ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

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, Dallas and Washington, D.C. law firm. Ashley Gillihan, Steven Mindy, 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 E-MAIL to Mr. Hickman at john.hickman@alston.com.

BENEFIT COMPLIANCE ISSUES THAT ARISE IN CONNECTION WITH EMPLOYER SPONSORED CLINIC ARRANGEMENTS: PART TWO

Many employers, particularly large employers, are evaluating on-site health clinic options as an additional benefit offering. Common reasons for instituting on-site clinics include enhancing worker productivity (i.e., "increasing "presenteeism"), reducing medical costs, integrating various health services, and improving access to care for employees. However, on-site clinics also pose a myriad of compliance obligations, particularly in the employee benefits arena.

This two-part article addresses the application of various employee benefit laws to coverage offered through employer-sponsored on-site medical clinics. The impact of the various laws discussed herein will depend on the structure and design of the clinic arrangement, so not all of the issues would apply in every situation. However, the discussion below should give an idea of the employee benefit compliance obligations associated with various arrangements.[1]

Part One of this article (in the November issue of The Self-Insurer) focused on the compliance concerns that are most frequently discussed with respect to on-site medical clinics include the application of ERISA, HIPAA (and other health information privacy laws, at the federal and state level), and the Affordable Care Act. Here in Part Two we look at other concerns which may also arise including COBRA and other group health plan requirements; the effect on plan participants' eligibility for Health Savings Accounts (HSAs); and various tax implications for plan participants.

I. COBRA

Coverage for on-site clinics can potentially be subject to COBRA, which may raise thorny practical issues. Under COBRA, an on-site clinic is not treated as a group health plan as long as: (1) the health care consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours; (2) the health care is available only to current employees; and (3) employees are not charged for the use of the facility. Treas. Reg § 54.4980B-2, Q&A-1(d). While there is some leeway under this provision (e.g., "primarily" consisting of first aid), the definitional provision seems to clarify that an exempt arrangement is restricted to treatment of illnesses or injuries that occur "during working hours."

Application of COBRA to an on-site clinic would mean that all of COBRA's notice, disclosure, and election requirements and procedures would apply to the clinic with regard to any employee who is eligible for clinic services. See *generally* IRC § 4980B. Thus, individuals who lose coverage due to a COBRA qualifying event (e.g., termination of employment for employees) must be extended an opportunity to extend coverage. COBRA raises some difficult compliance challenges, including that:

- An open enrollment right must be extended under *all employer sponsored plans* each year. Thus, if COBRA applies to clinic operations, each electing qualified beneficiary would be eligible to enroll (or re-enroll) in other health plans sponsored by the employer each year at annual enrollment.

This could significantly expand the COBRA rights available to individuals beyond what the employer originally anticipated (potentially affecting the actuarial calculations for any health plans);

- The right to elect COBRA for an on-site clinic could mean that employees who are not enrolled in the employer's group health plan or any other COBRA-covered benefit would still be entitled to elect to continue receiving clinic benefits, which could be administratively difficult; and

- Offering on-site clinic access to (potentially disgruntled) former employees could be problematic, for various reasons. [Employers may want to offer an alternative arrangement (such as a commercially available walk-in clinic) for COBRA coverage.]

II. OTHER GROUP HEALTH PLAN RULES

A stand-alone plan for on-site clinic coverage could be problematic under various group health plan rules, many of which can be onerous (for example, HIPAA's portability and nondiscrimination rules and the Mental Health Parity and Addiction Equity Act (MHPAEA)). This is particularly true if the arrangement is an ERISA plan; however, some of the laws noted below apply more broadly, and could capture an arrangement that is not an ERISA plan.[2]

While this is not an exhaustive list of potentially applicable laws, employers should consider the application of the following rules:

- QMCSO requirements (for plans that cover dependents) (ERISA § 609);

- Uniformed Services Employment and Reemployment Act (USERRA) continuation coverage and reinstatement rights (38 USC § 4301);

- Family and Medical Leave Act (FMLA) maintenance of benefit requirements (29 USC § 2614); and

- Medicare Secondary Payer (MSP) requirements (42 USC § 1395y) and, depending on whether prescription drugs are covered, Medicare Part D creditable coverage disclosures (42 CFR §423.56).

