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 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 E-MAIL to Mr. Hickman at john.hickman@alston.com.

Auld Lang Syne;

Farewell 2017 – Greetings 2018

The Health & Welfare Benefits Law Year in Review

Another year has come to an end. For many of us, the open enrollment period has long since ended and plan amendments for 2018 have been completed. As the famous Chinese philosopher Confucius said, "study the past if you would define the future." To help you with your period reflection and forecast, we take a cue from Confucius and look back at 2017 to see what was, what was almost and what might be in 2018.

Close but no Cigar-Efforts to Repeal and Replace the Affordable Care Act Fail-But is it here to stay?

Congress made several attempts in 2017 to "repeal and replace" the Affordable Care Act to no avail. Highlights of their efforts include:

- Initial "leaked" drafts of proposed legislation would have apparently capped the income exclusion under Code Section 106 for employer provided accident and health coverage in lieu of the Cadillac Tax. The Cadillac Tax ultimately won out.
- The employer shared responsibility taxes would have been retroactively reduced to $0.
- The limit on Health FSA salary reductions would have been repealed;
- The limitations on reimbursement of over the counter drugs without a prescription would also be repealed.
- None of the "health insurance reforms" would have been repealed. The "health insurance reforms include, but are not limited to, the prohibition against pre-existing condition exclusions, the requirement to offer coverage to dependent children until age 26, the requirement to issue a Summary of Benefits and Coverage, and the prohibition against annual or lifetime dollar limits on essential health benefits. It is the prohibition against annual and lifetime dollar limits on essential health benefits that ultimately precluded standalone HRAs and reimbursement of premiums for individual market major medical coverage. [But as we note below, a separate Executive Order initiative may address the individual premium reimbursement issue.]
- Congress also attempted to pass legislation that would have significantly improved HSAs and expanded access for small employers to "association" health plans- among other things.

Will there be additional efforts from Congress in 2018? While there is some talk of further Cadillac tax delay/reform, we seriously doubt that Congress will make additional attempts to "repeal and replace" the Affordable Care Act in 2018. In the meantime, the Trump administration is taking steps to reshape some of the rules through Executive Orders and regulations. In particular, we expect to see some relief for standalone HRAs and premium reimbursement arrangements as well as for association health plans.

Well if you won't, I will—Trump issues Executive Orders and Other Instructions—Potential Good News for Association Health Plans and HRAs

President Trump issued an Executive Order on January 20, 2017--the day he took office--that directed the Secretaries of the Departments of Labor, Treasury and Health and Human Services to "waive, defer, grant exemption from or delay implementation of any provision or requirement of the ACA". Employers who sponsor health plans breathed a great sigh of relief; however, such sighs of relief appeared to be premature.

It is unclear whether this Executive Order will have a significant impact on employer ACA obligations, but we do see some changes (e.g., with respect to ACA insurance mandates and state waivers). If you ask the applicable large employers that recently received significant penalty assessments from the IRS under the employer shared responsibility rules, they would quickly tell you in demonstrative fashion that it had no impact.

In October of 2017 President Trump issued another Executive Order that may actually have an impact on employer sponsored health plans. The order directs the heads of the tri-agencies to expand the use of HRAs and to improve access to association health plans (AHPs) for small employers.

As of the date of publication of this article, the DOL had already submitted regulations regarding AHPs to the Office of Budget and Management for review. Although we have yet to see or hear anything about HRA related guidance, the quick response by the DOL regarding the association health plans, and the ability of the agencies in the statute to issue guidance on HRAs leaves us optimistic that we will see something soon.

This Executive Order was followed by a Memorandum issued by the White House to the heads of the agencies freezing any regulations not yet published and delaying the effective date any regulations published but not yet effective. Unfortunately for the health and welfare plan world, there were few if any health and welfare plan related regulations affected by the order.

What HRA guidance should we expect? The Executive order is broad and the statute leaves the agencies with significant flexibility to issue guidance. Hopefully, the expected guidance will revive standalone HRAs and premium reimbursement arrangements for individual major medical insurance premiums that Notice 2013-54 and its progeny precluded.

