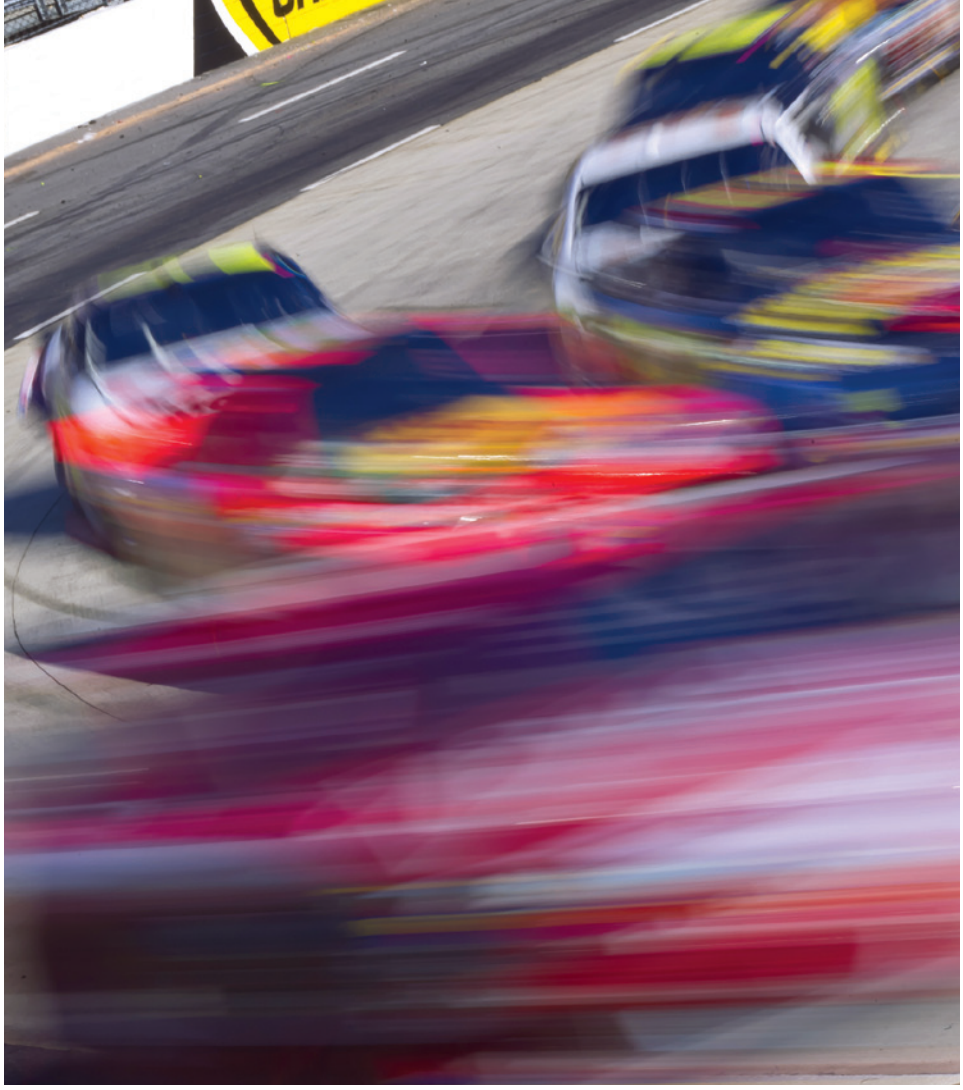

PPACA, HIPAA and Federal Health Benefit Mandates: Practical Q&A

Staying on the Compliance Track: The 2015 Health Benefits Year in Review

Have you ever attended a NASCAR race? We're not asking if you've ever watched a race on TV, but whether you have actually ever attended a race. Unlike TV, with the benefit of many camera angles and varied vantage points, you can't simply watch the cars go leisurely around the track when watching live. There are so many cars going so fast that you have to focus on a single car directly in front of you and stay focused on that one car and only that car, as it speeds down the front straightway. Otherwise, all you see is blur – total blur.

Lately, it has felt like monitoring legislative and regulatory activity related to health and welfare benefits is similar to watching a NASCAR race live. There are so many rules and regulations coming out and they come out so fast, that if you don't focus on each rule or regulation as it passes by you, then all you see is a blur.

