ERIC

The ERISA Industry Committee

November 9, 2015

Submitted through the Federal eRulemaking Portal

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building
Room 509F
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Nondiscrimination in Health Programs and Activities (RIN 0945-AA02)

Ladies and Gentlemen:

We are writing on behalf of The ERISA Industry Committee ("ERIC") to respond to the request of the Department of Health and Human Services (the "Department") for comments on the proposed rule interpreting Section 1557 of the Affordable Care Act.

ERIC's Interest in Section 1557

The ERISA Industry Committee is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor health, retirement, and compensation benefits for millions of employees, retirees, and their families.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with a high standard of cost containment, quality, and effectiveness.

Section 1557 of the Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in a health program or activity, any part of which is receiving Federal financial assistance. As interpreted in the Department's proposed regulation, this provision would extend far beyond its statutory boundaries, and would inappropriately encumber the design and day-to-day operation of employer group health plans that do not receive any form of Federal financial assistance. The proposed regulation would impose costly new

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mandates on employer group health plans that are already struggling under a heavy burden of Federal regulation. Moreover, some of these new rules are inconsistent with existing statutory and regulatory requirements that group health plans must satisfy.

The group health plans sponsored by ERIC's members do not discriminate against employees or their family members on the basis of race, color, national origin, sex, age, or disability. Employers and the plans they sponsor are already subject to a complex web of Federal statutes and regulations that prohibit all of these forms of discrimination, and more. ERIC's members are concerned, moreover, that the Department's proposed rule does not adequately reflect the way in which self-funded group health plans are designed and administered. The proposed rule would disrupt the administration of these plans and increase health care costs for employers and employees alike, without adding any additional protection against discrimination.

Background

Most Employer Group Health Plans Receive No Federal Financial Assistance

Most group health plans maintained by large employers are self-insured. The employer determines what benefits the plan will provide and describes the benefits in a written plan document. When an employee or dependent incurs a covered health expense, the expense is paid with funds provided by the employer, often supplemented by contributions from the participating employees.

Most self-insured employer group health plans do not receive any form of Federal financial assistance as defined in Section 1557. For example, an employee or dependent who is covered by an employer group health plan is not eligible for premium tax credits or cost-sharing reductions under the Affordable Care Act. Because the group health plan is not insured, Federal financial support provided to the insurance industry does not flow through to the plan. With limited exceptions,[1] employer group health plans do not receive payments under the Medicare or Medicaid programs.

The Limited Role of Third Party Administrators

As a matter of efficiency, most employers hire unrelated companies to administer the employers' self-insured group health plans. The third party administrator reviews claims and makes payments on behalf of the group health plan, and the administrator sometimes performs additional services, such as establishing provider networks.

Because licensed health insurance companies have the personnel and infrastructure necessary to process health claims for a group health plan that covers tens of thousands of employees, these companies often serve as third party administrators for large self-insured group health plans. The third party administrator does not insure the benefits provided by the group health plan, however. As a result, the third party administrator does not design the plan or decide what categories of individuals and health services the plan will cover. Instead, the third party administrator pays the

[1] A few large employers sponsor "employer group waiver plans" that provide prescription drug benefits to retirees and receive subsidies under Medicare Part D.

benefits determined by the employer and described in the plan document, using funds provided by the employer.

Existing Federal Regulations and Nondiscrimination Requirements

Group health plans are subject to extensive Federal regulation concerning the benefits they offer, the individuals they cover, the manner in which they operate, and the timing and content of the communications they provide to participants. The Employee Retirement Income Security Act of 1974, as amended ("ERISA") is the principal Federal statute governing employee benefit plans, including self-insured group health plans; but ERISA is supplemented by a variety of other tax, labor, employment, and civil rights statutes.

In addition, the non-discrimination policies adopted by ERIC member companies are generally far more expansive than any law (including the Department's proposed rule) requires. The result is that their group health plans are broadly inclusive and do not discriminate against individuals on any of the prohibited grounds.

The employment relationship generally, and employee benefit plans specifically, are subject to a complex array of Federal statutes and regulations that prohibit discrimination on the basis of race, color, national origin, age, sex, pregnancy, disability, health status, genetic information, military service, and a variety of other factors. We have attached an appendix to this letter that summarizes some of the principal nondiscrimination statutes that govern employer group health plans.

