to understand.

So employers should not feel bound to not alter the model notices and may add additional information designed to help the participants choose between COBRA and Marketplace coverage, provided the information does not make the notice too long or complicated.

New Form 5500 Has Been Proposed

While the close to 800 pages of just the proposal on the changes to the Form 5500 were just released without the proposed regulations that will be issued later this month, these are not yet effective and not contemplated to be in use in the next year or two. The summaries of the changes indicate that the new reporting requirements are intended to improve financial reporting, require reporting by many health and welfare plans not currently required to report, require more reporting by group health plans regarding their compliance with the ACA, provide more information on service provider fees and to enhance compliance with ERISA and the Code. These proposed changes in the reporting forms and governing regulations should be monitored as they develop as they may significantly impact plan sponsor obligations in reporting and given the increase in fees for failing to report under **the Federal Civil Penalties Inflation Adjustment Improvements Act of 2015 and the implementing regulations referenced above that increased the penalty for failure to file an annual Form 5500 report to $2,063 per day for penalties assessed after August 1, 2016**, failure to file is about to become far more costly. The filing obligations under the new proposed forms and the soon to be issued related regulations should be carefully monitored as there may be new filing obligations if some longstanding exemptions from or limitations on filing are altered.

Contact:

Greta Cowart
214.745.5275
gcowart@winstead.com