Hurry Up and Wait—the agencies delay the applicability date of fiduciary rule and disability plan claims procedures

In April 2016, the DOL issued final regulations that redefine and expand the definition of "investment fiduciary" and change the manner in which investments are offered to plan participants and the fees charged by investment fiduciaries to plans and plan participants. Basically, if you are receiving a fee for providing investment advice (as broadly defined by the regulations) you are an investment fiduciary and you have a conflict of interest that runs afoul of the prohibited transaction rules in ERISA and/or the Internal Revenue Code.

However, this compensation may still be permitted if you satisfy certain "best interest" conduct standards as well as written notice and contract requirements set forth in one of several prohibited transactions exemptions, the broadest of which was the Best Interest Contract Exemption (aka "BICE"). Investment fiduciaries were not only at risk of penalties under ERISA and/or the Code but also lawsuits from plans and plan participants related to poorly performing investments, even if the plan or the plan participant chose the investment.

Not surprisingly the new rules had a significant impact on qualified retirement plans but much to the surprise of many, the new rules also impacted the manner in which investments are offered to Health Savings Account beneficiaries.

HSA custodians and trustees are now at risk if they receive fees for providing investment advice—and merely offering an investment slate from which to choose could be considered "advice" under the new rules. The rule generally went into effect in April 2017; however, the DOL issued transition relief until January 1, 2018.

Under the transition relief, investment fiduciaries are still subject to the specific conduct standards but did not have to comply with the written notice, contract, and other "infrastructure" requirements in the various prohibited transaction exemptions. The DOL will apply a good faith compliance standard during the transition period. In November of 2017, this transition relief was extended until July 1, 2019.

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Caution: The transition relief does not delay the substantive conduct requirements of investment fiduciaries, as defined by the new rules. The transition relief merely gives relief from the BICE infrastructure requirements including the written notice and contract requirements.

The DOL also recently delayed the applicability date of the new disability plan claims and appeals procedure rules under ERISA Section 503. The new rules, which would have applied to claims and appeals filed on or after January 1, 2018, mandate the following additional claims and appeals requirements:

- The plan must provide the following additional disclosures in adverse benefit determination notices:
    - An explanation of the basis for disagreeing with the medical experts whose advice was obtained on behalf of the plan, or with disability determinations made by the Social Security Administration;
    - If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request);
    - A statement informing the claimant of his or her right to receive, upon request and free of charge, reasonable access to and copies of the entire claim file and other relevant documents;
    - A disclosure of the specific internal rules, guidelines, protocols, standards or other similar criteria used as a basis for the denial; and
    - A description of any applicable contractual limitations periods applying to the claimant's right to bring an action as well as the calendar date upon which any rights expire.
- The plan must also comply with the following procedural requirements:
    - No denial on appeal may be based on new evidence or rational unless the claimant is first notified of the new evidence and/or rationale and has a chance to respond before a final decision is made;
    - Third party claims adjudicators must be independent and not have conflicts of interest (e.g. no incentives based on denied claims)

As delayed, the new rules are now applicable to claims and appeals filed on or after April 2, 2018.

What plan changes are required? ERISA Section 102 requires the summary plan description to provide a description of the plan's claims and appeal procedures, so plan sponsors will arguably need to amend the summary plan description to reflect the new rules. Fortunately, a summary of material modification is not required to be distributed with respect to these changes until 210 days following the plan year in which the change is adopted. That gives plan sponsors a reasonable amount of time to communicate the changes. In the meantime, absent further changes by DOL, plan sponsors should ensure the actual procedures and adverse benefit determination notices comply by April 2. If the procedures are described in a separate plan document, the plan sponsor should also consider amending the plan prior to April 2.

The Courts Weigh in. . . . . on Wellness Programs!

More and more employers are implementing wellness programs these days to help improve employees' health. Properly designed wellness programs provide value to both the employee and the employer. Employees' health improves and, in return, health plan costs go down and productivity goes up. It is a win-win for all involved.