Summary of Comments

1. The nondiscrimination rule should not apply to a group health plan merely because the plan's third party administrator receives Federal financial assistance.

2. The nondiscrimination rule should not apply to a legal entity that is separate from the entity that receives Federal financial assistance.

3. If an employer is not in the business of providing health coverage, the nondiscrimination rule should apply only to the specific employee health benefit program with respect to which the employer receives Federal financial assistance, and not to other health benefits provided by the same employer or offered under the same group health plan.

4. If an employer is not in the business of providing health coverage, the nondiscrimination rule should not apply to the employer's group health plan solely because the employer receives Federal financial assistance with respect to other health-related activities.

5. Employer group health plans should not be subject to additional language-assistance requirements for disabled individuals or individuals with limited English proficiency, because these additional requirements are unnecessary and inconsistent with the legal protections already provided to these individuals.

6. To allow sufficient time for compliance, in the limited circumstances in which the nondiscrimination rule might apply to any employer group health plan or sponsoring employer,

the rule should not apply before the first plan year beginning at least twelve months after the final regulation is published.

Comments

1. The Rule Should Not Apply To Health Plans Based On The Administrative Services They Receive

If an entity is principally engaged in providing or administering health services or health insurance coverage, and the entity receives Federal financial assistance for any part of its business, the Department proposes to extend the nondiscrimination rule to all of the entity's businesses. For example, if a health insurance company sells individual health insurance policies through an Affordable Care Act Marketplace—an activity that is supported in part by Federal subsidies—the proposed nondiscrimination rule would apply not only to the company's insurance business, but also to its administrative-services business. The preamble of the proposed rule explains:

> [A]n issuer that participates in the Marketplace and thereby receives Federal financial assistance, and that also offers plans outside the Marketplace, will be covered by the proposed regulation for all of its health plans, *as well as when it acts as a third party administrator for an employer-sponsored group health plan*.[2]

The Department's expansive interpretation of Section 1557 is unworkable and inappropriate. To illustrate this point, suppose that a self-insured group health plan contracts for administrative services with a third party administrator, and the administrator receives Federal financial assistance in a different portion of its business. The plan, as a matter of design, excludes certain services related to gender transition from coverage. If the third party administrator believes that the exclusion is discriminatory under Section 1557, the administrator faces an impossible dilemma: the administrator is potentially liable under the Department's proposed rule if it refuses to pay for the excluded services, but it is potentially liable under ERISA if it agrees to pay for the services.

Section 404(a)(1)(D) of ERISA *requires* the third party administrator to administer the plan in accordance with its written terms. To pay a claim that the plan does not cover is a breach of the administrator's fiduciary duty under ERISA (and probably also a breach of the administrator's service contract with the employer). If neither the employer nor the group health plan receives Federal financial assistance, the plan is not required to comply with Section 1557. The third party administrator cannot insist that the employer expand the coverage provided under a self-insured plan, since the employer, and not the administrator, would bear the cost of the expanded coverage. Accordingly, the third party administrator must either administer the plan provision as written (and face possible liability under the Department's nondiscrimination regulation) or pay claims that the plan is not required to cover (and face possible liability under ERISA and under its service contract with the employer).

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[2] 80 *Fed. Reg.* 54,172, 54,189 (Sept. 8, 2015) (emphasis added).

The Department stated in the preamble of its proposed nondiscrimination rule that it seeks to ensure "that this rule includes the most robust set of protections supported by the courts on an ongoing basis." 80 *Fed. Reg.* at 54,177. We respectfully submit that it is not an appropriate exercise of the Department's rulemaking authority to push the boundaries of the statute as far as the courts will tolerate. The Department's goal should instead be to adopt a fair and reasonable interpretation of Section 1557 consistent with the statute's stated objective, which is to prevent discrimination in health programs and activities that receive Federal financial assistance.

