HEALTH & WELFARE PLAN LUNCH GROUP

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Employee Benefits & Executive Compensation ADVISORY

August 29, 2011

When Is a Summary More than a Summary: Agencies Issue Long-Awaited Guidance on the ACA's Uniform Summary of Benefits and Coverage Requirement

On August 22, 2011, the Departments of the U.S. Treasury ("Treasury"), Labor (DOL) and Health and Human Services (HHS) (collectively, the "Agencies") jointly published proposed regulations ("Regulations")[1] that identify the standards for the uniform explanation of coverage requirement under the Patient Protection and Affordable Care Act of 2010 (ACA).[2] The ACA directs the Agencies to develop standards for a uniform explanation of benefits and coverage ("Summary of Benefits Coverage" or SBC) to be provided by group health plans and health insurance issuers offering group or individual health insurance to enrollees. The long-awaited and much-anticipated Regulations propose the standards that will govern who provides an SBC, who receives an SBC, how the SBC is provided, when the SBC is provided and the contents of the SBC. In addition, the Agencies also published a draft template for the SBC, with over 30 pages of instructions, sample language for completing the template and a uniform glossary of terms used in health insurance coverage, such as "deductible" and "co-pay," as required by the Regulations.[3]

Practice Pointer: **The draft template SBC and uniform glossary were prepared by the NAIC and proposed by the Agencies without change. Consequently, the terminology in the draft SBC and uniform glossary is more consistent with the terminology typically used in an insurance policy—not a self-insured group health plan. For example, the term "renewal" is used instead of annual enrollment. The Agencies have requested comments on ways to modify the template to better suit a self-insured plan.**

The Agencies request comments on the standards proposed in the Regulations, the draft SBC template and the uniform glossary of terms, all of which are due **on or before October 21, 2011**.

The SBC requirement is statutorily effective *March 23, 2012*.[4] Presumably, this means that the requirements apply to enrollments—including new enrollees, mid-year or special enrollments and annual enrollments—after that date. The standards set forth in the Regulations for completing and distributing an SBC will likely have a significant impact on each group health plan's enrollment procedures and materials and, unless the effective

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1 *See* 76 Fed. Reg. 52442 (Aug. 22, 2011) at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21193.pdf.

2 PHSA Section 2715, as added by Section 1001 of the ACA. This requirement is also incorporated into ERISA (ERISA Section 715) and the Internal Revenue Code (Section 9815) by reference.

3 *See* 76 Fed. Reg. 52475 (Aug. 22, 2011) at http://www.gpo.gov/fdsys/pkg/FR-2011-08-22/pdf/2011-21192.pdf.

4 PHSA Section 2715(d) requires group health plans and health insurers to provide an SBC no later than 24 months after the enactment of the ACA.

date set forth in the statute is extended by the final rules, there is little time to prepare.[5] Health insurers and group health plan sponsors should begin analyzing the standards now!

> Practice Pointer: **The Agencies specifically request comments on the factors that may impact the feasibility of implementation by this due date.**

The following is an overview of the *who, what, when, where and how* of SBC compliance, as set forth in the Regulations, the draft template and the uniform glossary.

NOTE: The SBC requirements also apply to health insurance issuers who issue coverage in the individual market; however, the focus of our overview below is solely on group health plans.

Who must provide the SBC?

The Regulations obligate the group health plan (including the plan administrator) and, if applicable, the health insurance issuer offering coverage in connection with a group health plan (i.e., if the plan is fully insured) to provide the SBC in accordance with the standards described below.

> Practice Pointer: **The SBC requirement applies to all self-insured and fully-insured group health plans otherwise subject to the health insurance reforms set forth in Sections 1001 and 1201 of the ACA, *including grandfathered plans*.**[6]

Thus, if the group health plan is self-insured, the obligation to provide an SBC lies solely with the plan administrator. If the plan is fully insured, the obligation to timely send the SBC lies with both the plan administrator and the health insurer. The Regulations clarify that a responsible party may rely on another party to send an SBC, but only if a timely SBC is actually sent. In many cases, the health insurer may not have all of the information necessary to fulfill the SBC requirements (e.g., insurers of a multiple-option plan may not have census information on employees enrolled in other options or in eligible individuals who are not enrolled). Thus, some level of involvement and coordination by the employer plan sponsor will be required.

> Practice pointer: **Unlike the rules applicable to a certificate of creditable coverage required by HIPAA, a responsible party may not avoid liability simply because it has agreed in writing with another party, such as a health insurer, that the other party will timely send an SBC. Thus, if the plan administrator of a fully insured plan agrees in writing with the health insurer that the health insurer will timely send a compliant SBC but the insurer fails to timely send the SBC, both the plan administrator and the insurer are likely liable for the failure. Responsible parties who contract with third parties to send an SBC should obtain indemnification for the third party's failure to fulfill the SBC requirements.**

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[5] The Regulations do not extend the effective date set forth in PHSA Section 2715. Hopefully, the final regulations will extend the effective date to allow for adequate time for plan sponsors to comply,

[6] The health insurance reforms generally apply to "group health plans" other than "excepted benefits" defined in the HIPAA portability rules and, in most cases, stand-alone retiree medical plans.

Who must receive an SBC?

Basically, all individuals who are eligible to enroll in the group health plan are entitled to receive the SBC. The Regulations indicate that a "participant" and "beneficiary" as defined in ERISA Sections 3(7) and 3(8) are entitled to an SBC in accordance with the standards discussed herein. However, don't let the terms "participant" and "beneficiary" mislead you into believing that the SBC is provided only to those actually enrolled in the plan; the terms "participant" and "beneficiary" are defined broadly by ERISA and include not only those who are currently enrolled in the plan (i.e., covered employees and covered dependents), but *anyone who is eligible to enroll.*[7] Thus, employees (including former employees) and dependents that are eligible to enroll in the group health plan are entitled to receive an SBC. As noted in more detail below, the SBC must be incorporated into the plan's enrollment process.

Practice Pointer: **ERISA's definition of "participant" does not appear to include self-employed individuals such as independent contractors or partners covered under a plan. However, cases have held that self-employed individuals covered under an ERISA covered plan should be treated as participants. Thus, it would appear that such individuals participating in a group health plan are also entitled to receive an SBC.**[8]

In addition, the Regulations clarify that a group health plan is also entitled to receive an SBC from a health insurance issuer.

