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Summer 2020 Benefits Newsletter

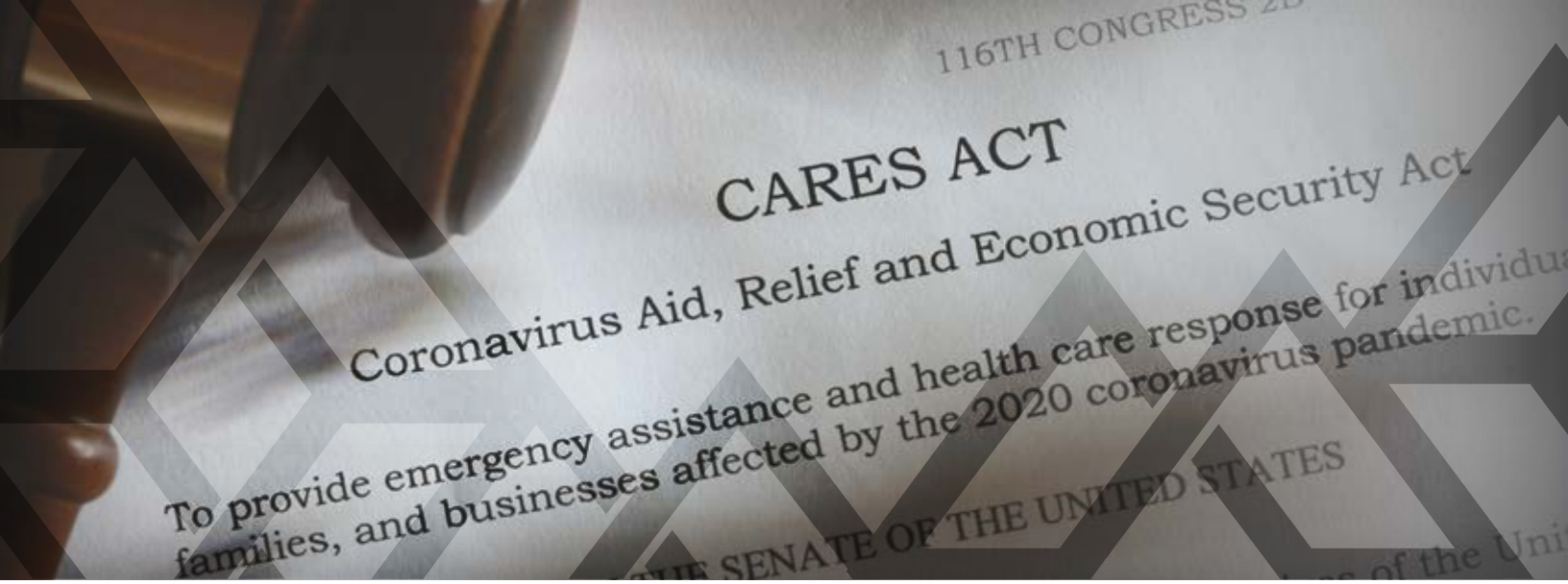
Supreme Court Finds Employers Violate Title VII When They Fire Employees Merely For Being Gay or Transgender

The U.S. Supreme Court has ruled that employers violate Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on race, color, religion, sex, or national origin, when they discharge employees merely for being gay or transgender. The 6-3 decision comes in three consolidated cases, which had divided the lower courts.

Because the Court viewed an employer's decisions based on homosexuality or transgender status as intentionally treating individual employees differently because of their sex (e.g., firing male, but not female, employees for being attracted to men), it held that an employer who discharges an employee for being homosexual or transgender necessarily discriminates on the basis of sex in violation of Title VII. The Court rejected the employers' argument that homosexuality and transgender status are excluded from Title VII's reach since they are not mentioned in the law's text–noting that sexual harassment also is omitted from the text but still within Title VII's scope. Moreover, the Court said, Congress's ongoing consideration of, but failure to adopt, amendments to add sexual orientation and transgender status to Title VII is not relevant in interpreting the existing statutory language. The Court also discounted the argument that an employer does not violate Title VII if it treats men and women equally, concluding that an employer who fires both gay men and lesbians due to their sexual orientation does not diminish but rather doubles its liability.