By proposing to extend the nondiscrimination rule to administrative services, the Department improperly seeks to regulate group health plans and employers that do not receive Federal financial assistance. The third party administrator does not have authority to change the terms of the plan, or to ignore the plan's terms and pay benefits the plan does not cover. Accordingly, if the nondiscrimination rule applies to the third party administrator, it is the group health plan (not the administrator) that must provide the required coverage, and it is the employer (not the administrator) that must bear the added cost of compliance. When the Department attempts to regulate the conduct of entities that are outside the scope of Section 1557, the Department exceeds its statutory authority.

By proposing to apply the nondiscrimination rule to third party administrators that also sell individual policies through an Affordable Care Act Marketplace, the Department has created a rule that would be unfair as well as unworkable. Although many third party administrators sell insurance through a Marketplace, not all administrators participate in the Marketplace. Accordingly, group health plans that receive administrative services from non-participating administrators would be exempt from the nondiscrimination requirement (because the plans' administrators would receive no Federal financial assistance), while group health plans that receive identical administrative services from participating administrators would be subject to the nondiscrimination requirement. Nothing in the language of Section 1557 or the policy underlying the statute justifies this result. We urge the Department to exclude a third party's administrative services for a self-funded group health plan from the health-related activities covered by the nondiscrimination rule.

2. The Rule Should Not Apply To Separate Legal Entities

The preamble of the proposed rule states, "Where an entity that acts as a third party administrator for an employer's employee health benefit plan is legally separate from an issuer that receives Federal financial assistance for its insurance plans, we will engage in a case-by-case inquiry to evaluate whether that entity is appropriately subject to Section 1557." 80 *Fed. Reg.* at 54,189 n.73. The preamble does not explain what standards the Department will apply to determine whether the separate legal entity is "appropriately subject" to Section 1557, and the proposed regulation itself does not mention this concept at all.

As we have explained in the preceding section of this letter, the receipt of Federal funds by a third party administrator should not cause its administrative services to be subject to Section 1557 when they are provided to a self-insured group health plan. This is true regardless of whether the plan's third party administrator is legally separate from the administrator's insurance affiliate or another part of the administrator's business that receives Federal subsidies.

In addition, however, the Department should acknowledge and clarify that the reach of Section 1557 does not ever extend beyond the legal entity that actually receives Federal financial

assistance. To do otherwise would be unprecedented and would clearly exceed the Department's regulatory authority.

Section 1557 refers to, and is modeled on, four other Federal civil rights statutes: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973. The Civil Rights Restoration Act of 1987[3] defines the scope of the "program or activity" to which these four statutes apply in relevant part as follows:

> "[T]he term program or activity and the term program mean all of the operations of— . . . (3) (A) *An entire corporation, partnership, or other private organization, or an entire sole proprietorship—*
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> (i) If assistance is extended to such corporation, partnership, private organization, or sole proprietorship as a whole; or
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> (ii) Which is principally engaged in the business of providing education, health care, housing, social services, or parks and recreation . . . ."[4]

Accordingly, although the nondiscrimination statutes extend in some circumstances to the entire corporation, partnership, sole proprietorship, or other legal entity if part of the legal entity receives Federal financial assistance, the statutes do not in any circumstance extend beyond the boundaries of that legal entity to other legally separate entities that receive no Federal funding.

The same principle applies under Section 1557. For example, suppose that a health company operates through two separately-incorporated subsidiaries. One subsidiary sells health insurance policies both through the Marketplace and outside the Marketplace; the other subsidiary provides only third party administrative services. Under the Department's proposed regulation, the entire insurance subsidiary will be subject to the nondiscrimination rule because one of its activities (selling insurance through the Marketplace) receives Federal financial assistance. In contrast, however, there is no reasonable interpretation of Section 1557 that would permit the Department to extend its proposed nondiscrimination rule to the legally separate administrative-services subsidiary, which receives no Federal financial assistance.

The employers that sponsor group health plans and the entities that administer them must know in advance whether the third party administrator is subject to Section 1557, so that they can take the steps necessary to ensure that the administrator complies with the statute. The question whether Section 1557 applies to administrative services provided by a separate legal entity should not be left to the Department's case-by-case determination based on undisclosed criteria.