The time periods for providing the SBC and the manner in which the SBC must be provided are discussed in more detail below.

Practice Pointer: **Don't forget—only those "group health plans" subject to the health insurance reforms are subject to the SBC requirement. Thus, an SBC is not required to be sent to an eligible employee or eligible dependent with respect to an excepted benefit, such as limited scope dental or vision coverage or a Health FSA.**

When must the SBC be provided?

Generally, the SBC is provided to a participant or beneficiary at three different times:

- at any enrollment,
- upon request, and
- when there is a material modification in the information.

It must also be provided by a health insurer to a plan at certain times. We discuss the time periods and dates by which an SBC must be provided in more detail below.

Practice Pointer: **The effective date of the SBC requirement is March 23, 2012. Thus, the SBC need only be provided at any enrollment, or upon request, that occurs on or after March 23, 2012.**

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[7] A "participant" is specifically defined by ERISA 3(7) as an employee or former employee of an employer, or member of an employee organization who is or may become eligible for benefits.

[8] *Raymond B. Yates, M.D., P.C. Profit Sharing Plan v. Hendon*, 541 U.S. 1, 32 EBC 1097 (2004) (citing DOL Opinion 99-04A).

Newly Eligible Participants and Beneficiaries (Other than Special Enrollment)

Individuals who first become eligible for coverage on or after March 23, 2012, other than during a special enrollment period, must receive the SBC in connection with any written (or electronic) enrollment materials distributed by the plan as part of the initial enrollment process. If the plan does not distribute written or electronic enrollment materials as part of the initial enrollment process, the plan must distribute the SBC no later than the first day on which the individual is otherwise eligible to enroll.

Example: Bob becomes eligible for coverage under ABC's group health plan on July 1, 2012. ABC's plan administrator sends Bob written enrollment materials on July 5, 2012. The SBC is timely provided if it is included with the written enrollment materials sent to Bob on July 5, 2012.

Practice Pointer: **What if ABC's enrollment process is conducted *by telephone* and it does not otherwise send any written materials? The instructions to the draft SBC clarify that the SBC may not be provided orally. Thus, a written copy must be provided, but when? Read literally, the Regulations suggest that ABC, the plan in our example above, must send a written copy of the SBC on or before the first date that Bob is able to enroll, which is July 1, 2012, in our example above. Fortunately, the instructions to the draft SBC template also indicate that the plan must offer to provide a written SBC *within seven days* to the address provided by the enrollee or, alternatively, it may be provided electronically, at the enrollee's discretion, (i) to an email address provided by the enrollee, (ii) via a link to a website or (iii) by any other method mutually agreed to by the responsible party and the enrollee.**

The SBC must generally be provided with respect to *each benefit package* offered by the plan for which the newly eligible individual is eligible. See "How is the SBC provided?" below for a more detailed discussion.

Practice Pointer: **What is a "benefit package option" for purposes of the SBC requirement? The Regulations do not define "benefit package option"; however, the special enrollment regulations under HIPAA's portability rules (the same subpart in ERISA, the PHSA and the Code to which the health insurance reforms were added by the ACA) define a benefit package as any coverage arrangement with a difference in benefits or cost sharing.**

If any of the information required to be in the SBC changes before the first day of coverage (e.g., prior to the end of the waiting period), then an updated SBC must be provided *prior to the first day of coverage*.

Newly Eligible Participants and Beneficiaries (Special Enrollment)

Individuals enrolling pursuant a HIPAA special enrollment on or after March 23, 2012, must receive the SBC within seven days of the request for enrollment. The SBC must be provided with respect to each benefit package option for which the special enrollee is eligible.

If any of the information required to be in the SBC changes before the first day of coverage (e.g., prior to the effective date of coverage), then an updated SBC must be provided *prior to the first day of coverage*.

Annual Enrollment (Renewal)

The SBC must be provided as part of the plan's annual enrollment process, even if the participants and beneficiaries have already received an SBC as part of the initial enrollment process. According to the Regulations, if eligible individuals must enroll in writing (or electronically), the SBC must be provided with the written or electronic annual enrollment materials that are provided. If annual enrollment is automatic, the SBC must be provided no later than 30 days prior to the first day of coverage for the new plan year.

Practice Pointer: **In some cases, a health plan's annual enrollment procedure is passive or "negative," which means that all elections currently in effect (including a prior election not to participate) are renewed for the following plan year unless an election change is affirmatively made. In such cases, notice of the annual enrollment opportunity is typically provided via postcard or email prior to the actual annual enrollment period; however, if the participant has no desired changes for the following plan year, the participant takes no action during the annual enrollment period and his/her election is automatically renewed. In the case of a negative annual enrollment period, where elections are automatic, must the SBC be provided when the notice of the enrollment period is sent or no later than 30 days prior the first day of the plan year? Although not clear, we believe the better approach is that the SBC must be provided when notice of the enrollment period is sent. Thus, if notice of the annual enrollment opportunity is sent 60 days before the beginning of the plan year, the SBC should be provided at that time as well.**

Due to restrictions on the manner in which the SBC is distributed, this could be problematic for plans and insurers. See "How must the SBC be sent?" below for a more detailed discussion.

Unlike the initial enrollment and special enrollment periods, only an SBC for the benefit package in which the individual is currently enrolled must be provided during annual enrollment, even if the covered individual is eligible for other benefit package options. Nevertheless, the covered individual is entitled to receive a copy of the SBC for the other benefit package options for which he is eligible upon request (see "Upon Request by a Participant or Beneficiary" below for a more detailed discussion).

Practice Pointer: **Individuals who are eligible, but not enrolled, must be sent a copy of the SBC for <u>each</u> benefit package for which they are eligible to enroll during the annual enrollment period. If a plan's current enrollment system is unable to distinguish between those who currently have coverage and those who don't, then the plan may have to provide everyone a copy of each SBC for which they are eligible, regardless of whether they are enrolled or not.**

If any of the information required to be in the SBC changes before the first day of coverage (e.g., between the date the SBC is provided in connection with annual enrollment and the first day of the next plan year), then an updated SBC must be provided *prior to the first day of coverage*.