Responding to assertions that Congress would not have anticipated this application when it enacted Title VII in 1964, the Court noted other broadly accepted interpretations of Title VII that would not have been envisioned at the time of enactment (such as a prohibition on sex-segregated job postings). The Court concluded: "In Title VII, Congress adopted broad language making it illegal for an employer to rely on an employee's sex when deciding to fire that employee. We do not hesitate to recognize today a necessary consequence of that legislative choice: An employer who fires an individual merely for being gay or transgender defies the law."

Although this is unquestionably a landmark ruling, its full implications will be developed in future cases. The majority emphasized that its holding is limited to employees discharged for being homosexual or transgender and does not address other employment policies (such as sex-segregated bathrooms, locker rooms, or dress codes) or the impact of employers' religious convictions. The consequences for employee benefit plans likewise remain to be seen, but plan sponsors should proceed with caution in the implementation of eligibility and benefit provisions based on sexual orientation (e.g., limiting eligibility to opposite-sex spouses) or transgender status (e.g., blanket exclusions of coverage for gender dysphoria). Other state and federal laws must be considered as well, so consultation with legal advisors is advised.



Recent FAQ Guidance on COVID-19 Related Issues

The DOL, IRS, and HHS have issued another round of FAQ guidance (Part 43) (https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-43.pdf) addressing implementation of the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) for group health plans. As background, the FFCRA generally requires group health plans and insurers to cover (without cost-sharing, prior authorization, or other medical management requirements) certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 (diagnostic tests). The CARES Act requires coverage of a broader range of diagnostic items and services and generally requires plans and insurers to reimburse any provider of diagnostic tests the cash price listed by the provider on a public website or a lower negotiated rate.

Here are highlights of FAQs Part 43:

Diagnostic Tests: Providing more specifics on which diagnostic tests are required to be covered without cost-sharing, Q/A-2 points out that all diagnostic tests that have received a Food and Drug Administration (FDA) emergency use authorization are listed on the FDA website, along with clinical laboratories and commercial manufacturers that have notified the FDA that they have validated their own diagnostic test and are offering the test as outlined in FDA guidance. The agencies advise that it is very reasonable to assume that the individual listed laboratories and manufacturers have requested or intend to request an authorization, and therefore, plans and insurers must cover listed diagnostic tests. Q/A-4 explains that diagnostic tests intended for at-home testing must generally be covered, while Q/A-5 states that testing conducted to screen for general workplace health and safety (e.g., employee return-to-work programs), public health surveillance, or any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 is beyond the FFCRA's scope.

Out-of-Network Coverage: Noting that plans and insurers that do not already have a negotiated rate with an out-of-network provider for diagnostic tests may negotiate a rate, Q/A-9 cautions that the CARES Act generally precludes balance billing for mandated diagnostic testing. For tests administered in an out-of-network hospital emergency department, Q/A-12 advises that the CARES Act supersedes the Affordable Care Act's (ACA) regulatory requirement to pay the greatest of three amounts, requiring the plan or insurer to reimburse out-of-network emergency providers the cash price listed by the provider on a public website, or a negotiated lower rate. For all other out-of-network emergency services, the ACA payment standards continue to apply.

SBC Notice of Revoked Coverage:
In FAQs Part 42, the agencies announced enforcement relief for plans or insurers that adopt modifications to provide greater coverage for COVID-19 diagnosis or treatment without providing the minimum 60-day advance notice to enrollees required for material modifications to the Summary of Benefits and Coverage (SBC). In Q/A-13, the agencies add that if a plan or insurer reverses these changes once the COVID-19 emergency ends, the plan or insurer will be considered to have satisfied its obligation to provide advance notice of a material modification if it previously notified participants, beneficiaries, and enrollees of the general duration of the additional benefits coverage or reduced cost-sharing, or if it notifies them within a reasonable time in advance of the reversal of the changes.