We urge the Department to address the treatment of separate legal entities in the final regulation in two ways. First, the regulation should make clear that administrative services provided by a separately-incorporated subsidiary or other separate legal entity do not become subject to Section 1557 merely because an affiliated company receives Federal financial assistance. Second, this

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[3] Pub. L. No. 100–259, Sec. 3(a), § 908, 102 Stat. 28, 28–29 (1988) (codified at 20 U.S.C. § 1687).

[4] *Id.* (emphasis added).

clear-cut and objective rule should appear *in the final regulation itself,* and not merely in the preamble. The Department cannot expect those who seek to understand the nondiscrimination rule in the future to read old *Federal Register* notices to discover whether the Department has acknowledged in a long-forgotten preamble that the rule is subject to important exceptions or limitations. Instead, each substantive provision of the Department's rule, including limitations on its scope and exceptions to its application, should appear in the Code of Federal Regulations.[5]

3. The Rule Should Make Clear That Health Benefit Programs Are Not Aggregated

The Department's proposed rule creates an exception for a circumstance in which an employer maintains an employee health benefit program for its own employees but is not otherwise in the business of providing or administering health coverage.[6] If the employer "receives Federal financial assistance a primary objective of which is to fund the [employer's] employee health benefit program," the employer is liable for violations of the nondiscrimination rule only with respect to the employee health benefit program for which it receives Federal financial assistance.

Although ERIC supports this exception, we urge the Department to clarify the exception in two ways. First, the Department should make clear that the nondiscrimination rule applies in this circumstance only to the specific program for which the employer receives Federal financial assistance, and not to other health benefit programs offered by the same employer or included as part of the same group health plan. Second, the Department should make clear that the group health plan itself does not become a "covered entity" merely because the employer receives Federal financial assistance whose primary objective is to fund the plan. We explain the need for both clarifications below.

A. The Nondiscrimination Rule Should Be Limited To The Specific Health Program For Which The Employer Receives Federal Financial Assistance

Large employers provide a variety of different health benefits that are combined in different ways for different purposes. For example, a large employer might operate a wellness program that is considered to be part of the employer's group health plan for some purposes, such as for purposes of filing a single annual report with the Department of Labor on Form 5500. Employees who elect to participate in the wellness program might be eligible for reduced cost-sharing under the group health plan, but the wellness program often is administered separately from the group health plan.

The Department apparently contemplates that an "employee health benefit program" can be a smaller component of a group health plan, since the definition of the term refers to health benefits coverage provided by a group health plan (rather than to the group health plan as a whole). In illustrating the application of the nondiscrimination rule to employers, the preamble explains, "Where, for example, an entity receives Federal financial assistance that is specifically designated to support its employee wellness program, this part will apply to the entity's administration *of that wellness program*." 80 *Fed. Reg.* at 54,190 (emphasis added). This example is helpful, but it

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[5] For the same reason, we urge the Department to include in the final regulation itself the statement that "the definition of Federal financial assistance does not include Medicare Part B," an important substantive exception that currently appears only in the preamble. *See* 80 *Fed. Reg.* at 54,174.

[6] 80 *Fed. Reg.* at 54,220 (to be codified at 45 C.F.R. § 92.208(b).

would be more helpful if it said "this part will apply only to the entity's administration of that wellness program, even if the wellness program is part of a larger group health plan."

We urge the Department to make clear that the application of the nondiscrimination rule in this circumstance is limited to the specific employee health benefit program with respect to which the employer receives Federal financial assistance. The nondiscrimination rule does not apply to any other part of the employer's group health plan, or to other group health plans sponsored by the same employer or covering the same employees.

B. The Employer's Receipt Of Federal Financial Assistance Should Not Cause The Group Health Plan To Be Treated As A Covered Entity

The proposed rule identifies a group health plan as one type of entity that is "principally engaged in providing health services." Under the proposed rule, if any part of the group health plan receives Federal financial assistance, the group health plan will be a "covered entity," and *all* of the group health plan's activities (including activities that receive no Federal financial assistance) will be subject to the nondiscrimination rule.[7]

This result would undermine the Department's limited-liability rule for employers, which properly applies the nondiscrimination rule to the employer only with respect to the specific employee health benefit program for which the employer receives Federal financial assistance, and not to the entire group health plan. As we have explained, a self-insured group health plan is funded by the sponsoring employer. If the entire group health plan is subject to the nondiscrimination rule, the employer is financially responsible for any liability the plan incurs; if the group health plan must expand its coverage to comply with the nondiscrimination rule, the employer will bear the cost of the expanded coverage. Accordingly, once the group health plan becomes a "covered entity," there is no effective limit on the employer's liability.