Upon Request by a Participant or Beneficiary

The SBC must be provided to an eligible individual in connection with a request for information about a plan or policy as soon as practical, but no later than seven days following the request.

Practice pointer: **Can a plan or health insurer charge the individual for copies provided upon request? The preamble to the Regulations indicate that the SBC must be provided free of charge.**

Material Modifications

Where a material modification is made to the terms of the plan that would impact the information in the most recently distributed SBC, and such change is made other than in connection with "renewal" (i.e., it is not a change required to be reflected in the SBC provided during annual enrollment), then notice of the modification must be provided at least 60 days prior to the effective date of the change. The preamble to the Regulations reflects that the mid-year notice can either be a separate notice describing the change or an updated SBC.

Otherwise, the format of the notice and the manner in which it must be delivered must comply with the format and delivery requirements of the SBC.

Practice Pointer: **Changes to the plan that are effective on the first day of the next plan year are typically communicated during the annual enrollment period, which for many plans is less than 60 days prior to the start of the plan year. A literal reading of the statute suggested that notice of material modifications had to be provided 60 days prior to the effective date of the change, even if the effective date was the first day of the next plan year. This would have caused plans that wanted to continue notifying participants and beneficiaries in the annual enrollment period of changes effective as of the first day of the plan year to revise the date they send annual enrollment materials. The Regulations seem to apply the 60-day rule only to changes that are effective during the plan year.**

From Health Insurance Issuer to Plan

A health insurance issuer must provide an SBC to a group health plan (or its sponsor) at the following times:

- With the plan's application or as soon as reasonably practical, but no later than seven days following a request for information (e.g., by a group health plan not currently insured by the health insurer) by the group health plan. If the health plan (or its sponsor) requests information and then subsequently applies for coverage, the health insurer must provide another SBC *only* if the information provided in the first SBC provided upon request has changed.
- If there is a change in the information before the coverage is offered, an updated SBC must be provided before the offer is made. Likewise, if there is a change in the information before the first day of coverage, an updated SBC must be provided before the first day of coverage.
- If written application for renewal is required, then the SBC must be provided when the written materials for renewal are provided.
- If renewal is automatic, then the SBC must be provided to the plan no later than 30 days prior to the first day of the new policy year.
- As soon as practical but no later than seven days following a request by a plan.

How must the SBC be delivered?

An SBC provided by a plan or health insurer to a participant or beneficiary may be provided in paper form. Alternatively, for plans and issuers subject to ERISA (plans sponsored by private employers) and/or the Internal Revenue Code (e.g., church plans), the SBC may be provided electronically if the requirements of DOL's electronic disclosure safe harbor at 29 CFR Section 2520.104b-1(c) are met. Nonfederal governmental plans may comply with either ERISA's electronic disclosure safe harbor requirements or, alternatively, the requirements applicable to insurers in the individual market.

Nonfederal governmental plans that wish to comply with the electronic disclosure requirements for insurers in the individual market must provide an SBC (and any subsequent SBC) in paper form if, upon the individual's request for information or request for an application, the individual makes the request in person or by phone, fax, U.S. mail or courier service. A nonfederal governmental plan may provide an SBC (and any subsequent SBC) in electronic form (such as on the Internet or via email) if an individual requests information or requests an application for coverage electronically, or if an individual submits an application for coverage electronically.

Practice Pointer: **ERISA's electronic disclosure safe harbor currently set forth in the regulations generally imposes strict requirements on plan administrators to ensure that the information sent electronically is sent by means "reasonably calculated to ensure receipt." For example, if a participant is effectively able to access the electronic information from any location where the participant is reasonably expected to perform his duties and access to the employer's electronic information system is an integral part of his/her duties ("worksite employee"), then the plan may generally provide the information electronically without consent provided that the participant is notified that a paper form will be provided upon request and certain other requirements are satisfied. On the other hand, if the participant is not a worksite employee, or the individual receiving the information is not an employee (e.g., a former employee or spouse), then special consent requirements must be satisfied. Plans may find it difficult to revise their electronic enrollment process to match the safe harbor requirements. Moreover, the SBC must be sent to spouses and dependents who would have to satisfy the special consent requirements in order to receive the SBC electronically. Obtaining such consent may not be practical.**

See also the instructions to the draft SBC template.

Generally, the SBC must be a stand-alone document; however, the Agencies request comments as to whether the SBC may be sent with the plan's summary plan description if the SBC is intact and provided at the front of the SPD. The Regulations further propose that a single SBC may be sent to the address at which all individuals to whom the SBC must be sent reside. However, if any eligible dependent's address is different than the eligible employee's address, a separate SBC must be provided to the beneficiary residing at a separate address.

Practice Pointer: **Must another SBC be sent if the spouse enrolls at a different location than the employee but resides at the same address as the employee? Although not clear, a separate SBC distributed to the spouse would appear to be required.**

For an SBC provided by an issuer to a plan, the SBC may be provided in paper form or electronically. For electronic forms, the format must be readily accessible by the plan, and the SBC must be provided in paper form upon request.

What are the format and content requirements for an SBC?

An SBC must satisfy the following format requirements:

- four double-sided pages (i.e., a total of eight printed pages, front and back); and
- no less than 12-point font (and the instructions to the draft template reflect that the font must be Times New Roman).

An SBC must satisfy the following content requirements:

- uniform definitions of standard insurance terms and medical terms, so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;
- a description of the coverage, including cost sharing, for each category of benefits identified by the Departments;
- the exceptions, reductions and limitations on coverage;
- the cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

- the renewability and continuation of coverage provisions;
- coverage examples that illustrate common benefits scenarios (under the proposed regulations, a normal childbirth, breast cancer treatment and diabetes management) and related cost-sharing based on recognized clinical practice guidelines;
- a statement about whether the plan provides minimum essential coverage as defined under Section 5000A(f) of the Internal Revenue Code, and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements (this information does not have to be provided until on or after January 1, 2014);
- a statement that the SBC is only a summary and that the plan document, policy or certificate of insurance should be consulted to determine the governing contractual provisions of the coverage;
- a contact number to call with questions and an Internet address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained;
- for plans and issuers that maintain more than one network of providers, an Internet address (or similar contact information) for obtaining a list of network providers;
- for plans and issuers that maintain a prescription drug formulary, an Internet address where an individual may find more information about the prescription drug coverage under the plan or coverage;
- an Internet address where an individual may review and obtain the uniform glossary; and
- premiums (or cost of coverage for self-insured group health plans).

