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GRS INSIGHT

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Clarifications to Pension Accounting for Governmental Plans

In This Issue

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The Governmental Accounting Standards Board (GASB) issued new guidance to address concerns faced by governmental plans under prior GASB Statements. Specifically, the following issues were raised regarding governmental plan reporting under Statements Nos. 67, 68 and 73: 1) how to present certain payroll-related measures for GASB 67 and 68 purposes; 2) the treatment of deviations from actuarial standards of practice when selecting actuarial assumptions; and 3) the classification of employer payments made to satisfy employee contribution requirements. These issues were addressed in the new guidance – GASB Statement Number 82 (GASB 82), which was issued in March 2016.

Presentation of Payroll Information

Prior to GASB 82, Statements 67 and 68 required that covered-employee payroll (i.e., the payroll of employees that are provided with pensions through the pension plan) be the measure of payroll used to report the payroll and various payroll ratios in schedules of supplementary information. However, this standard only included the payroll of active employees. Because the intended standard was broader, GASB 82 established a new standard, clarifying that the payroll measure is not just the payroll for covered employees, but all payroll on which contributions to the pension plan are based.

Selection of Assumptions

GASB 82 provides that a deviation from the Actuarial Standards of Practice (ASOP) issued by the Actuarial Standards Board for selecting assumptions to determine total pension liability and related measures is not in conformity with GASB 67, 68 or 73. Under the ASOP, a deviation occurs when an actuary departs from the guidance provided under the ASOP, but is still able to comply with the standards because the actuary properly discloses the deviation. GASB 82 explicitly provides that such a deviation is not consistent with GASB reporting requirements, even if disclosed.

Classification of Employer-Paid Member Contributions

In some cases, employers make payments to a plan to satisfy contribution requirements that are defined under the plan as employee contributions (i.e., "pick-up" contributions). GASB 82 clarifies that employee contributions that are "picked-up" should be classified as "plan member contributions" under GASB 67 and as "employee contributions" for purposes of GASB 68. Further, GASB 82 provides that the employer's expense and expenditures for those contributions should be recognized in the period for which the contribution is assessed and classified in the same manner as the employer classifies similar compensation other than pensions (e.g., salaries, wages, or fringe benefits).

Previously, for example, GASB 67 and 68 permitted these contributions to potentially be classified as employer contributions for purposes of the applicable Statement. Specifically, those Statements provided that where such contributions are recognized by the employer as salary expense, those contributions should be classified as employee contributions for purposes of those Statements. Otherwise, those contributions should be classified as employer contributions. The changes made by GASB 82 provide consistency by allowing employers to classify employer-paid member contributions in the same manner for both plan and employer reporting purposes.

Effective Date

These new requirements are generally effective for reporting periods beginning after June 15, 2016. However, if an employer measures liabilities on a date other than the most recent fiscal year-end, the deadline for selecting actuarial assumptions is applicable for the next measurement on or after June 15, 2017.

Treatment of Phased Retirement Payments

The Internal Revenue Service ("IRS") recently issued guidance (the "Notice")[1] on whether payments received by an employee from a qualified defined benefit (DB) plan during phased retirement would be amounts received as an annuity under Section 72 of the Internal Revenue Code of 1986, as amended (the "Code"). For this purpose, phased retirement is an arrangement under which a participant in a qualified DB plan commences the distribution of a portion of retirement benefits while continuing to work on a part-time basis.

In order to avoid being classified as annuities, defined benefit pension payments received during phased retirement must meet the three criteria outlined below. The Notice also discusses present value factors and the time for determining basis recovery if amounts are not received as an annuity.