In order to make the limited-liability rule for employers workable, the Department must make clear that a group health plan does not become a "covered entity" merely because the employer that sponsors the plan receives Federal financial assistance and uses the assistance to defray the employer's cost of providing a specific benefit under the plan. For example, a retiree health plan does not become a "covered entity" merely because the employer receives the retiree drug subsidy with respect to the prescription drug benefit provided to Medicare-eligible retirees.

4. The Rule Should Not Apply To Group Health Plans Maintained By Employers That Are Not Principally Engaged In Health Businesses

If an employer is not principally engaged in providing or administering health services, but the employer receives Federal financial assistance for a health activity *other than* a group health plan for its employees, the Department's proposed regulation would apply the nondiscrimination rule to the employer's group health plan benefits provided to employees who participate in the Federally-assisted activity. This proposed rule significantly exceeds the Department's statutory authority. It should be replaced with a rule appropriately tailored to the language and purpose of Section 1557.

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[7] 80 *Fed. Reg.* at 14,216 (to be codified at 45 C.F.R. § 94.2, definition of "health program or activity").

First, the Department must make clear that if an entity is not principally engaged in providing or administering health services, the entity does not become subject to the nondiscrimination rule merely because it provides some limited services to individuals who qualify for Federal financial assistance. Consider, for example, a major retailer that includes a retail pharmacy in stores that also offer many other goods and services for sale. Some of the individuals who have prescriptions filled or receive flu shots at the retail pharmacy might be eligible for Federal financial assistance under Medicare Part D, Medicaid, TRICARE, or health programs for veterans. The fact that the retail pharmacy provides health services to these individuals should not cause the retailer to be subject to Section 1557, since it is the customer, not the pharmacy, that qualifies for Federal financial assistance. The proposed rule should make this distinction clear.[8]

Second, if an entity is not principally engaged in providing or administering health services, but the entity receives Federal financial assistance for a health activity *other than* a group health plan, the entity should be subject to the nondiscrimination requirement only with respect to the Federally-assisted activity, and not with respect to the employer's group health plan. The preamble of the Department's proposed rule uses the example of a State that receives Federal financial assistance for its Medicaid program. The Department proposes to apply Section 1557 not only to the Federally-assisted Medicaid program (ensuring that Medicaid beneficiaries will receive benefits on a nondiscriminatory basis), but also to the health benefits provided to the State's employees who administer the Medicaid program. *See* 80 *Fed. Reg.* at 54,191.

The extension of the nondiscrimination rule to the employer's group health plan in this circumstance is entirely unjustified. The Department's theory apparently is that if the Medicaid program receives Federal financial assistance, some portion of the Federal funds must be used to support the health benefits that the employer provides to its own employees. We doubt this is true as a factual matter in many circumstances to which the proposed rule would apply. Even if some portion of the Federal financial assistance were used to provide benefits under the entity's group health plan, however, the group health plan still would not be an activity "receiving Federal financial assistance" within the meaning of Section 1557. The group health plan is too remote from the purpose of the Federal financial assistance to derive more than an incidental benefit from the assistance, if it derives any benefit at all.

There is no basis for extending the nondiscrimination rule beyond the specific health program that receives Federal financial assistance (the State's Medicaid program, in this example) to the employer's own group health benefits for employees who administer that program. This extension of the statute is not only unjustified, it is also unworkable. In order to promote both efficiency and fairness, employers seek to create uniform health programs for their employees. It is not practicable for a large employer to carve out a limited population and to apply special nondiscrimination requirements to the group health benefits only of those employees. The lack of uniformity associated with this targeted application of the nondiscrimination rule presents administrative difficulties that will be insurmountable for many employers, and it also creates inequities, uncertainties, and complexities that are not present in the more traditionally uniform

[8] It is especially important to clarify this point in view of the fact that the proposed regulation treats premium tax credits provided to individuals as a form of Federal financial assistance received indirectly by insurers selling qualified health plans in an Affordable Care Act Marketplace. *See* 80 *Fed. Reg.* at 54,216 (to be codified at 45 C.F.R. § 92.4(2), definition of "Federal financial assistance").

laws that govern employer group health plans. The Department should recognize that the proposed rule exceeds its statutory authority, and should revise the rule to make clear that the nondiscrimination requirements do not apply to a group health plan solely because the employer receives Federal financial assistance in connection with some other health activity.