Practice Pointer: **The draft template SBC indicates that the premium reflected is the total premium charged by the insurer (if fully insured) or the total cost of the coverage, if self-insured, and instructs the recipient to contact the employer for the employee's portion of the cost. The Agencies are requesting comments on whether the SBC should include the employee's portion of the cost.**

- In addition, if at least 10 percent of the population in the county are literate only in a particular non-English language and speak English less than "very well," as determined by the American Community Survey data published by the United States Census Bureau, then each SBC sent to a recipient with an address in that county must include a one-sentence statement in that non-English language about the availability of language services provided by the plan.

What happens if I don't comply?

Potential penalties for failure to comply with the SBC requirement are severe, including agency-induced fines of up to $1,000 for each failure to distribute an SBC and the self-reported excise tax applicable to group health plans (other than governmental plans) under Section 4980D of the Internal Revenue Code. The Department of Labor (which has enforcement authority over ERISA plans) has indicated that it will issue separate enforcement penalty regulations in the near future.

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Employee Benefits & Executive Compensation ADVISORY

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HHS Issues New Women's Preventive Services Required Health Plan Coverage Guidelines

On August 1, 2011, the Department of Health and Human Services (HHS) issued new Guidelines on Women's Preventive Health (the "Guidelines").[1] Under Section 2713 of the Public Health Service Act (PHSA), as added by the Affordable Care Act and incorporated under ERISA, a group health plan and a health insurance issuer offering group or individual health insurance coverage must provide benefits for, and may not impose cost-sharing (with certain out-of-network exceptions) with respect to, preventive care and screening provided for under these Guidelines. These Guidelines supplement the previously adopted preventive care guidelines, and are subject to the same rules regarding cost-sharing.[2]

When are the Guidelines effective?

Under the Guidelines, non-grandfathered plans and issuers are required to provide the new preventive coverage in the first plan year (or, in the individual market, the first policy year) that begins on or after August 1, 2012. Thus, for non-grandfathered plans that operate on a calendar year, the Guidelines are effective for the plan year beginning January 1, 2013.

What preventive services are covered under the Guidelines?

The following preventive services must be offered under the Guidelines:[3]

- **Well-woman visits:** Group health plans and health insurance issuers must provide an annual well-woman health care visit for adult women to obtain the recommended services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in the guidelines, as well as other preventive care referenced in Section 2713 of the PHSA (such as some routine immunizations).

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1 *See* http://www.healthcare.gov/news/factsheets/womensprevention08012011a.html.

2 For more on the preventive care requirements, see our prior Employee Benefits advisory at http://www.alston.com/files/Publication/bb1750fb-8a95-4dcb-b276-c14a151e19eb/Presentation/PublicationAttachment/c20db36b-b8cf-4245-ac7d-c15734d3dcaa/10-399%20EBEC%20Preventatitve%20Care%20Coverage.pdf.

3 The actual preventive care guidelines can be found at http://www.hrsa.gov/womensguidelines/.

- **Gestational diabetes screening:** Women 24- to 28-weeks pregnant, and those identified to be at high risk of developing gestational diabetes, should be screened.
- **HPV DNA testing:** Women who are 30 years of age or older must have access to high-risk human papillomavirus (HPV) DNA testing every three years, even if they have normal pap smear results.
- **STI counseling, and HIV screening and counseling:** Sexually-active women must have access to annual counseling on HIV and sexually-transmitted infections (STIs).
- **Contraception and contraceptive counseling:** Women must have access to all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling. This recommendation excludes abortifacient drugs (i.e., drugs that induce abortion).
- **Breastfeeding support, supplies and counseling:** Pregnant and post-partum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment, in conjunction with each birth.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence should be provided for all women.

Are there any exceptions to the Guidelines?

The requirements to cover recommended preventive services (without any cost-sharing in-network) do not apply to grandfathered health plans. Thus, any plan that remains in grandfathered status will not be subject to these Guidelines or any of the other recommended preventive services guidelines.

Additionally, the IRS, DOL and HHS jointly issued an interim final regulation in connection with the Guidelines to exempt certain religious employers from the Guidelines with regard to contraceptives if their faith deems the provision of contraceptives contrary to its religious tenets. The interim final rule, at 47 CFR § 147.130(a)(i)(iv) provides that certain religious employers are exempt from the requirement to cover contraceptives. A "religious employer" is an organization where (1) the inculcation of religious values is the purpose of the organization, (2) the organization primarily employs persons who share the religious tenets of the organization, (3) the organization serves primarily persons who share the religious tenets of the organization and (4) the organization is a nonprofit organization as described in Section 6033 of the Internal Revenue Code. The federal exemption for religious employers was modeled on state exemptions that are already in force in a number of states that already require contraceptive services coverage.

The exemption for religious employers applies only to group health plans sponsored by certain religious employers and group health insurance offered in connection with such plans. Fully and self-insured group health plans not sponsored by a religious employer and health insurance issuers in the individual market must provide contraceptive services coverage as of the applicable effective date.

This advisory was written by Sara Burke, John Hickman and Ashley Gillihan.

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Employee Benefits & Executive Compensation ADVISORY

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So What Are My Internal and External Claim Review Requirements? A Question Every Group Health Plan Is Asking.

Recently, the U.S. Departments of Treasury, Labor (DOL) and Health and Human Services (HHS) (collectively, the "Agencies") jointly issued new interim final regulations ("New Final Regulations") and new related technical guidance[1] ("New Technical Guidance") regarding the internal and external claim review requirements set forth in new Public Health Service Act Section 2719 ("Claim Review Rules"), as added by Section 1001 of the Patient Protection and Affordable Care Act of 2010 (ACA). The Final Regulations amend interim final regulations related to the Claim Review Rules issued by the Agencies on July 23, 2010 ("Original Regulations"), and the New Technical Guidance comes on the heels of technical guidance issued earlier in 2011 and in 2010.

Although the New Final Regulations and the New Technical Guidance provide much needed clarification around the Claims Review Rules, the flurry of guidance regarding the Claims Review Rules has left group health plan sponsors, administrators and insurers with many questions relating to their new responsibilities. We summarize below the recent clarifications and revisions with the hope of providing an integrated roadmap for these new legal requirements.