Factors for Determining Whether Payments are Received as an Annuity

The Notice outlines three specific measures for determining whether payments received by an employee during a phased retirement are received as an annuity. Specifically, payments are not received as an annuity for purposes of Code Section 72 if all of the following apply:

1. The employee begins to receive a portion of retirement benefits upon entering phased retirement and beginning part-time employment, and will begin receiving full plan benefits when ceasing employment and commences full retirement at an indeterminate future time (even if a full retirement date is agreed upon when commencing phased retirement, the full retirement date remains indeterminate if it is possible that date could change);[1]
2. The plan's obligations to the employee are based in part on the employee's continued part-time employment; and
3. Under the plan terms, the employee does not have an election as to the form of the phased retirement benefit to be paid during phased retirement, but elects a distribution option at full retirement that applies to the employee's entire retirement benefit, including the portion that commenced as phased retirement benefits.

[1] Notice 2016-39 (Jun. 10, 2016).

Present Value Factors for Calculating a Phased Retiree's Accrued Benefit

If phased retirement benefit payments meet the criteria outlined above and, therefore, are amounts not received as an annuity, the basis recovery rules of Code Section 72(e)(8) apply. Specifically, the amount of each payment that is excludable from the participant's gross income is the portion that is determined by multiplying the amount of the payment by the ratio of the employee's investment in the contract (e.g., basis) to the total value of the employee's accrued benefit (the basis recovery fraction). Further, the present value factors to be used to calculate lump sum distributions under the plan, if any, should be used to calculate the value of an employee's accrued benefit for purposes of determining the excludible portion of each payment.

Time Period for Determining Basis Recovery

The employee's basis recovery fraction must be applied to each payment received by the employee. This fraction may be fixed at the time payments commence – it does not have to be recalculated for each individual payment, even if the employee makes additional after-tax contributions during the period of part-time employment. The investment in the contract as of the employee's full retirement date will take into account any investment in the contract recovered during the phased retirement and any additional after-tax contributions made during that period.

Application

The Notice applies to taxable years beginning on or after January 1, 2016, but may be applied to taxable years beginning before that date. In addition, the Notice does not apply to amounts received from non-qualified contracts.

Direct Rollovers for the Purchase of Service Credit

Governmental plans often accept direct rollovers for the purchase of service credit. In addition to long-standing regulations,[2] the IRS most recently issued guidance which delineates two simplified safe harbor procedures for validating direct rollovers into qualified plans,[3] procedures which would also be applicable in the context of service credit purchases. These procedures provide new ways for a plan administrator to reasonably conclude that certain direct rollovers are valid.

IRS regulations have historically required that the plan administrator of a receiving qualified plan reasonably conclude that a rollover contribution is valid before accepting it. If it is later discovered that a rollover was not an eligible rollover contribution, the plan was required to distribute it (plus earnings) within a reasonable period after such discovery to maintain its tax-qualified status. This distribution requirement remains the same under the most recent guidance.

Current regulations also provide safe harbors for accepting rollover contributions (e.g., asking for either a copy of the latest IRS determination letter or a certification from the plan administrator of the distributing plan regarding its tax-qualified status). The following summary of the new guidance provides additional, simplified ways to meet the requirements for a direct rollover from certain plans – without having to contact the prior plan administrator.

[2] Treas. Reg. Sec. 1.401(a)(31)-1, Q&A-14.
[3] Revenue Ruling 2014-9, I.R.B. 2014-17 (Apr. 3, 2014).

New Safe Harbor Methods

Revenue Ruling 2014-9 sets forth simplified due diligence procedures for a plan administrator to confirm the tax-qualified status of the distributing plan or IRA and conclude that a rollover contribution is valid. Specifically, the following procedures are generally found to be sufficient: 1) employee certification of the source of the funds; 2) verification of the payment source (on the incoming rollover check or wire transfer) as the participant's IRA or former-plan; and 3) if the funds are from a plan, looking up that plan's Form 5500 filing, if any, in the Department of Labor's database for assurance that the plan is intended to be a qualified plan. The Revenue Ruling also explicitly provides that it is not necessary for the distributing plan to have a determination letter for a receiving plan administrator to conclude that a rollover contribution is valid.

The Revenue Ruling also sets forth two examples to further delineate the application of these procedures.