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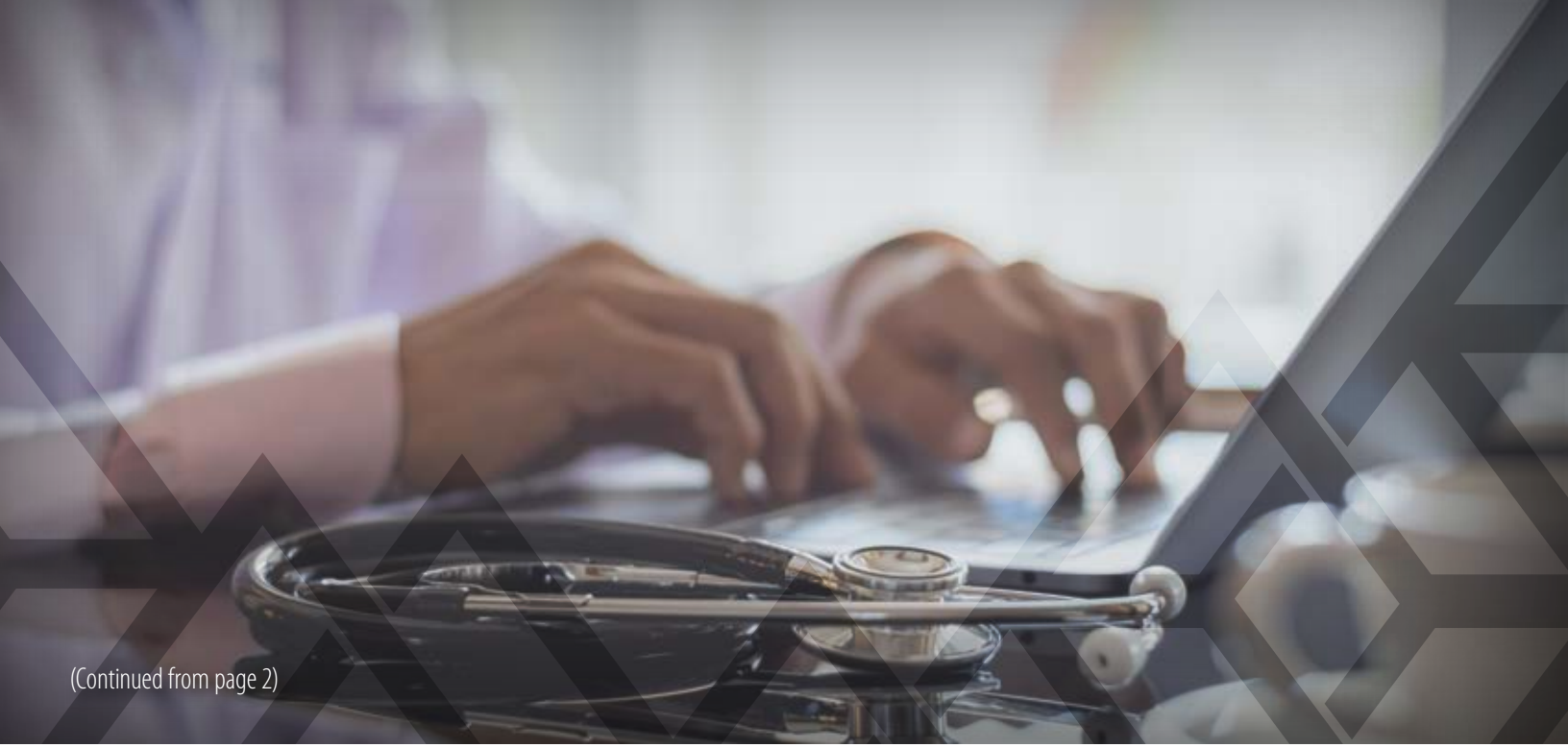

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Grandfathered Status: To the extent that a plan or insurer added benefits or reduced or eliminated cost-sharing pursuant to the agencies' safe harbor in FAQs Part 42, Q/A-15 provides that, for the period in which the COVID-19 emergency is in effect, the plan will not lose its grandfathered status solely because these changes are later reversed.