Practice Pointer: **The new Claims Review Rules added by the ACA incorporate by reference the claims review regulations set forth in ERISA ("ERISA Claims Regulations").[2] Thus, if your group health plan is subject to ERISA, and your group health plan is not a grandfathered plan as defined by the ACA, you are responsible for complying with both ERISA's claims procedure rules and the new Claims Review Rules set forth in the ACA. More importantly, a failure to comply with the ERISA Claims Regulations may now result in imposition of the $100 per day excise tax under the Internal Revenue Code (Section 4980D) imposed on failures to comply with the various health insurance reforms added by Sections 1001 and 1201 of the ACA, including but not limited to new Section 2719.**

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[1] The guidance includes the Final Regulations, Technical Release 2011-22 (Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes) and model notices of adverse benefit determinations, all of which are available on the DOL EBSA website at http://www.dol.gov/ebsa/healthreform/.

[2] *See* 29 C.F.R. 2560.503-1, as amended from time to time.

The New Final Regulations address both the internal and external review requirements of the Claims Review Rules. We address each in turn below.

I. Requirements Relating to Internal Claims and Appeals

Up to 72 hours now allowed for benefit determinations relating to urgent care

The Final Regulations generally return the maximum determination period for claims involving urgent care from 24 hours to the pre-ACA rule in the ERISA claims regulations of 72 hours. However, the plan or insurer must defer to the provider's determination as to whether a claim involves urgent care. Consistent with the ERISA Claim Regulations, the Agencies emphasize in the preamble to the New Final Regulations that 72 hours is a maximum time period (as opposed to a safe harbor) and that medical exigencies may require a more rapid determination.

Diagnosis and treatment codes now only required upon request

The New Final Regulations eliminate the requirement that notices of adverse benefit determinations (ABDs) automatically include diagnosis and treatment codes and their meanings. Instead, plans and insurers must provide such codes and their meanings as soon as practicable following a request from a plan participant or beneficiary. Importantly, the notice of an ABD must inform participants and beneficiaries of their right to obtain such codes.

Requirement that notices be provided in a culturally and linguistically appropriate manner ("CLA requirements")

The New Final Regulations significantly simplify the requirement imposed by the Original Regulations that notices of adverse benefit determinations be provided in a culturally linguistic and appropriate (CLA) manner. Under the Original Regulations, if the plan covers less than 100 participants at the beginning of the plan year, the plan is considered to comply with the CLA requirement if it provides notices, upon request, in a language in which 25 percent or more of its participants are literate (only in the same non-English language). If the plan covers 100 or more participants at the beginning of the plan year, the plan is considered to comply with this requirement if it provides notices, upon request, in a language in which the lesser of 500 or more participants or 10 percent of all participants are literate (only in the same non-English language). If the threshold is satisfied, all notices must state in the relevant non-English language indicating that the notice will be provided upon request in the non-English language. The New Final Regulations replace the somewhat complex, plan-by-plan determination imposed by the Original Regulations with a single standard based on the county to which the recipient of the notice resides.

Under the new standard, if at least 10 percent of the population in the county are literate only in a particular non-English language and speak English less than "very well," as determined by the American Community Survey data published by the United States Census Bureau, then each notice of an adverse benefit determination sent to a recipient with an address in that county must include a one sentence statement in that non-English language about the availability of language services

provided by the plan. The plan must also provide oral language services in the non-English language and provide written notices in the non-English language upon request.

Practice Pointer: **The preamble to the Final Regulations contains a current list of relevant counties and languages. There are 255 counties (78 of which are in Puerto Rico) that meet the threshold.[3] In the vast majority of cases, Spanish is the relevant non-English language; however, Chinese, Tagalog and Navajo are present in a few counties affecting just five states, Alaska, Arizona, California, New Mexico and Utah.**

The Final Regulations also eliminate the "tagging and tracking" requirement under which all subsequent notices to a claimant who requested a notice in an applicable non-English language had to be in that language. This requirement was challenging for many current systems. In lieu of this requirement, the Final Regulations require that the English versions of all notices include a prominently displayed statement in any applicable non-English language describing how to access the language services provided by the plan. Targeted notices are not required—i.e., the statements may be included in all notices. The Agencies have published model notices that contain sample statements in each of the relevant languages.[4] The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) in any applicable non-English language and, upon request, must provide a written translation of any notice in any applicable non-English language.

The Final Regulations constrict the "strict adherence" standard for exhaustion of remedies

The Original Regulations allow claimants to bypass the internal appeals process if the plan fails to strictly comply with the procedural requirements. The New Final Regulations provide an exception to this strict adherence requirement for errors that are minor and meet certain other requirements. In particular, claimants may be required to exhaust internal administrative remedies despite a failure of a plan or insurer to strictly comply with the applicable rules if the failure was *de minimis*; non-prejudicial to the claimant; attributable to good cause or matters beyond the control of the plan or insurer; in the context of an ongoing good-faith exchange of information; and not reflective of a pattern or practice of noncompliance.

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[3] The Department of Labor will update this guidance annually if there are changes to the list of counties determined to meet this 10 percent threshold.

[4] The model notices may be found on the DOL's EBSA website at http://www.dol.gov/ebsa/healthreform/.

Practice Pointer: **The DOL has followed a similar approach with respect to the ERISA Claims Review Regulations. According to the DOL, not every deviation by a plan from the requirements of the ERISA Claims Regulation permits a claimant to exhaust the plan's internal review procedures and file suit.[5] If the plan's procedures provide an opportunity to effectively remedy the inadvertent deviation without prejudice to the claimant, then there ordinarily will not have been a failure to establish or follow reasonable procedures as contemplated by the ERISA Claims Regulations. On the other hand, the DOL has viewed systematic deviations from the plan procedures, or deviations not susceptible to meaningful correction through plan procedures, such as the failure to include a description of the plan's review procedures in a notice of an adverse benefit determination, as justifying a bypass of the internal procedures.**

Effective date of internal review changes

Each of the changes and clarifications related to a plan's internal review process discussed above relate to provisions delayed by Technical Release 2011-01 until plan years beginning on or after January 1, 2012. Thus, the clarifications and changes set forth in the New Final Regulations related to a plan's internal review process are delayed until plan years beginning on or after January 1, 2012.