Example 1 – Rollover Contributions from an ERISA—Covered Plan

Plan M, a profit-sharing plan, does not accept rollover contributions of after-tax amounts or Roth contributions. Employee A makes a direct rollover from a retirement plan via a check payable to the trustee for Plan M, with a copy of the check stub that indicates the prior plan name as the source of the funds. The employee also certifies that the rollover does not include after-tax or Roth contributions.

The plan administrator accesses DOL's EFAST2 database (www.efast.dol.gov), reviews the latest Form 5500 for the prior plan, and confirms that line 8a (line 9a of Form 5500-SF) does not include Code 3C (for a plan not intended to be qualified under Code Sections 401, 403, or 408).

This process satisfies the safe harbor verification process, absent any evidence to the contrary. This is true even if the employee had reached age 70-1/2, as it is reasonable to assume that the minimum required distribution (MRD) payment was made by the distributing plan prior to the rollover distribution.

It should be noted that this process should extend to any ERISA-covered plan that files Form 5500 or Form 5500-SF, for example, an ERISA-covered 403(b) plan. However, it will not apply to governmental plans, SEPs, or non-electing church plans, all of which do not file 5500s.

Example 2 – Rollover Contributions from a Traditional IRA

Employee A makes a direct rollover from a traditional IRA (not a Roth, SEP, SIMPLE or inherited IRA) to Plan M via a check payable to the trustee for Plan M, with a copy of the check stub that indicates "IRA of Employee A" as the source of the funds. The employee also certifies that the rollover does not include after-tax contributions, and that the employee will not attain age 70-1/2 by the end of the year in which the check is issued.

This process satisfies the safe harbor verification process, absent any evidence to the contrary. However, unlike in the ERISA plan context, if the employee had attained age 70-1/2 by the end of the year in which the check was issued, the plan administrator must obtain additional evidence indicating that the check does not include an MRD payment. Presumably, this means that, for direct rollovers from an IRA, the plan administrator needs to confirm: 1) the employee's age; and 2) if at least age 70-1/2 during the year, that the rollover does not include an MRD amount.

Notably, these same rules apply if there is no check stub, as long as the check itself (or the wire transfer or other electronic means) identifies the source of the funds as a traditional IRA or the name of the employer-sponsored plan.

Application

This guidance is helpful in that it does not require any change in existing reasonable validation procedures, but provides two new streamlined, safe harbor methods that plan administrators may use, if desired. This may ease the burden on plan sponsors who accept direct rollovers for the purchase of service credit. Therefore, it may be helpful to revise current direct

rollover procedures to incorporate one or both of these new procedures.

Summary of Benefits and Coverage Templates and Accompanying Documents

On April 6, 2016, the Departments of Health and Human Services, Labor, and Treasury (the "Departments") jointly released final changes to the Summary of Benefits and Coverage ("SBC") template, the Uniform Glossary, and accompanying documents. This release follows the Departments' release of the SBC final rule.[4]

The Affordable Care Act requires health insurance issuers and group health plans – including self-funded group health plans – to provide SBC templates to consumers, in an effort to help them make more informed choices among health plan options and to understand their coverage better. Health insurance issuers and group health plans are currently using SBC templates released April 23, 2013. Issuers and plans must use the new SBC templates by the following dates:

- For calendar year plans, on the first day of open enrollment beginning on or after April 1, 2017;
- For non-calendar year plans, the first plan year beginning on or after April 1, 2017.

The Departments made the following changes to the SBC template:

- Described what an SBC is at the top of the first page of the template.
- Changed some of the language in the *Certain Important Questions* portion of the template. For example, they added a row about services covered before an individual meets his or her deductible.
- Changed some information in the *Common Medical Event* portion of the template. For example, in the "Limitations, Exceptions, & Other Important Information" column of the sample completed template, they added information about preauthorization for certain medical events (i.e., specialist visits, outpatient surgery and hospital facility fees, and hospice services).
- Removed definitions pertaining to cost sharing (e.g., copayments and coinsurance) at the top of page two. Instead, the new template includes language stating that copayments and coinsurance are imposed after a consumer hits his or her deductible.
- Added a third example – *a simple fracture* – to the existing coverage examples of having a baby and type 2 diabetes.