But wellness programs are subject to a variety of complex and often ambiguous federal rules and regulations that make wellness program administration a challenge for even the most astute employer and put inattentive employers who sponsor such programs at risk of liability.

Two recent lawsuits highlight the regulatory complexity surrounding wellness programs: *AARP v. EEOC* and *Acosta v. Macy's*. Employers who sponsor wellness programs (or who are thinking about implementing a wellness program) and wellness program administrators should take note of these lawsuits.

The AARP filed suit against the EEOC, claiming that the 30 percent incentive limitation it crafted in its 2016 ADA and GINA regulations is inconsistent with the ADA's and GINA's voluntary requirements and that the EEOC failed to adequately justify its position that a wellness program with an incentive up to 30 percent is voluntary. Having found that the EEOC acted arbitrarily, the court in its Memorandum of Opinion remanded the regulations back to the EEOC for reconsideration.

The AARP asked the court to vacate the regulations, but the court rejected that request because doing so would cause significant disruption to existing wellness programs that are in operation based on the rules. Consequently, the EEOC's 2016 final ADA and GINA regulations are still in effect—FOR NOW.

So now what? It is business as usual until the AARP case reaches its final disposition. When that happens, it is possible that the court will find that the EEOC cannot justify its position. That could mean that wellness programs can only provide nominal incentives under the ADA and GINA.

On August 16, the DOL filed a complaint against Macy's Inc. (and others) regarding, in part, Macy's wellness program. In 2014, Macy's wellness program imposed a premium surcharge on employees who certified tobacco use unless they further certified that they completed the reasonable alternative during the plan year (presumably a tobacco cessation program) and either were tobacco-free or had stopped using tobacco products and were working toward being tobacco-free.

In other words, tobacco users could not avoid the surcharge simply by satisfying the reasonable alternative standard; they also had to stop using tobacco products. The DOL alleged, among other things, that Macy's wellness program violated HIPAA's nondiscrimination requirements.

The DOL's allegation is interesting because it underscores the DOL's apparent position reflected in the final HIPAA nondiscrimination rules that you cannot require participants to stop using tobacco products in order to avoid the surcharge. This may seem counterintuitive to many wellness program sponsors.

What is the point of having a tobacco cessation program if you cannot require employees to stop using tobacco products, right? But the final HIPAA nondiscrimination regulations, as amended to reflect the requirements of the Affordable Care Act, make it clear that you must offer all who fail to satisfy a health-outcome-based standard a reasonable alternative regardless of medical necessity.

Consequently, if the employee uses tobacco products, he or she is entitled to a reasonable alternative without having to show that a medical condition prevents the employee from stopping the use of tobacco.

Caution: We are aware that the DOL is also focusing heavily in audits on whether the plan sponsor provided notice in ALL materials that describe the wellness program and its incentives or surcharges.

Treasury issues much needed QSEHRA guidance (but we still don't know how to say "QSEHRA")

In December of 2016, Congress passed the Cures Act, which includes a provision that permits employers who are not applicable large employers for purposes of the employer shared responsibility rules to establish "qualified small employer health reimbursement arrangements" or "QSEHRAs" to reimburse medical expenses incurred by eligible employees and their dependents, including but not limited to major medical premiums for individually issued policies.

The statutory framework for QSEHRAs was confusing to say the least and several significant legal and practical limitations and potentially significant penalties may arise for unwary small employers adopting a QSEHRA arrangement.

For example, QSEHRAs are only available to employers that are not subject to the Affordable Care Act (ACA) employer responsibility penalties – i.e., employers that have less than 50 full-time and full-time equivalent employees and thus are not applicable large employers (ALEs). In addition, while many small employers are likely to find QSEHRAs attractive, there are some features that should be looked at carefully before deciding to move forward.

These include a requirement that a QSEHRA can only be funded through direct employer contributions (meaning that no employee salary reduction contributions are permitted), nondiscrimination rules, and a provision prohibiting employers from maintaining another group health plan. See recent IRS FAQ guidance in Notice 2017-67, which you can find at https://www.irs.gov/pub/irs-drop/n-17-67.pdf. The guidance, although lengthy, helps you avoid the compliance traps.