Unfortunately, if you are reading this, you are already an active participant in the race and charged with knowing all of the rules and regulations that impact your plans and/or your clients' plans. This is why we do this "year in review" each year – so that you can better see all the cars on the compliance track and hopefully avoid a year-end crash. In 2015, there was so much activity – legislation, regulations, Supreme Court cases, FAQs and other subregulatory guidance – that we aren't able to cover everything. We do, however, hit the high points of 2015.

Final Health Insurance Reform Regulations

In November, the Department of Labor (DOL), Department of the Treasury and Department of Health and Human Services (HHS) issued final, final tri-agency health insurance reform regulations. The final regulations, which are applicable for plan years beginning on or after January 1, 2017, combine the interim final regulations issued during the first few years after the health insurance reforms became effective and the subregulatory guidance (e.g., the FAQs posted on the agencies' websites) subsequently issued by the agencies without significant changes or clarifications; however, there are a few clarifications worth noting.

Grandfather Plan Status

If applicable, grandfathered status enables plans to avoid some, but not all, of the ACA insurance reform provisions. The regulations clarified the following:

- A loss of grandfather plan status that occurs during a plan year due to a decrease in the employer's share of the total cost of a fully insured plan is not effective until the start of the next renewal date (as opposed to the effective date of the change) so long as the employer warranted grandfather plan status at the time of the prior renewal.
- Adding new contributing employers to a multiemployer health plan does not, in and of itself, cause the multiemployer plan to lose grandfather plan status.

Practice Pointer: *The regulations fail to address a few open issues related to grandfather status, including the potential impact that a wellness program premium surcharge has on grandfather plan status or, for purposes of losing grandfather status due to a coverage reduction, when benefits necessary to treat or diagnose a condition have been substantially eliminated.*

Dependent Child

- An HMO cannot limit eligibility to children under age 26 who live in the service area. NOTE: The regulations do not require the HMO to provide services outside of the service area; the regulations merely prohibit limiting eligibility to children who live in the service area.

Year End Update:

As addressed in our separate advisory (www.alston.com/advisories/year-end-employee-benefits/), the PATH Act, which was signed into law December 18, provides for a two-year delay of the 4980I tax (the so-called "Cadillac Plan" tax), making its start date 2020 and makes the tax deductible. The thresholds will continue to be adjusted for inflation during this period. The legislation also provides for permanent parity for transit benefits retroactive for 2015. Also, the IRS issued comprehensive guidance in Notice 2015-87 that addresses health reimbursement accounts (HRAs) and cafeteria plans and Notice 2013-54; affordability, creditable hours and other issues under 4980H; and certain compliance issues associated with flexible spending account (FSA) carryovers, including COBRA. IRS Notice 2015-87 will be the subject of a forthcoming article.

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Rescissions

- Voluntary retroactive terminations are not rescissions. Thus, if an employee erroneously enrolls in a group health plan and wishes to retroactively undo that enrollment, the plan may allow that (subject, of course, to any Code Section 125 restrictions) even in the absence of fraud or failure to pay the applicable premiums.

Claims and Appeals

- For plans subject to the federal external review process (e.g., self-funded ERISA plans), the final regulations make permanent the limitation on external review of benefit claims to those adverse benefit determinations that the independent, external reviewer determines involve medical judgment and rescissions.
- In addition, the final regulations add two more to the list of claims subject to external review:
  - » Whether an individual is entitled to an alternative standard under a wellness program due to a medical condition.
  - » Whether the plan satisfies the nonquantitative treatment limitation requirements of the Mental Health Parity and Addiction Equity Act.

Practice Pointer: *The external review requirements appear to only apply to wellness programs that condition the reward upon completion of an activity (such as walking, exercise or a diet program). If a reward is conditioned on completion of an activity, then a plan must provide an alternative standard only to those who are unable to complete the activity due to a medical condition. If, however, the reward is conditioned on achieving a health standard (e.g., cholesterol below a certain level), the plan must make available a reasonable alternative to those who are unable to achieve the standard without regard to medical condition.*

Prohibition Against Annual Dollar Limits on Essential Health Benefits

- Self-funded plans may use any of the effective State or Federal Employees Health Benefit Plan benchmark plans to determine which of its benefits qualify as "essential health benefits." Prior guidance indicated that any of the plans that could have been adopted as a benchmark (whether adopted by a state as a benchmark or not) could have been selected.