In addition, the Departments added definitions to the Uniform Glossary, which is a repository of commonly-used health coverage and medical terms that plans and issuers must provide to consumers. In the updated instructions, the Departments state that "[t]erms defined in the Uniform Glossary should be underlined in the SBC." Plans and issuers providing electronic SBCs may also hyperlink the terms to a micro-site HHS will maintain at https://www.healthcare.gov/sbc-glossary/.

Plans and issuers must still use 12-point font size and replicate all symbols, formatting, bolding, and shading where applicable, on the SBC template. However, to maintain the statutorily-required four-page (double-sided) limit, the updated instructions add some explicit flexibility. Although they encourage plans and issuers to use Arial Narrow font, they allow plans and issuers to use different font types and to modify the margins as necessary.

Tri-Agency Issues FAQs Addressing Various Provisions

On April 20, 2016, Departments of Health and Human Services, Labor, and Treasury (the "Departments") jointly prepared FAQs regarding implementation of the Affordable Care Act (ACA). The new guidance covers a broad range of topics, including the following requirements:

[4] 80 Fed. Reg. 34292 (http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=28304)

- **Preventive services:**
  - Colonoscopy: prohibiting cost sharing for certain medications to prepare for a colonoscopy.
  - Contraception: allowing plans and issuers to develop a standard exception form with instructions that a provider may use to prescribe a service or FDA-approved item based on a determination of medical necessity.
- **Rescissions:** clarifying that a retroactive termination of health coverage is a rescission and prohibited under the Public Health Service Act ("PHS Act") 2712 if: 1) it is a cancellation or discontinuance of coverage that has retroactive effect; 2) it is not attributable to a failure to timely pay premiums toward coverage; 3) there was no fraud or intentional misrepresentation of material fact; and 4) the other limited circumstances exceptions specified in the regulations do not apply.
- **Out-of-network emergency services:** requiring plans subject to ERISA to disclose how it calculated the amount under the minimum payment standards of PHS Act 2719A.
- **Clinical trials:** clarifying that plans and issuers may not deny the coverage of routine patient costs for items or services furnished in connection with participation in an approved clinical trial.
- **Annual limitation on cost-sharing:** requiring a non-grandfathered large group plan or a self-insured group health plan to count an individual's out-of-pocket expenses toward the maximum out-of-pocket limit for reference-based pricing for particular procedures if the plan does not ensure "that participants have adequate access to quality providers that will accept the reference price as payment in full."
- **Mental health parity:** prohibiting issuers from basing projected plan payments for purposes of financial requirements and quantitative treatment limitations testing on an issuer's entire book of business; emphasizes disclosure requirements; and provides that Medication Assisted Treatment for Opioid Use Disorder is a substance use disorder benefit.
- **The Women's Health and Cancer Rights Act ("WHCRA"):** clarifying required coverage under WHCRA.

The FAQs are available at: http://www.dol.gov/ebsa/faqs/faq-aca31.html

EEOC Releases Final Rules on Wellness Programs

On May 17, 2016, the Equal Employment Opportunity Commission ("EEOC") published a final rule on wellness programs under the Americans with Disabilities Act ("ADA")[5] as well as a companion rule under the Genetic Information Nondiscrimination Act ("GINA").[6]

Background

The ADA generally prohibits an employer from making disability-related inquiries or requiring medical examinations. There is an exception, however, for "voluntary" medical examinations and medical histories that are part of an employee health program (including wellness programs) available to employees at the work site. The final rule under the ADA addresses the extent to which employers may use incentives to encourage employees to participate in wellness programs that include disability-related inquiries and/or medical examinations. It generally finalizes, with some notable changes, the provisions of the proposed rule issued in April 2015.