5. The Rule Should Not Impose Additional Notice Requirements On Plans

As we have explained, most self-insured group health plans maintained by large employers should not be subject to Section 1557 at all, since the group health plans do not receive Federal financial assistance as defined by the statute. In the limited circumstances in which the nondiscrimination rule applies to a group health plan, however, the Department should recognize that the plan is already subject to a well-developed disclosure regime under ERISA. The Department should not impose unnecessary and potentially inconsistent disclosure requirements on group health plans.

The proposed rule equates English-language proficiency with national origin, and requires covered entities to take a number of affirmative steps to ensure that they do not discriminate against individuals with limited English proficiency. [9] For example, the rule requires a covered entity to notify its beneficiaries and the general public of, among other things, the availability of translation services and other assistance, the procedure for filing a grievance against the covered entity, and the process for filing a discrimination complaint with OCR. The covered entity must post this notice in publications targeted to beneficiaries, in conspicuous physical locations, and in a conspicuous location on the covered entity's Web site. A covered entity might also be required to offer a qualified interpreter or other language assistance services free of charge. In addition, the covered entity must provide taglines, in the top 15 languages spoken nationally by individuals with limited English proficiency, notifying these individuals of the availability of language assistance services. Further, the covered entity is encouraged to make the required notice regarding translation services and grievance procedures available in these 15 non-English languages, and also in other languages spoken by the covered population.

These requirements are both inappropriate and unnecessary as applied to employer group health plans. ERISA establishes a detailed disclosure regime for group health plans, and ERISA's disclosure requirements already provide extensive protections for individuals with limited English proficiency. For example, a group health plan must provide covered individuals with a "summary plan description" that explains their rights and benefits under the plan. If ten percent or more of the participants are literate only in the same non-English language, the summary plan description must display a notice in the non-English language offering assistance that will give the participants a reasonable opportunity to become informed of the plan's provisions.[10]

A group health plan must also provide participants with a separate eight-page "summary of benefits and coverage" that presents required information in a manner that is "culturally and linguistically appropriate."[11] When the summary of benefits and coverage is delivered to any address in a county where ten percent or more of the population is literate only in the same non-

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[9] 80 *Fed. Reg.* at 54,217-18 (to be codified at 45 C.F.R. § 92.8).

[10] 29 C.F.R. § 2520.102-2(c)(2).

[11] 29 C.F.R. § 2590.715-2715(a)(5).

English language, the summary must include a statement notifying the recipients that the summary is available upon request in the non-English language.[12]

If a group health plan denies a participant's claim for benefits, the plan must notify the participant "in a culturally and linguistically appropriate manner" of the reason for the denial and the participant's right to appeal the denial.[13] If the claim is denied again on appeal, the plan must provide a second notice explaining the reasons for the denial and the participant's right to seek independent review of the claim or to pursue the claim in court.[14] When these notices of claim denials are delivered to any address in a county where ten percent or more of the population is literate only in the same non-English language, each notice must include a statement explaining that the notice is available upon request in the non-English language.[15] The notice must also offer oral language services (such as a telephone customer assistance hotline) in the non-English language that will answer the participant's questions and provide assistance with filing claims.[16]

These requirements were developed by the Department of Labor, which is charged with protecting the rights of group health plan participants under ERISA. The Department of Labor developed the requirements concerning the summary of benefits and coverage and the notices of claim denials jointly with the Internal Revenue Service and with the Department of Health and Human Services in order to implement provisions of the Affordable Care Act that apply specifically to group health plans. These provisions are tailored to the communication requirements that group health plans must satisfy, and they provide ample assurance that individuals will not be subject to discrimination as a result of their limited English proficiency.