II. Requirements Relating to External Reviews – In General

Plans and issuers must follow either a federal external review process or a state external review process. Ultimately, both the federal and state processes are to include, at a minimum, the consumer protection provisions of the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (the "NAIC Model Act"). The process that applies depends on whether the plan is fully insured or self-insured.

A. Requirements Relating to External Reviews – Self-Insured Plans Subject to ERISA or the Code

Self-insured plans subject to ERISA and/or the Code are generally required to comply with a federal external review process that uses independent reviewing organizations or IROs (the "private IRO process).[6] DOL Technical Release 2010-017 sets forth a safe harbor process for complying with the federal external review requirements. The Final Regulations make several key changes with respect to the federal external review process.

Scope of the federal external review process

The breadth of claims with respect to which the federal external review processes applied was the subject of great concern to many employers. Under the Claims Review Rules, all benefit denials, other than questions of eligibility, were subject to external reviews. In contrast, the NAIC Model Act

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[5] *See* Q-F2 at http://www.dol.gov/ebsa/pdf/CAGHDP.pdf.

[6] Plans may also voluntarily comply with a state process if state makes the process available to self-insured plans.

[7] The release may be found at http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

is limited to claims relating to medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit.

The Final Regulations temporarily narrow the scope of the federal external claim review so that it more closely resembles the NAIC Model Act, although it is not identical. Under the Final Regulations, the scope of the federal review includes adverse benefit determinations by a plan that involve "medical judgment," as determined by the independent review organization, or "rescissions" (as set forth in new PHSA Section 2712). The New Final Regulations indicate that medical judgment includes, *but is not limited to*, claims based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit or a determination that a treatment is experimental. Claims involving medical judgment do not include claims that only involve contractual or legal interpretations. The regulations provide a couple of examples to illustrate a claim involving medical judgment. In one example, the plan covers 30 visits to a particular specialist, but will cover more in the event of an approved treatment plan submitted by the health care provider. The provider submits a treatment plan for a 31st treatment, which is denied due to lack of medical necessity. In this example, the claim involves a determination of medical judgment and would be subject to external review. On the other hand, if there is just a specified number of treatments, with no exception, the denial of the 31st visit would not involve medical judgment and would not be subject to external review. In the other example, the plan does not provide coverage for out-of-network services unless the service cannot be effectively provided in-network. Claimant seeks coverage for a procedure performed out of network. The plan denies coverage for the treatment on the basis that it is out-of-network (in other words, it can be effectively provided in-network). This claim involves medical judgment and is subject to the external review requirement.

The preamble lists a number of other examples of situations that involve medical judgment, including (to list a few) whether a participant is entitled to a reasonable alternative standard for a reward under a wellness program; the frequency, method, treatment or setting for a required preventive service where none is specified in the recommendations; and whether a plan is complying with the non-quantitative treatment limitations under the Mental Health Parity Act.

The narrowing of the scope of the federal external review is temporary, and will be revisited by the Agencies by January 1, 2014, when the remainder of the health reforms become effective. If the Agencies revert to a broader scope of review, they will provide some time for plans and issuers to adjust.

Practice Pointer: **Do HRA claims involve "medical judgment"? HRAs typically limit reimbursement to expenses that qualify as "medical care" as defined in Code Section 213(d) or, alternatively, the claimant's share of an expense that is covered by the employer's major medical plan but for a deductible or other financial limit (e.g., copayment or coinsurance). In either case, we believe there is a strong argument that HRA claims do not involve medical judgment as contemplated by the New Final Regulations. Instead, HRA claim determinations involve legal or contractual interpretations. For example, in the case of an HRA that reimburses any expenses that qualify as Code Section 213(d) medical care, the determination under the HRA is limited to whether the expense satisfies the legal definition of "medical care." Even claims for "dual purpose" services or treatments—services or treatments that qualify as "medical care" only if they would not be received but for a medical condition—do not constitute medical judgment because the plan or the claims administrator must simply determine whether a health care provider has recommended the service for a condition—not whether the service or treatment is medically necessary or appropriate.**

Effective date of change: The change in the scope of the federal external review is effective with respect to claims for external review initiated on or after September 20, 2011. This raises some question as to whether the narrower standard can be applied before the effective date.

Practice Pointer: **Unlike many of the internal review requirements set forth in the Claims Review Rules that were delayed, the obligation to make an external review available was not. Thus, group health plans are arguably obligated to comply with the broader-scope external review process with respect to requests for external review initiated prior to September 20, 2011.**

IRO assignment process

The original DOL safe harbor guidance on the external review process provided that, to be eligible for the safe harbor, the plan (or the plan's TPA) must contract with at least three IROs. The purpose of this requirement was to ensure an independent and impartial review process. In subsequent Frequently Asked Questions, the Agencies clarified that failure to contract with at least three IROs would not be a *per se* violation of the Claims Review Rules and that, instead, the plan could demonstrate other steps taken to ensure that its external review process was independent and without bias.

Under revised DOL guidance, a plan must contract with at least two IROs by January 1, 2012, and rotate assignments among them. As this is a safe harbor, a plan may use an alternative process to demonstrate that reviews are independent and unbiased. However, DOL and the Treasury Department will "look closely" at any alternative means. At a minimum, these agencies expect plans to document how any alternative process constitutes random assignment, as well as how it ensures that the process is not subject to undue influence by the plan and without bias.[8]

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[8] DOL Technical Release 2011-02 may be found at http://www.dol.gov/ebsa/newsroom/tr11-02.html.

Practice Pointer: **If an HRA involves no claims involving medical judgment, must it engage the services of two or more IROs? Technically, the IRO is responsible for making the determination as to whether a claim involves medical judgment—not the plan sponsor administrator—so the conservative answer is that an HRA must still engage two or more IROs. On the other hand, it seems misleading to offer claimants the opportunity to request an external review for claims that are not ever eligible for external review by plan design. Plan sponsors and administrators should discuss the issue with legal counsel.**

B. Requirements Relating to External Reviews – Fully Insured Plans

In general, in the case of a fully insured plan, the issuer is responsible for complying with the external review requirements. If the state has a compliant external review process, then the issuer must comply with that process.[9] If the state does not have a compliant process, then a federal external review process applies. The original regulations provided a transition period to allow states to bring their laws into compliance with the NAIC Model Act. The Final Regulations end the transition rule for existing state processes on December 31, 2011, regardless of the plan year. A further transition period is provided until January 1, 2014, for state processes that are similar to the NAIC Model Act process. Beginning January 1, 2014, state processes must comply with the NAIC Model Act. In states without a qualifying state process, the insurer may elect either to follow an HHS process administered through the federal Office of Personnel Management or the IRO process that applies to self-funded plans.