Title II of GINA restricts employers from requesting, requiring or purchasing genetic information, with certain limited exceptions. "Genetic information" includes, among other things, information about the manifestation of a disease or disorder in family members of an individual (i.e., family medical history). An exception to this restriction is available to employers that offer health

[5] 81 Fed. Reg. 31126 (https://www.gpo.gov/fdsys/pkg/FR-2016-05-17/pdf/2016-11558.pdf)
[6] 81 Fed. Reg. 31143 (https://www.gpo.gov/fdsys/pkg/FR-2016-05-17/pdf/2016-11557.pdf)

or genetic services, including those offered as part of voluntary wellness programs. The final rule under GINA addresses the extent to which employers may offer employees inducements where the employee's spouse completes a health risk assessment and/or takes a biometric screening (together, an "HRA"). It generally finalizes, with some significant changes, the provisions of the proposed rule issued in October 2015.

ADA Final Rule

Major provisions of the ADA final rule include the following:

- **"Employee Health Programs" Involving a Disability-Related Inquiry or Medical Examination Are Subject to the Final Rule.** Unlike the proposed rule, the final rule makes clear that all of the provisions of the final rule, including the requirement to provide a notice and limitations on incentives, apply to all employee health programs that ask employees to respond to disability-related inquiries and/or undergo medical examinations – regardless of whether included as part of a group health plan or a stand-alone wellness program.
- **Employee Health Programs Must Be "Reasonably Designed to Promote Health or Prevent Disease."** The final rule imposes a requirement that each employee health program be reasonably designed. This requirement is similar to that imposed under HIPAA with respect to health-contingent programs; however, the ADA's reasonable design requirement applies to both health-contingent programs and participation-only programs. The reasonable design requirement is satisfied if a program:
    - Has a reasonable chance of improving the health of, or preventing disease in, participating employees;
    - Is not overly burdensome;
    - Is not a subterfuge for violating the ADA or other laws prohibiting employment discrimination; and
    - Is not highly suspect in the method chosen to promote health or prevent disease.
- **Employee Health Programs Must Be "Voluntary."** As with the proposed rule, the final rule also requires that a program be "voluntary." To be a voluntary program:
    - An employer may not require employees to participate in the program;
    - An employer may not deny coverage under any group health plan (or particular benefits packages within a group health plan) to employees for non-participation (generally encompasses common "gatekeeping" practices) or limit the extent of benefits (except for permitted limited incentives, described below);
    - An employer may not take any adverse action, retaliate against, or coerce employees who choose not to participate; and
    - An employer must satisfy a specific notice requirement. The EEOC has provided a sample notice on its website.
- **Employee Health Programs Must Limit Incentives to be Voluntary.** The final rule reaffirms that an employer may offer incentives, whether in the form of a reward or penalty, to promote an employee's participation in a wellness program that includes disability-related inquiries and/or medical examinations as long as participation is voluntary.

  Notably, the final rule limits the use of incentives *with respect to the employee only* to no more than 30% of the total cost of self-only coverage. The final rule does not govern the financial incentives used with respect to the spouse.

  The ADA incentive limit with respect to the employee applies regardless of whether the wellness program is: 1) offered only to employees enrolled in an employer-sponsored group health plan; 2) offered to all employees whether or not they are enrolled in such a plan; or 3) offered as a benefit of employment where an employer does not sponsor a group health plan or

group health insurance coverage. Similarly, it applies regardless of whether the program is a participation-only or health-contingent program for purposes of HIPAA.