Relief for Telehealth and Remote Care: Group health plans and insurers that solely provide benefits for telehealth or other remote-care services are exempt from certain ACA requirements for the duration of any plan year beginning before the end of the COVID-19 emergency. Q/A-14 specifies that the relief is limited to telehealth/remote care plans sponsored by a large employer (generally, one with at least 51 employees) and offered only to employees or dependents who are not eligible for coverage under any other group health plan offered by that employer. Plans and insurers providing such coverage are exempt from the prohibition on annual and lifetime limits and the preventive services mandate. But other mandates, such as prohibitions of pre-existing condition exclusions and discrimination based on health status, the prohibition of rescissions, and mental health parity requirements continue to apply.

Mental Health Parity Compliance: Q/A-16 provides that for purposes of compliance with the mental health parity "substantially all" and "predominant" tests for financial requirements and quantitative treatment limitations, the agencies will temporarily forgo enforcement action against any plan or insurer that disregards benefits for the items and services that are covered without cost-sharing under the FFCRA.

Wellness Program Waivers: In Q/A-17, the agencies explain that plans and insurers are permitted to waive a standard (including a reasonable alternative standard) for obtaining a reward under a health-contingent wellness program if participants or beneficiaries are having difficulty meeting the standard because of circumstances related to COVID-19. However, the waiver must be offered to all similarly situated individuals, as described in the wellness regulations.

The 18 Q&As in FAQs Part 43 cover a lot of ground. From whether plans have to cover multiple tests for a single participant to how plans reimburse out-of-network providers that have not posted a cash price for diagnostic tests on a public website, these FAQs are a must-read for group health plan sponsors and advisors.

How Long Are the Extended HIPAA Special Enrollment Periods during the COVID-19 Emergency?

QUESTION: We understand that we are required to extend the HIPAA special enrollment periods under our group health plan due to the COVID-19 emergency. How long is the extension?

ANSWER:

In response to the COVID-19 emergency, the DOL and IRS issued a joint rule extending the HIPAA special enrollment periods for group health plans that are subject to ERISA or the Code. (HHS announced that non-federal governmental health plans are encouraged but not required to adopt the extended special enrollment periods.) As background, 30-day special enrollment periods may be triggered when eligible employees or dependents lose eligibility for other health plan coverage, or when an eligible employee acquires a dependent through birth, marriage, adoption, or placement for adoption. Sixty-day special enrollment periods may be triggered by changes in eligibility for Medicaid or state premium assistance under the Children's Health Insurance Program.

The rule extends the 30- and 60- day HIPAA special enrollment periods by requiring plans to disregard the COVID-19 "outbreak period," which started March 1, 2020, and ends 60 days after the end of the COVID-19 national emergency or a different date announced by the agencies. At the time the final rule was issued, it was not possible to predict the end of the outbreak period, but the rule's preamble suggests that the end date could be different for different parts of the country.

An example in the final rule assumes, hypothetically, that the COVID-19 national emergency ended on April 30, 2020, with the outbreak period ending 60 days later, on June 29. Thus, if an employee experienced a 30-day special enrollment event on March 31, 2020, the employee's special enrollment period ends on July 29, 2020–30 days after the end of the hypothetical outbreak period.

The rule does not address the situation of a special enrollment event before March 1 (i.e., before the start of the outbreak period). However, a similar extension issued in response to Hurricane Katrina indicated that any days prior to the disregarded period would count against the special enrollment period. For example, if 14 days of a 30-day special enrollment period had elapsed before the disregarded period started, then only 16 days would be added to the end of the disregarded period.