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[9] Note that plans that are exempt from ERISA, such as nonfederal governmental plans, may be subject to state law because ERISA preemption does not apply.

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Employee Benefits & Executive Compensation ADVISORY

August 22, 2011

HEALTH CARE REFORM UPDATE:

- **HHS Annual Limit Waiver Program Will Close on September 22, 2011**
- **No Waiver Application Required for Certain HRAs**

The Affordable Care Act (the "Act") prohibits covered group health plans (including grandfathered plans) from including an annual dollar cap on benefit payments (an "annual cap"). The Department of Health and Human Services (HHS) previously allowed annual waivers from the annual cap requirement for plans that requested a waiver, met certain requirements and agreed to certain annual notice and recordkeeping requirements. As discussed herein, HHS has issued two new pieces of guidance with respect to the process for obtaining such waivers (including a deadline for requesting waiver extension or a new waiver).

First, HHS has announced that the waiver process will be concluded on September 22, 2011. A plan that has already received a wavier and wishes to extend the wavier must submit a wavier extension form to HHS no later than September 22, 2011. A plan that has not yet applied for or been granted a waiver ("new applicants") may apply for a waiver if the plan was offered before September 23, 2010, and the waiver application is submitted no later than September 22, 2011. Guidance with respect to applying for an extension or a new waiver is provided in supplemental guidance issued in the form of a memorandum issued by the Centers for Consumer Information and Insurance Oversight (CCIIO), which may be found at http://cciio.cms.gov/resources/files/06162011_annual_limit_guidance_2011-2012_final.pdf (the "June 17, 2011, Supplemental Guidance").

In addition, HHS has announced that certain health reimbursement arrangements (HRAs) that are subject to the restrictions on annual limits and that were in effect before September 23, 2010, do not have to file a waiver, but rather are exempt as a class from the annual limit requirements for plan years beginning before January 1, 2014. Such HRAs are subject to certain recordkeeping and participant notice requirements. The guidance with respect to HRAs is also provided in CCIIO Supplemental Guidance and may be found at http://cciio.cms.gov/resources/files/final_hra_guidance_20110819.pdf (the "August 19, 2011, Supplemental Guidance").

This advisory addresses the impact that this new guidance will have on group health plans.

BACKGROUND

Annual Limits

The Act generally prohibits plans from imposing annual dollar limits on essential health benefits. For plan years beginning before January 1, 2011, regulations permit "restricted" annual limits to be imposed as follows:

- for plan years beginning on or after September 23, 2010, but before September 23, 2011 – $750,000;
- for plan years beginning on or after September 23, 2011, but before September 23, 2012 – $1.25 million; and
- for plan years beginning on or after September 23, 2012, but before January 1, 201 – $2 million.

The restrictions on annual limits apply to grandfathered group health plans.[1]

Waiver Program

In addition to allowing plans to impose restricted annual limits, HHS established a process whereby plans that were offered before September 23, 2010, could obtain a complete waiver from the annual limit requirements if HHS determined that compliance with the annual limit requirements would result in a significant decrease in access to benefits or a significant increase in premiums. Waivers granted pursuant to this process were effective for one year only—i.e., the first plan year beginning between September 23, 2010, and September 23, 2011.

Application of Annual Limits to HRAs

Interim final regulations provide that the restrictions on annual limit do not apply to health flexible spending arrangements (FSAs) as defined under Internal Revenue Code section 106. Under this definition, a health FSA is a benefit program which provides employees with coverage under which:

A. specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

B. the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

Many HRAs will be FSAs under this definition, in which case the annual limits should not, barring a regulatory change, apply.

In addition, the preamble to the interim final regulations distinguishes between stand-alone HRAs and HRAs that are integrated with other coverage. The preamble states that if an HRA is integrated

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[1] The restrictions on annual limits do not apply to grandfathered individual health insurance coverage.

with coverage that satisfies the annual limit requirement, then the HRA does not have to separately satisfy the annual limit requirement. The preamble specifically requested comments on application of the annual limit requirement to stand-alone HRAs.

Extensions of Existing Waivers/New Waiver Applications

CCIIO has issued detailed instructions ("Technical Instructions") regarding how to file an extension of an existing waiver or to make a new waiver application. The instructions may be found at http://cciio.cms.gov/resources/files/annual%20_limit_waivers_technical_instructions_update_081911.pdf, and were updated on August 19, 2011.

Certain deadlines must be met in order for the plan to continue to be exempt from the annual limits through the first plan year beginning on or after January 1, 2014. If these deadlines are not met, then the restricted annual limits will apply:

- September 22, 2011–deadline for filing an extension of an existing waiver or an application for a new waiver
- December 31, 2012–deadline for submitting the first annual limit update in order to keep a wavier in effect
- December 31, 2012–deadline for submitting the second annual limit update in order to keep a waiver in effect

The Technical Instructions also provide guidance in various situations as to when an applicant is considered a new applicant (e.g., because a waiver application was previously denied) and thus must comply with the procedures for new applicants.

HRAs

The August 19, 2011, Supplemental Guidance provides that HRAs that were in existence prior to September 23, 2010, and that are subject to the restricted annual limits do not need to file an extension for a previously granted waiver or a new waiver application. Rather, such HRAs are deemed as a class to be exempt from the annual limits. The rationale for this blanket exception is that all non-exempt HRAs have limits on the amount that can be spent that are less than the restricted annual limits. Certain HRAs (e.g., retiree-only HRAs, vision- or dental-only HRAs and possibly even HRAs that qualify as FSAs) should be exempt from the Act's annual limit requirement even without a waiver.