GINA Final Rule

Major provisions of the GINA final rule include the following:

- **Employer May Offer Inducement to Employee for Employee's Spouse to Provide Information about Spouse's Manifestation of Disease or Disorder as Part of HRA.** The final GINA rule makes clear that providing a financial incentive for a spouse to complete an HRA regarding the spouse's own medical information generally will not give rise to a GINA violation, as long as the requirements of the final rule are satisfied.
- **GINA Rule Applies Broadly to Wellness Programs, Whether or Not Offered as Part of a Group Health Plan.** The final rule applies to employer-sponsored wellness programs regardless of whether they are related to a group health plan.
- **GINA-Subject Programs Must Satisfy a Reasonable Design Requirement.** The final rule retains the proposed requirement that employers may request, require, or purchase genetic information as part of health or genetic services only when those services, including any acquisition of genetic information that is part of those services, are "reasonably designed" to promote health or prevent disease.
- **GINA-Subject Programs Must Satisfy a Reasonable Design Requirement.** The final rule retains the proposed requirement that employers may request, require, or purchase genetic information as part of health or genetic services only when those services, including any acquisition of genetic information that is part of those services, are "reasonably designed" to promote health or prevent disease.
- **GINA-Subject Programs Must Limit Incentives.** The final GINA rule limits the maximum total inducement for a spouse to provide information about his or her manifestation of a disease or disorder to 30% of the total cost of (employee) self-only coverage, similar to the limit imposed on an employee's incentive under the ADA. As a result, the combined total inducement for an employee and his or her spouse will be no more than twice the cost of 30% of self-only coverage.
- **GINA-Subject Programs Cannot Deny Access to Group Health Plan Coverage (or a Particular Benefits Package Within a Group Health Plan) Solely for Failure to Complete an HRA.** The final rule clarifies that it is a violation of Title II of GINA for an employer to deny access to health insurance or any package of health insurance benefits to an employee and/or his or her family members (i.e., common "gatekeeping" practices), or to retaliate against an employee, based on a spouse's refusal to provide information about his or her manifestation of disease or disorder to an employer-sponsored wellness program.
- **GINA-Subject Programs Cannot Provide Any Financial Incentives for Use with Child HRAs.** The final rule provides that no inducements are permitted in return for information about the manifestation of disease or disorder of an employee's children and makes no distinction between adult and minor children or between biological and adopted children.

Next Steps

While the final regulations are technically effective 60 days after publication in the *Federal Register*, they are generally applicable immediately as the EEOC has characterized the guidance as a clarification of existing law. New expanded notice requirements (under the ADA rules) and the rules regarding the use of financial inducements (under both rules) apply for plan years beginning on or after January 1, 2017. Employers and wellness providers should perform a careful review of their wellness programs to ensure compliance with these new rules.

HHS Issues Final Rule on ACA Nondiscrimination Provisions

Background

On May 18, 2016, the Office of Civil Rights ("OCR") at the U.S. Department of Health and Human Services ("HHS") published a final rule implementing Section 1557 of the Patient Protection and Affordable Care Act ("ACA").[7] This rule prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability.

Applicability/Scope

Section 1557 of the ACA applies to health programs and activities receiving Federal financial assistance, health programs administered by an executive agency, and any health program or activity administered by an entity established by Title I of the ACA. OCR declined to extend the final rule to health programs and activities receiving Federal financial assistance from Departments other than HHS. Thus, the final rule applies to: 1) all health programs and activities, any part of which receives Federal financial assistance from HHS (with the exception of Medicare Part B payments); 2) health programs and activities administered by HHS, including the Federally-facilitated Marketplaces; and 3) health programs and activities administered by entities established under Title I of the ACA, including State-based Marketplaces.

Health Insurance Issuers

The nondiscrimination provisions of the final rule apply to any health insurance issuer receiving Federal financial assistance from HHS (e.g., by participating in the Marketplaces, Medicare Advantage, or Medicaid). Because a health insurance issuer is an entity principally engaged in providing or administering health services or health insurance coverage, the rule applies to *all of the operations* of the health insurance issuer. This includes an issuer's administrative functions as a third-party administrator ("TPA") or an administrative-services only ("ASO") provider, with certain limited exceptions (e.g., 1) an entity's actions as an employer for hiring, firing, promotions, and terms and conditions of employment other than health benefits; and 2) TPAs that are legally separate from the issuer based on a case-by-case inquiry by OCR).