Practice Pointer: *A literal interpretation of the rule suggests that no nexus is required between the benchmark plan and the geographic reach of the plan. For example, a plan with no participants in Utah could nevertheless use Utah's chosen benchmark plan as its guide to define essential health benefits.*

- Account-based plans may be integrated with an employer's group health plan in order to satisfy the annual dollar limit prohibition. Account-based plans are defined as any fixed amount reimbursement arrangement that reimburses medical expenses, other than insurance premiums for coverage in the individual market. Account-based plans include HRAs, health FSAs and medical expense reimbursement plans (MERPs). This clarification was needed because Public Health Service Act Section 2711 contains an exclusion only for integrated HRAs, which technically require a carryover.
- In an expansion of the relief in Notice 2015-17, these regulations indicate that an employer with fewer than 20 employees that offers coverage to non-Medicare eligible employees but does not offer coverage to Medicare eligible employees may still reimburse a Medicare eligible employee's premiums.
- In order to allow group health plan participants to be eligible for an exchange subsidy, Notice 2013-54 indicated that to be integrated, HRA funds must be forfeited upon termination or the participant must be permitted to opt out and waive reimbursements. It was unclear whether any such waiver was permanent under Notice 2013-54. These regulations clarify that the waiver is effective even if the reimbursements can be reinstated at a later date (e.g., the start of the next plan year or death or the earlier of the two) so long as the waiver is irrevocable prior to the occurrence of the reinstatement event.

Patient Protections

- Plans may impose reasonable geographic limitations on primary care physicians who may be chosen by a participant; however, they do not define reasonable geographic limitations.

Proposed Disability Plan Claims Procedures

On the same day that the agencies issued the final health insurance reform regulations, the DOL issued proposed claims procedure rules applicable to disability plans. The proposed rules would incorporate into ERISA's claims procedure rules the following requirements previously made applicable to group health plans by the ACA:

- Rescissions of disability benefits not triggered by a claim (e.g., through an audit) are considered adverse benefit determinations.
- Letters must be available in a culturally and linguistically appropriate language.
- If new evidence is relied on during appeal, the plan must provide the claimant with the new evidence prior to the due date of the determination and the claimant must be provided a reasonable opportunity to respond.

Practice Pointer: *The regulations do not specifically address employer payment plans. Employer payment plans were defined by Notice 2013-54 and subsequent FAQs as plans that facilitate the payment or reimbursement of premiums for policies issued in the individual market. The regulations indicate that the subregulatory guidance that severely constricts such arrangements for individual major medical coverage continues to apply.*

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- Claimants can forgo the internal appeal process if the plan fails to follow a full and fair review process, as set forth in Section 503 (and the regulations), unless those failures are minor.

EEOC Proposed Wellness Program Rules Under the ADA and GINA

Not to be outdone by the agencies, the Equal Employment Opportunity Commission (EEOC) issued proposed regulations in 2015 that attempt to clarify the application of the Americans with Disability Act (ADA) and the Genetic Information Nondiscrimination Act (GINA) to wellness programs. These proposed regulations were the subject of our prior Self-Insurer articles.

U.S. Supreme Court Cases

There were three U.S. Supreme Court cases in 2015 that significantly impact health and welfare plans:

Obergefell v. Hodges In a 5-4 decision written by Justine Kennedy, the Court held it unconstitutional for a state to deny same-sex couples the right to marry. While the case did not specifically require welfare plans to offer the same benefits to same-sex spouses that are offered to opposite-sex, the case paved the way for federal-like income tax exclusions under state law for employers that offer benefits to same-sex spouses (although not every state has changed its laws to be consistent with *Obergefell*). Also, the case likely paves the way for federal (e.g., Title VII) and state anti-discrimination claims (to the extent not preempted by ERISA) against employers that choose not to offer the same benefits to same-sex spouses.