Absent specific guidance, it is likely best to assume that these rules would apply – particularly if the arrangement is an ERISA group health plan.[3] Given these compliance requirements, the combination of the clinic into a larger group health plan (which should already be set up to address these requirements) would likely be preferable to establishing a separate plan.

III. IMPACT ON HSA ELIGIBILITY

Under IRC § 223, health coverage (including coverage offered through an on-site clinic) would make an individual ineligible for HSA contributions unless (i) the coverage meets certain (e.g., high deductible) requirements or (ii) the individual pays fair market value for treatment until they satisfy their deductible.[4] See IRS Notice 2008-59. To meet the first requirement, the coverage must not offer significant benefits in the nature of medical care or coverage other than preventive care or permitted coverage.[5] While the determination of what is "insignificant" would depend on the facts and circumstances, the IRS has indicated that physicals, immunizations, allergy shots, nonprescription pain relievers, and treatment of injuries caused at a plant should be considered insignificant benefits. *Id.*

While this is an issue that can cause problems for participants in high-deductible health plans if not considered in advance, many employers have adopted innovative approaches (e.g., putting employer funds in the HSA for clinic visits) to address this issue.

IV. TAX ISSUES

Finally, as a self-insured plan, coverage for an on-site clinic would be subject to the nondiscrimination testing requirements under IRC § 105(h). Thus, the plan could not discriminate (with respect to either eligibility or benefits) in a way that favored highly compensated employees. The employer would need to run nondiscrimination testing to ensure that IRC § 105(h) was not violated (unless the on-site clinic is part of a larger group health plan, in which case the testing for that plan would encompass the clinic).

CONCLUSION

With the increasing popularity of on-site health clinics, it is becoming more important to understand the benefits compliance issues raised by this type of arrangement. This white paper addresses, at a relatively high level, the various compliance issues raised by employer-sponsored on-site clinics. Employers should consult with their own legal counsel to further analyze the issues outlined above as applied to any specific situation. ■

References

1 Please note that this white paper does not address all regulatory issues that will be applicable to the clinic, particularly aspects relevant to health care providers and medical facilities – e.g., OSHA standards; fraud and abuse rules (including the Stark Law, Anti-kickback laws, and the False Claims Act); or rules regarding corporate practice of medicine, disposal of medical waste, dispensing of pharmaceuticals, or clinical laboratories.

2 See, e.g., 42 USC §12112(a), which applies the ADA's nondiscrimination provisions to "employee compensation, job training, and other terms, conditions, and privileges of employment." This is broad enough to capture arrangements that are not ERISA group health plans. The ADA nondiscrimination regulations also have a broad reach; 29 CFR §1630.4 provides that it is unlawful for a covered entity to discriminate on the basis of disability with respect to "fringe benefits available by virtue of employment, whether or not administered by the covered entity." In addition, the PDA, at 42 USC § 2000e(k), mentions "fringe benefit programs," which the regulations at 29 CFR § 1604.9 define broadly as "medical, hospital, accident, life insurance and retirement benefits; profit-sharing and bonus plans; leave; and other terms, conditions, and privileges of employment."

3 Unfortunately, the group health plan provisions discussed herein are not uniform, and generally have different definitions of what type of plan or arrangement would be subject to the rules (except that they all would, based on the definition in the statute and/or regulations, likely include employer-sponsored on-site clinics). A detailed analysis of the application of each of these requirements—including any sub-regulatory guidance issued by the relevant agency – is outside the scope of this white paper.

4 Note that coverage provided only after the deductible has been satisfied would not endanger HSA eligibility.

5 IRC § 223 defines permitted coverage as "coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care," and preventive care as preventive coverage "within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary)."