Self-Funded Group Health Plans and TPAs

OCR has clarified that, since TPAs often do not have any responsibility for, or control over, self-funded benefit designs, OCR will determine whether responsibility for the decision or other alleged discriminatory action rests with the employer or with the TPA. If the conduct is related to the administration of the plan (e.g., timing of claim processing), then OCR will process the complaint against the TPA (assuming the TPA is a covered entity). If the conduct is related to a decision or action by the employer, and if OCR has jurisdiction over the employer, then OCR will proceed against the employer. If OCR does not have jurisdiction over the employer, OCR may refer matters to other Federal agencies with jurisdiction over the employer (e.g., the Equal Employment Opportunity Commission ("EEOC")). Therefore, while some employers may not be subject to this rule, the employer may be subject to nondiscrimination provisions of other Federal agencies.

Employer Liability for Discrimination in Employee Health Benefit Programs

The final rule generally does not apply to the employer-employee relationship. However, a covered entity may be subject to the rules with respect to its own employee health benefit program under the following circumstances:

- If the entity is principally engaged in providing or administering health services, health insurance coverage, or other health coverage (e.g., a health insurance issuer or hospital);
- If the entity received Federal financial assistance, a primary objective of which is to fund

[7] S. 2680 is at: https://www.congress.gov/bill/114th-congress/senate-bill/2680

the entity's employee health benefit program (e.g., employee wellness programs or employers receiving Medicare Part D funds); or

- If the entity is not principally engaged in providing or administering health services, health insurance coverage, or other health coverage, but operates a health program or activity (which is not an employee health benefit program) that receives Federal financial assistance; except that the entity is liable for the provision or administration of employee health benefits only with respect to the employees in that health program or activity (e.g., a pharmacy housed within a department store would be liable for employee health benefits, but only with respect to the employees in the pharmacy).

While Section 1557 has limited applicability to employers, OCR has indicated that EEOC is already enforcing nondiscrimination provisions under Title VII of the Civil Rights Act of 1964.

Prohibited Discrimination

The final rule generally prohibits discrimination based on an individual's race, color, national origin, sex, age, or disability, so that an individual cannot be: 1) excluded from participation in; 2) be denied the benefits of; or 3) otherwise be subject to discrimination under any health program or activity. Discriminatory actions specifically include: denying or limiting health coverage; denying a claim; employing discriminatory marketing or benefit designs; and imposing additional cost sharing.

The final rule does not define benefit design, nor does it provide any specific examples of benefit designs that would be discriminatory. Rather, OCR will determine whether certain benefits designs are discriminatory on a fact-specific, case-by-case basis. OCR has confirmed that covered entities are able to use reasonable medical management techniques and apply neutral, nondiscriminatory standards to health -related coverage. Specifically, OCR will consider whether an entity used a "neutral rule or principle" when deciding to adopt the design feature or take the challenged action or whether the reason for its coverage decision is pretext for discrimination. Therefore, documenting a neutral, nondiscriminatory standard may be critical to defending a benefit design against a Section 1557 claim.

Sex Discrimination

While the final rule does not provide much detail with respect to how benefit designs may discriminate on the basis of age, race, national origin or disability, it does provide some detail on the prohibition of discrimination based on sex. Specifically, discrimination on the basis of sex includes sex stereotyping and gender identity. Under the final rule: 1) individuals cannot be denied health care or health coverage based on their sex, including their gender identity; 2) individuals must be treated consistently with their gender identity, including in access to facilities; 3) sex-specific health care cannot be denied or limited only because the person seeking such services identifies as belonging to another gender; and 4) explicit categorical exclusions in coverage for all health services related to gender transition are facially discriminatory.