Practice Pointer: *See IRS Notice 2015-86, which was issued in early December, for a more detailed description of the impact Obergefell has on welfare plans.*

King v. Burwell In a 6-3 decision written by Justice Roberts, the Court held that premium tax credits and advance premium subsidies were available to individuals enrolled in policies issued by federally run exchanges. Had the Court held that they weren't available, then exchange participants in a majority of states would have lost their premium subsidies/tax credits. For employers, a different decision would have lessened the impact of the ACA's employer-shared responsibility provisions (i.e., the IRC 4980H so-called "pay or play" provisions) on "applicable large employers," especially employers with most if not all of their employees in states with federally run exchanges.

M&G Polymers v. Tackett In a 9-0 decision written by Justice Thomas, the Court held that you cannot infer an intent by parties to a collective bargaining agreement to vest retiree health benefits merely because a termination provision is absent in the collective bargaining agreement, reversing the inferences created by the Sixth Circuit's decision in *Yard-Man* (716 F.2d 1476).

ACA Reporting

After several draft forms and instructions, the IRS issued 2015 final instructions and draft 2015 Forms 1094 and 1095 B and C series to be used in connection with reporting required under Code Sections 6055 and 6056. The final instructions contained a few clarifications and changes from previous instructions and guidance.

Practice Pointer: *See also Notice 2015-68 for additional guidance regarding various aspects of reporting, including special rules for reporting coverage under an expatriate health plan and guidance on exemptions from reporting for coverage the enrollment that is conditioned on having other minimum essential coverage.*

Code Section 6055

- Each employer that "maintains" a self-insured plan that provides minimum essential coverage has a reporting obligation under Code Section 6055 to identify all employees and their dependents who are covered under the plan. IRS officials informally indicated that the employer would be obligated to report under Section 6055 for former employees last employed by that employer. However, members

of a controlled group that each participate in a single self-insured plan but are not also applicable large employers may designate a single employer to file on behalf of all employers.

- An applicable large employer that maintains a self-insured plan that provides minimum essential coverage **must** satisfy its Section 6055 obligation for any individual employed at any time during the year. Such employers may use a C-Series form to satisfy the Code Section 6055 reporting obligation for non-employees (e.g., a former employee whose termination of employment occurred last year) so long as they have the social security number of the responsible individual (typically the individual who has the enrollment right under the plan).
- Employers that maintain a self-insured plan (such as an HRA), the eligibility of which is conditioned on being enrolled in other minimum essential coverage, have no Code Section 6055 reporting obligation for that self-insured plan coverage. If eligibility is conditioned on being enrolled in another employer plan, then the exception from reporting applies only if the other coverage is maintained by the same employer.

Practice Pointer: *Employers that maintain self-insured retiree medical plans for retirees age 65 and older (i.e., Medicare eligible retirees) are not exempt from reporting unless the employer conditions enrollment in the plan on actually being enrolled in Medicare. Likewise, an employer that maintains a self-insured account-based plan (such as an HRA) is exempt from reporting the account-based plan only to the extent eligibility is conditioned on being enrolled in a major medical plan maintained by the same plan sponsor.*

Code Section 6056

- Applicable large employers that contribute to multiemployer plans need not report offers of coverage or enrollment in the plan by an employee who is full time at least one month during the year if the employer is taking advantage of the multiemployer transition relief from Code Section 4980H excise taxes. In other words, employers report no offer of coverage – even if coverage is actually offered by the multiemployer plan – for each month that the employer is also indicating that it made a contribution that month to the plan for that employee.
- Applicable large employers also report no offer of coverage for former employees offered COBRA coverage, even though COBRA was offered. There is still much confusion regarding the rules for reporting offers of COBRA coverage to active employees. The instructions prescribe a somewhat ambiguous rule and even though FAQs issued shortly after the final instructions were issued provide a clear and concise rule (with examples), IRS officials have informally indicated that the FAQs need to be updated.

Code Section 4980I (So-Called "Cadillac Tax") Guidance

The IRS issued two notices in 2015, Notices 2015-17 and 2015-52, regarding the so-called "Cadillac tax" imposed by Code Section 4980I. The notices were primarily a request for comments on a variety of issues necessary to implementation and administration of the tax; however, the IRS did propose a number of possible rules, including the following:

- Self-insured dental and vision plans that qualify as excepted benefits (under final agency regulations) would likely be excluded from the definition of applicable employer-sponsored coverage (the statute only literally excludes fully insured dental and vision benefits). This provides an exception for most standalone vision and dental plans, including limited purpose vision/dental HRAs.
- Employee assistance plans that qualify as excepted benefits would also likely be excluded from the definition of applicable employer-sponsored coverage.
- Health FSAs are not excluded and neither are employer and employee pre-tax HSA contributions (although much effort is underway to get them excluded).