Similarly, Title I of the Americans With Disabilities Act requires employers to provide reasonable accommodations to qualified individuals with disabilities. These accommodations might include, in appropriate cases, providing a qualified reader or interpreter for individuals with impaired vision or hearing.[17] The nondiscrimination requirements of the Americans With Disabilities Act extend to fringe benefits (such as group health benefits) that are available by reason of employment: the employer must provide the accommodations necessary to ensure that an employee with a disability is able to enjoy these benefits to the same extent as similarly-situated employees without disabilities.[18] These requirements have been interpreted by the Equal Employment Opportunity Commission, which has specific authority to develop and enforce rules prohibiting discrimination against individuals with disabilities in the workplace and to determine what steps are necessary to provide reasonable accommodations to these individuals. Accordingly, the requirement in the Department's proposed rule[19] concerning communications with disabled individuals are redundant.

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[12] *Id.*

[13] 29 C.F.R. § 2590.715-2719(b)(2)(ii)(E).

[14] *Id.*

[15] 29 C.F.R. § 2590.715-2719(e).

[16] *Id.* at § 2590.715-2719(e)(2).

[17] 29 C.F.R. § 1630.2(o)(2)(ii).

[18] 29 C.F.R. § 1630.4(a)(1)(vi) & (o)(1)(iii).

[19] 80 *Fed. Reg.* at 54,219 (to be codified at 45 C.F.R.§ 92.202).

The Department should not subject group health plans to additional foreign-language requirements or disability-assistance requirements that will serve only to increase the cost of plan administration. The group health plans that are subject to the nondiscrimination rule should be deemed to satisfy these requirements if they include an English-language notice in the summary plan description informing participants of the assistance available under existing laws (not including Section 1557) for individuals with disabilities or limited English proficiency, and if they satisfy ERISA's requirements concerning communications in languages other than English.

A group health plan that is a "covered entity" under Section 1557 should not be subject to new and conflicting assistance requirements, or to a separate enforcement regime administered by the Department, since existing laws and enforcement mechanisms provide ample protections for group health plan participants who need language assistance. Neither the group health plan nor the sponsoring employer should be required to post additional notices in other publications, in conspicuous physical locations, or on a Web site. ERISA's comprehensive disclosure rules already specify when, where, and how a group health plan must provide information to participants. Forcing group health plans that are "covered entities" or their sponsoring employers to comply with additional disclosure requirements will serve only to confuse participants and increase administrative costs, without providing any additional protection.

6. The Rule's Effective Date Should Allow Sufficient Time for Compliance

The proposed rule states that it will be effective 60 days after the final rule is published in the *Federal Register*. To the extent that the nondiscrimination rule applies to self-insured group health plans, their sponsoring employers, or their third party administrators, the rule might require changes in the plan's design or administration, or both. Any changes must be communicated to employees before the employees enroll in the group health plan, so that the employees will understand the choices offered under the plan and the cost associated with each choice. The proposed effective date will not allow a fraction of the time that group health plans will need to implement the nondiscrimination rule in an orderly way.

Most large employers begin designing their group health plan provisions and communications in early spring for the next calendar year. The employer must determine the cost of any required changes in plan design, and must make difficult judgments concerning the need to eliminate other plan benefits in order to keep the plan affordable for the employer and employees alike. A large group health plan might offer a number of different coverage options in different geographic regions, so that it is necessary for the employer to coordinate with a variety of third party vendors to ensure that the plan's provisions can be administered efficiently and that participant communications are accurate. Employers must finalize employee communications and open enrollment materials and develop the systems requirements to support open enrollment well in advance of the open enrollment period—which usually begins in October or November—to allow sufficient time for printing and Web site development.

ERIC recommends that any regulation interpreting the nondiscrimination requirement become effective, for those employer group health plans and sponsoring employers that are subject to the regulation, no earlier than the first plan year that begins at least twelve months after the final regulation is published in the *Federal Register*. This effective date will permit employers to evaluate the nondiscrimination requirement as interpreted in the final regulation, develop a compliance strategy, and design enrollment material that will satisfy the requirement.