The Taxman Cometh and Taketh Away—IRS Begins Assessing Employer Mandate Penalties

The IRS has finally begun enforcing the employer shared responsibility requirement (the "employer mandate") in the Affordable Care Act, and is mailing notices now to employers who may owe a penalty for 2015. Because of data quality issues, many employers will be assessed amounts they do not owe.

However, employers have only 30 days to appeal the assessment, and because of the timing of the notices, and the manner in which they are addressed, it is likely that many notices will not reach the right individuals in time for employers to respond. Your first challenge in appealing an assessment is receiving the notice in the first place.

Dealing with the IRS can be daunting in any situation, but it may be especially so here in light of the rocky rollout of the employer mandate reporting on which the assessments are based and the quick and quiet manner in which the IRS rolled out the assessment process. Many applicable large employers consist of a parent company with a benefits/HR department,

and numerous subsidiaries that rely on the parent for this type of function. Getting an IRS notice into the hands of the parent in a timely fashion could be a challenge.

We are aware that some applicable large employers have been assessed the "sledgehammer" penalty (i.e. the 4980H(a) penalty) and in some cases, the penalty is in the millions. We want you to be prepared in the event a notice arrives at your company or a subsidiary. Here is your list of "things you need to know" to start preparing:

- The notice of assessments will come in the form of a "Letter 226j." It will come from the Department of the Treasury, Internal Revenue Service, and will start by saying, "We have made a preliminary calculation of the Employer Shared Responsibility Payment (ESRP) that you owe."
- ***You will have only 30 days to respond.*** Thus, your mail rooms should be on the lookout for the notice and know where to route it. It may be addressed to the contact identified on the 1094-C you filed, but there are no guarantees of that. You should alert the mail rooms for letters from "The Department of Treasury, Internal Revenue Service." There is a specific response process prescribed by the IRS, but the requirements regarding an extension of time to respond have yet to be provided.
- Since each subsidiary of an applicable large employer was required to file its own 1094-C and 1095-Cs with the IRS, employers wishing to coordinate the response to the IRS should also alert the subsidiaries (and their mail rooms) that a notice may be coming.
- The assessments may not be correct. There are any number of reasons that an employee may have received a subsidy and triggered an employer penalty notice, even when all of the requirements for a penalty have not been met.
- An applicable large employer may be subject to an employer mandate penalty for a month if a full-time employee receives a subsidy that month for coverage purchased on an Exchange. Employees will only qualify for a subsidy on an Exchange if, among other things, they are not eligible for affordable, minimum value coverage from their employer. However, due to deficiencies in the process of collecting data, some employees may have received subsidies for which they did not qualify, and even if an employee did qualify for the subsidy, the employer may be exempt from the penalty for other reasons. The standard for determining the affordability of coverage, for example, is different from the perspective of the employee and the employer.

Key Cost of Living Adjustments for 2018

The IRS has now released the cost of living adjustments for 2018 applicable to health and welfare benefit plans, as reflected in the chart below.

Benefit Plan	*2017 Limit*	*2018 Limit*
Health FSA	$2600	$2650
Transit Pass	$255	$260
Parking Expenses	$255	$260
HSA-HDHP minimum deductible	Self-only: $1,300 (self only) Family: $2600 (other than self only)	Self-only: $1,350 Family: $2700 (other than self only)
HSA-OOP maximum	Self-Only: $6,550 Family:$13,100	Self-Only: $6,650 Family: $13,300
HSA-contribution maximum	Self-Only: $3,400 Family: $6,750	Self-Only: $3,450 Family: $6,900
ACA-OOP Maximum	Self-only: $7,150 Family: $14,300	Self-Only: $7,350 Family: $14,700
Affordability Percentage for 4980H purposes	9.69%	9.56%

In addition, the PCORI fee for plan years ending prior to October 1, 2018 is $2.39. This is the fee due July 31, 2018 for calendar year plans ending December 31, 2017. ■