As addressed in our separate advisory,[1] the PATH Act, which was signed into law December 18, provides for a two-year delay of the 4980I tax (the so-called "Cadillac tax"), making its start date 2020 and makes the tax deductible. The thresholds will continue to be adjusted for inflation during this period.

Miscellaneous Roundup

Deadlines Expiring December 31

December 31 marks an important deadline for two different requirements:

- The transition relief provided by Revenue Ruling 2014-32, allowing cash reimbursement of transit pass expenses in areas where the only "transit voucher" that is readily available in the area is a terminal restricted card, will come to an end. Beginning January 1, 2016, if the only voucher that is readily available in an area is a terminal restricted card, cash reimbursement will no longer be available. As addressed in our separate advisory, the PATH Act, which was signed into law December 18, provides for permanent parity for transit benefits retroactive for 2015.
- Cafeteria plans that implemented the new election changes prescribed by Notice 2014-55 in 2014, have until December 31, 2015, to retroactively amend the cafeteria plan.

Other Guidance

- The IRS approved issuance of a 12-month transit pass so long as one-twelfth of the annual value did not exceed the monthly limit for transit passes (see PLR 201532016).
- The IRS issued Revenue Notice 2015-43, which addresses the application of certain ACA-related requirements to expatriate health plans.
- The IRS issued an information letter that expands the circumstances that permit an employer to recoup contributions erroneously made to an HSA. The September 9, 2015, information letter provides that if there is "clear documentary evidence demonstrating that there was an administrative or process error," corrections can be made. Although not binding,[2] this guidance seems to express the IRS's view that in certain circumstances, a mistaken HSA contribution can be reversed.
- The IRS issued a chief counsel memorandum (CCA 201547006) addressing the situations in which an HRA can

reimburse premiums for coverage provided through a spouse's employer's health plan.

- Also, the IRS issued comprehensive guidance in Notice 2015-87 that addresses HRAs and cafeteria plans and Notice 2013-54; affordability, creditable hours and other issues under 4980H; and certain compliance issues associated with FSA carryovers, including COBRA. IRS Notice 2015-87 will be the subject of a forthcoming advisory. ■

2016 COLA Adjusted Amounts

Very few limits were adjusted for 2016. We identify below the relevant limits for 2016 *(amounts that changed for 2016 are in* **bold***)*.

ITEM	2015	2016
Health FSA Salary Reduction	$2550	$2550
Transit Pass	$130	$130
Parking	$250	**$255**
Health Savings Account Contribution Limits (self only)	$3350	$3350
Health Savings Account Contribution Limits (other than self only)	$6650	**$6750**
Health Savings Account Minimum Deductible (self only)	$1300	$1300
Health Savings Account Minimum Deductible (other than self only)	$2600	$2600
Health Savings Account Maximum OOP (self only)	$6450	**$6550**
Health Savings Account Maximum OOP (other than self only)	$12,900	**$13,100**
ACA Maximum OOP (self only)	$6600	**$6850**
ACA Maximum OOP (other than self only)	$13,200	**$13,700**
PCORI	$2.08	**$2.13**
Transitional Reinsurance Fee	$44.00 ($33 contribution/ $11 for treasury)	**$27 ($21.60 contribution/ $5.40 for treasury)**
4980H(a) Excise Tax	$2080 ($173.66/mo)	**$2160 ($180/mo)**
4980H(b) Excise Tax	$3120 ($260/mo)	**$3240 ($270/mo)**
Definition of HCE for 414(q) and Cafeteria Plan testing purposes	$120,000	$120,000
Key Employee Officer Compensation Threshold for Section 125	$170,000	$170,000
SS Wage Base	$118,500	$118,500

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by email to Mr. Hickman at john.hickman@alston.com.

References

[1] *www.alston.com/advisories/year-end-employee-benefits/*

[2] *According to Section 2.04 of IRS Rev. Proc. 2015-1, information letters call attention to certain general principles of law and are not binding on the IRS*