There are a few things of note with respect to this exemption. First, in order for the exemption to apply, the HRA must comply with the record retention and annual notice requirements that are part of the original waiver program. The earlier guidance may be found at http://cciio.cms.gov/resources/regulations/index.html#alw. The Technical Instructions provide further information on the notice requirement, as well as a model notice.

Second, the August 19, 2011, Supplemental Guidance defines an HRA as a self-insured medical reimbursement plan funded solely by employer contributions and not through salary reduction that:

- reimburses some or all of the medical care expenses of participating employees, spouses and dependents up to a maximum dollar amount for a coverage period; and
- allows participants to carry forward unused amounts remaining at the end of the coverage period for use in subsequent coverage periods.

By referring specifically to HRAs with a carry-forward, the Supplemental Guidance raises some doubt as to whether the Guidance applies with respect to a non-exempt HRA without a carry-forward.

Finally, the Supplemental Guidance addresses the wavier program only, which ceases to apply with respect to plan years beginning on or after January 1, 2014. Thus, there are still open issues remaining to be resolved as to whether the annual limits will apply to stand-alone HRAs at that time. This issue remains to be addressed in regulations.

This advisory was written by Carolyn Smith, John Hickman and John Anderson.

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Employee Benefits & Executive Compensation ADVISORY

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Court Decision Clears the Air (Somewhat) for Wellness Programs

Employer wellness programs face a number of potential compliance issues under a variety of federal (e.g., HIPAA, GINA, Affordable Care Act) and state law provisions. Recently, the Equal Employment Opportunity Commission (EEOC) and private litigants have challenged employer-sponsored wellness programs that offer incentives for providing biometric and other health-related information under the Americans with Disabilities Act (ADA). (The EEOC is the federal agency charged with enforcing the ADA.)

The ADA generally prohibits employers from requiring employees to undergo a medical examination or answer medical inquiries (the "ADA Prohibition"). An important exception exists for wellness programs that are considered to be voluntary under ADA guidance. Based on current informal guidance from the EEOC, a wellness program will only be considered to be voluntary if it neither requires participation nor penalizes employees who do not participate. This raises concern with respect to the vast number of employers implementing wellness programs with a financial reward (or surcharge) for participation (or non-participation) (e.g., does a participation incentive of a 20 percent medical premium discount essentially *force* employees to participate in the wellness program?). Nonetheless, such financial components are almost universally included as part of employer-sponsored wellness programs. Earlier this spring, a federal district court in Florida handed down a ruling that, if followed by other courts, provides employers with some breathing room under the ADA. In this advisory, we summarize the court's ruling and briefly discuss its potential impact on the design of employer-sponsored wellness programs.

Seff v. Broward County[1]

In 2009, Florida's Broward County adopted a wellness program as part of its consumer-driven health plan's open enrollment process. Just like countless other employer plans around the country, Broward County's wellness program consisted of a confidential health risk assessment questionnaire and confidential biometric screening for glucose and cholesterol levels. Employees who completed the program and were identified as having one of five disease states—asthma, hypertension, diabetes, congestive heart failure or kidney disease—were given the option to participate in a disease management coaching program, after which the employee was eligible to receive relevant medications at no additional cost.

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[1] U.S. District Court for the Southern District of Florida, Case No. 10-61437-CIV-Moore/Simonton.

Participation in the wellness program was not required for coverage under Broward County's group health plan, and Broward County (as employer/plan sponsor) received only de-identified aggregate data that it might consider in creating future benefit plans. In mid-2010, a financial incentive component was added so that those who declined to participate in the program incurred a $20 charge on each of their bi-weekly paychecks. Just a few months later, Broward County found itself the defendant in a class action lawsuit claiming that it violated the ADA Prohibition.[2]

Ruling in favor of Broward County, the court stated that the county's wellness program did not violate the ADA Prohibition because the program comes under ADA's "safe harbor" exception to the ADA Prohibition. In other words, the court did not even need to address whether the financial incentive rendered participation in the arrangement "involuntary."

The Safe-Harbor Exception

The safe-harbor exception[3] protects employers and plan administrators (and other covered entities under the ADA) from "establishing, sponsoring, observing or administering" a wellness program if the program is:

i) part of "the terms of a bona fide benefit plan";

ii) "based on underwriting risks, classifying risks or administering such risks"; and

iii) "based on or not inconsistent with State law" and is not used "as a subterfuge to evade the purposes" of the ADA Prohibition.

Applying these requirements to the Broward County wellness program, the court ruled that Broward County's wellness program was part of the county's group health plan and therefore met requirement (i) above because the insurer under the plan pays for and administers the program under its healthcare contract with the county, only those enrolled in the county's health plan may participate in the wellness program and the county included a description of the wellness program in its benefits plan handout. The court also found that there was a "strong argument" that the wellness program itself is a bona fide benefit plan because it offers benefits—disease coaching and medication cost waivers—for certain participants.

The court found that the purpose of the second requirement is to permit the development and administration of benefit plans in accordance with accepted principles of risk assessment. Thus, requirement (ii) was met because the program's ultimate goal is to sponsor insurance plans that maintain or lower its participants' premiums. More specifically, the court stated that Broward County's wellness program renders aggregate data that the county may analyze when developing future benefit plans and uses to classify various risks on a macroscopic level so it may form economically sound benefits plans for the future.

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2 The ADA Prohibition reads, "A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity." 42 U.S.C. § 12112(d)(4)(A).

3 *See* 42 U.S.C. § 12201(c).

Finally, the court stated that requirement (iii) was met because there is no Florida law that is inconsistent with the wellness program and the plaintiffs did not allege any sort of subterfuge to avoid the purposes of the ADA. Further, the court stated that it was hard to see how the wellness program relates to discrimination in any way and, rather, is "enormously beneficial" to all employers of the county.

Is the Voluntary/Involuntary Analysis Still Relevant?

Only one other court has applied the approach adopted in *Seff v. Broward County*, and that decision was under a fully insured program. It is unclear whether the EEOC, as the ADA enforcement agency, will follow this ruling. We are aware of several EEOC challenges where the EEOC has disputed the validity of employer wellness programs that offered financial incentives based on the "voluntariness" of the arrangement. Nonetheless, *Seff v. Broward County* provides employers some breathing room, and an alternate approach to support the validity of their wellness programs.

This advisory was written by **John Hickman**, **Carolyn Smith** *and* **Johann Lee**.

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