As the points raised in this letter illustrate, the Department's proposed regulation raises substantial questions concerning the application of the nondiscrimination rule to self-insured group health plans, their third party administrators, and their sponsoring employers. For plan years beginning after the effective date of Section 1557 and before the regulatory effective date, the final rule should make clear that self-insured group health plans, third party administrators, and sponsoring employers will be deemed to satisfy the nondiscrimination requirement as long as they comply with a reasonable, good-faith interpretation of the statute.

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Thank you for your consideration of these comments. We would be pleased to discuss this letter with you if you have any questions.

Sincerely,

Annette Guarisco Fildes
President & CEO

Gretchen K. Young
Senior Vice President, Health Policy

APPENDIX

Federal Nondiscrimination Statutes That Apply to Employer Group Health Plans

Listed below are some of the Federal statutes that prohibit discrimination in employer group health plans.

The statutes listed below are in addition to a number of Federal statutes that mandate specific health benefits for protected groups. For example, the Women's Health and Cancer Rights Act, Pub. L. No. 105-277, § 902(a) (1998), requires group health plans to cover reconstructive surgery following mastectomies; the Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, § 603(a)(5) (1996), requires group health plans to cover a minimum hospital stay following childbirth; the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 4301(a) (1993), requires group health plans to maintain coverage of pediatric vaccines (later expanded in the Affordable Care Act to mandate coverage of preventive care generally); the Uniform Services Employment and Reemployment Rights Act of 1994, Pub. L. No. 103-353, requires group health plans to provide continued coverage during periods of military service; and so on.

Age

An employer may not discriminate against an employee on the basis of age in any aspect of employment, including group health plan coverage and benefits. Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202.

The Older Workers Benefit Protection Act of 1990, Pub. L. No. 101-433, amended the Age Discrimination in Employment Act of 1967 to clarify the protections given to older individuals under employee benefit plans, including group health plans.

Disability

An employer may not discriminate against a qualified individual with a disability in any aspect of employment, including group health plan coverage and benefits. Americans With Disabilities Act, Pub. L. No. 101-336.

A group health plan may not deny coverage or discriminate against a participant based on the disability of the participant or a family member. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

Genetic Information

A group health plan may not deny coverage or discriminate against a participant based on the genetic information of the participant or a family member. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

A group health plan may not discriminate against a participant or family member based on the participant's or family member's genetic information. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233 (expanding the protections provided under HIPAA).

Health Status

A group health plan may not discriminate against an individual based on the individual's health status or the health status of a family member. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

A group health plan may not deny coverage or limit coverage for an individual's pre-existing health condition. Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

Income Level

A self-insured group health plan may not discriminate in favor of highly-compensated individuals. Revenue Act of 1978, Pub. L. No. 95-600.

An insured group health plan may not discriminate in favor of highly-compensated individuals. Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

Medicare Eligibility

A group health plan may not discriminate against a participant or spouse based on the person's eligibility for Medicare. Social Security Act § 1862(b)(1).

Mental Health

A group health plan that covers mental health conditions must apply annual and lifetime limits that are no more restrictive than the corresponding limits for medical and surgical benefits. Mental Health Parity Act of 1996, Pub. L. No. 104-204.

A group health plan that provides mental health and substance abuse benefits must cover these conditions at a level comparable to its coverage of medical and surgical benefits. Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343.

Military Service

An employer may not discriminate against a person in any aspect of employment, including group health plan coverage and benefits, on the basis of the fact that the person is performing, will perform, or has performed military service. Uniformed Services Employment and Reemployment Rights Act of 1994, Pub. L. No. 103-353 (amending and restating prior statutes that provided similar protections).

Pregnancy

An employer may not discriminate against an employee on the basis of pregnancy in any aspect of employment, including group health plan coverage and benefits. Pregnancy Discrimination Act of 1978, Pub. L. No. 95-955.

Sex

An employer may not discriminate against an employee on the basis of sex in any aspect of employment, including group health plan coverage and benefits. Title VII of the Civil Rights Act of 1964, Pub. L. No. 88–352.

Race, Color, Religion, National Origin

An employer may not discriminate against an employee on the basis of race, color, religion, or national origin in any aspect of employment, including group health plan coverage and benefits. Title VII of the Civil Rights Act of 1964, Pub. L. No. 88–352.