Physical, Electronic, and Language Accessibility

The final rule also incorporates accessibility standards that are consistent with existing standards under Title II of the Americans with Disabilities Act ("ADA"). Covered entities are required to comply with the 2010 ADA accessibility standards for buildings and facilities. In addition, covered entities must ensure that health programs and activities provided through electronic and information technology are accessible to individuals with disabilities. Specifically, covered entities must ensure their health programs and activities provided through websites comply with the requirements of Title II of the ADA. While ADA web accessibility standards have not yet been finalized, OCR notes that the regulatory language incorporates future changes to the Title II ADA regulations.

In addition, the final rule requires covered entities to provide meaningful access for individuals with limited English proficiency ("LEP"), which includes providing language access services free of charge,

offering qualified oral interpreters or written translators to LEP individuals if these services would provide meaningful access, and making communications with individuals with disabilities as effective as communications with other individuals in health programs.

Other Requirements

Notice and Statement of Nondiscrimination

Covered entities must post a notice of nondiscrimination in a conspicuously-visible font size in: 1) "significant publications and significant communications" targeted to beneficiaries, enrollees, applicants and members of the public; 2) conspicuous physical locations where the entity interacts with the public; and 3) a conspicuous location on the covered entity's website accessible from the homepage of the website. The notice must state that: 1) the entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs or activities; 2) the entity provides appropriate auxiliary aids and services where necessary (free of charge); 3) the entity provides language assistance services; 4) how to obtain these auxiliary aids and language assistance services; 5) identification of the person responsible for compliance (if applicable); 6) availability of a grievance procedure; and 7) how to file a discrimination complaint with OCR. Covered entities may include a shorter statement of nondiscrimination (i.e., that the entity does not discriminate on the basis of race, color, national origin, sex, age, or disability in its health programs or activities) on small-sized publications and communications.

Taglines

Covered entities must also post taglines alerting LEP individuals that language assistance services are available; the taglines must be in the same three places as the notices (discussed above). The final rule requires covered entities generally to post taglines in at least the top 15 non-English languages spoken in the state in which the entity is located or does business. For smaller communications, entities must post taglines in at least the top two non-English languages spoken in the state in which the entity is located or does business. Covered entities that serve individuals in more than one state may aggregate the number of individuals with LEP in those states to determine the top 15 (or the top two) languages, where each respective provision applies.

Enforcement

OCR finalized the proposal that the enforcement mechanisms under the Federal civil rights laws apply for violations of Section 1557. Thus, the final rule provides for a private right of action and damages for violations of Section 1557 to the same extent that such enforcement mechanisms are provided for under the current Federal civil rights laws with respect to recipients of Federal financial assistance, making it clear that individuals have the ability to file a lawsuit under Section 1557. The final rule does not require administrative exhaustion (i.e., filing a complaint first with OCR), except for age discrimination claims.

Effective Date

The final rule is generally effective July 18, 2016 (60 days after publication in the *Federal Register*). However, if provisions of the rule require changes to health insurance or group health plan benefit design (e.g., cost sharing, covered benefits, or benefit limitations or restrictions), the rule will be effective on the first day of the first plan or policy year beginning on or after January 1, 2017. In addition, the rule's notice requirements, specifically the posting of a nondiscrimination notice, and statement and taglines are effective within 90 days of the effective date.

Conclusion

Section 1557 includes broad nondiscrimination requirements and applies to a wide range of health programs and services. This rule is of critical importance to health insurance issuers, including those operating in a TPA or ASO capacity, health care providers (including pharmacies and health clinics), and some group health plans. While OCR has clarified that the final rule does not extend to certain employers or self-funded group health plans, OCR may nevertheless refer complaints about benefit design discrimination against employers that designed group health benefits to other Federal agencies that may have jurisdiction over the employer.

About GRS

GRS is a national actuarial and benefits consulting firm. We help our clients develop fiscally sustainable benefit programs that preserve financial security for millions of Americans. Our reputation for providing independent advice and quality consulting services has remained unmatched for over 75 years.

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