It is likely that some special enrollment periods had already ended under the normally applicable rules before the extension was announced on April 28. Although the rule does not specifically address the issue, it appears that plans must re-open enrollment periods that expired during the period from March 1 to April 28. However, it does not seem necessary to restart the 30- or 60- day period. Rather, only days remaining in the original 30- or 60-day period as of March 1 would be added after the outbreak period. Because this aspect of the COVID-19 extension may be difficult to administer, plans and plan sponsors should be proactive and review these situations with legal counsel.

Utah Federal Court Allows Fiduciary Duty and Mental Health Parity Claims Against TPA and Plan

In Daniel R. v. UMR, 2020 WL 1188144 (D. Utah 2020), following the denial of residential mental health treatment benefits for a self-insured health plan participant's child, the child's parents sued the plan and the third-party administrator (TPA) that processed the plan's claims. They asserted that the claim for their child's sub-acute mental health treatment was processed using acute care criteria, constituting a breach of ERISA fiduciary duty and a violation of the federal mental health parity rules. Seeking dismissal, the TPA argued that it was an improper party to sue, and the TPA and plan both argued that there were insufficient facts to support the mental health parity claim. The court disagreed, allowing the lawsuit to proceed against both parties.

Under ERISA, money judgments are normally enforceable only against the plan–not service providers such as the TPA. Thus, the TPA argued that even if it was a fiduciary, it could not be held liable for a monetary award representing the recovery of unpaid benefits. Acknowledging this general principle, the court nevertheless pointed out that while recovery of unpaid benefits may be the parents' primary goal, other forms of relief may be available. For example, if the court were to find that the claim was not afforded full and fair review under ERISA's claims procedure rules, it could order the TPA to reprocess the claim. Because the court could grant relief that would be enforceable against the TPA, it ruled that releasing the TPA from the lawsuit at this point would be premature.

As for the mental health parity claim, which requires showing a disparity between coverage of mental health benefits and medical or surgical benefits, the TPA and plan argued that the parents hadn't identified medical or surgical services analogous to the child's treatment or facts indicating a disparity in the plan's treatment limitations. But the court determined that the parents had identified treatment at a skilled nursing or rehabilitation facility as analogous to the child's sub-acute residential treatment and had asserted that acute treatment standards would not have been applied to sub-acute care in the medical or surgical context. The court found this was "*just enough*" to support the parents' mental health parity claim.

ERISA's statutory language does not specify who may be sued, and courts may be reluctant to dismiss TPAs from lawsuits early on, even though their ultimate financial responsibility may be limited. Likewise, as more courts allow mental health parity claims to proceed, health plan sponsors considering residential mental health treatment exclusions or limitations will need to consult their legal advisors to ensure the provisions are carefully drafted to comply with federal and state parity rules.

Can Participants Change Their HSA Contribution Elections Under Our Cafeteria Plan Due To COVID-19?

QUESTION: Some of our employees would like to reduce their pre-tax HSA contribution elections under our cafeteria plan due to the COVID-19 health crisis. For example, one employee's spouse was laid off and another employee's spouse is working reduced hours as a result of the crisis. Under what circumstances can our employees make midyear changes to their HSA elections?

ANSWER:
Under proposed IRS regulations (which may be relied upon until final regulations are issued), employees may prospectively start, stop, or otherwise change an election to make HSA contributions through pre-tax salary reductions under a cafeteria plan at any time during the plan year. Under these regulations, a cafeteria plan that offers pre-tax HSA contributions must allow participants to prospectively change their salary reduction elections for HSA contributions at least monthly. The plan must also allow participants who become ineligible to make HSA contributions to revoke prospectively their salary reduction elections for HSA contributions. Among other requirements, an individual must have coverage under a high-deductible health plan to be eligible to make HSA contributions.

Remember that other cafeteria plan election changes may be made only if they are permitted under IRS rules. Consequently, an employee who elects to reduce or discontinue HSA contributions during a plan year may be limited to receiving the difference as taxable compensation–additional nontaxable benefits cannot be elected unless the cafeteria plan election change rules otherwise allow a midyear change to the elections for those benefits. The IRS has provided some relief from these rules in response to the COVID-19 health crisis, announced on April 28.

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