Western Pension & Benefits Council
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presented by: Ellen Mondress

Employer Health Plans: Legal Developments

Part I: Legal developments under the Affordable Care Act during 2015 and the first few months of 2016

Part II: Other legal developments during 2015 and the first few months of 2016

Part III: Issues to watch in 2016

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Part I

Legal developments under the Affordable Care Act (PPACA) during 2015 and the first few months of 2016

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The Cadillac Tax is a tax on health plan benefits provided by employers to their employees. The tax is 40% of the value of benefits over a threshhold amount. It's a money maker for the federal government, meant to offset some of PPACA's costs.

Last October the International Foundation of Employee Benefit Plans released a survey that found 60% of employers would trigger the tax in 2018 unless they reduced benefits, with an added 10% each year thereafter.

In December 2015 Congress passed a law that **delays the Cadillac Tax for two years** (to 2020) and allows employers to deduct the tax. There have been bipartisan efforts to repeal or reduce the Cadillac tax and we anticipate those efforts will continue.

In February 2016 President Obama proposed to **raise the Cadillac Tax threshold** to the greater of the current amount, or a gold Exchange Plan in the applicable state. The current amount is $10,200 for individual coverage and $27,500 for families (as adjusted). This will benefit those in states where the cost of health care is higher than the current amount.

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The Supreme Court first upheld PPACA in June 2012, when it ruled that the individual mandate, the requirement that all individuals have health coverage or pay a tax, was Constitutional. The decision was a fractured 5 to 4 decision, with Chief Justice Roberts joining the Court's 4 more liberal members.

In June 2015 the U.S. Supreme Court decided the *King v. Burwell* case, in which the plaintiffs used a literal reading of PPACA to argue that the government may only **subsidize health coverage** that is purchased on a state-based Exchange. The Court rejected this argument, reasoning that Congress intended to treat the state and federal Exchanges the same for purposes of subsidies.

Justice Scalia famously stated in his dissent that the majority's opinion was "pure applesauce" and "interpretive jiggery pokery."

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Services to treat **gender dysphoria** received attention in 2015, including the following:

The DOL issued an FAQ in May 2015 that sex-specific preventive care services cannot be limited based on sex assigned at birth or gender identity. Rather, they are based on the medically appropriate service for the individual, as determined by the individual's attending provider.

In September 2015 HHS proposed regulations prohibiting discrimination based on gender identity and sex stereotyping under a health program that is receiving federal financial assistance.

Reminder: gender dysphoria is a mental health diagnosis, and so protected under the MHPAEA. The MHPAEA does not require health plans cover transgender services, however, once any treatment for gender dysphoria is provided, with some exceptions the MHPAEA will require most all medically necessary services and supplies be provided. Treatments for gender dysphoria include counseling, hormone therapy and surgery.

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Under PPACA, non-grandfathered plans must provide in-network **preventive care benefits** without cost-sharing. This requirement continued to receive attention in 2015, including the following:

- Agency FAQs that preventive care must include **at least one form of female contraception in each of 18 categories established by the FDA.**
- The categories range from surgical sterilization to IUDs and oral contraceptives. Plans may use "reasonable medical management techniques" to encourage the use of certain contraceptives within a particular category—for example, plans could limit coverage of birth control pills to generics only.
- The Agencies also confirmed that the rules for preventive care contraceptives apply to all females of child-bearing age who are covered by the plan, including dependent children.

Note: required preventive care does not include male contraceptives or vasectomies.

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Agency FAQs and U.S. Preventive Services Task Force updates to several **preventive care** requirements include:

- genetic counseling and BRCA genetic testing
- screening for obesity in adults and behavioral interventions for adults with a BMI of 30 kg/m2 or higher
- lactation counseling and breastfeeding equipment
- colonoscopy-related services (anesthesia, polyp removal, consultation)
- high blood pressure screening
- abnormal blood glucose and diabetes type 2 screening
- tobacco use counseling

Other examples of preventive care that plans must cover without cost sharing: childhood immunizations, annual well-care visits, prenatal care, mammograms, smoking cessation.

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Self-funded plans are not required to offer any particular Essential Health Benefit ("EHB"). But if a plan does provide coverage for an EHB, it must do so without a lifetime or annual dollar cap on benefits.

Under PPACA, plans cannot impose dollar limits on EHBs. In general, a self-funded plan's EHBs are those benefits covered by the plan's chosen state's benchmark plan. The current benchmark plan options apply through plan years beginning in 2016, and CMS recently announced the **new EHB benchmark plans** that will apply after that.

As a state's new benchmark plan may differ from its current benchmark, self-funded plans should reevaluate their choice of benchmark plan by 2017.

Note: a self-funded plan needn't have any nexus to a state in order to select its benchmark plan.

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"Out of pocket maximum" is the greatest amount of cost sharing permitted under an employer-sponsored health plan. It includes deductibles, copays and coinsurance. The out of pocket maximum does not have to apply to out-of-network benefits.

For 2016, **out-of-pocket maximums** on in-network benefits cannot exceed $6,850 for self-only coverage and $13,700 for family coverage.

For 2017 the limits are $7,150 for self-only coverage and $14,300 for family coverage.

The Agencies interpret the self-only maximum as a per person maximum, effective for plan years beginning in 2016 or later. In other words, for any individual covered by the plan, that individual's out-of-pocket costs cannot exceed the self-only maximum—and if the individual has family coverage, the family's out-of-pocket costs cannot exceed the family coverage maximum.

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The **transitional reinsurance contribution** is $44 per covered life for 2015 and $27 per covered life for 2016 (the last year for which the TR contribution is owed). The total transitional reinsurance amount to be paid to the government was predicted to be $25 billion.

The **Patient Centered Outcomes Research Institute ("PCORI") fee** increased to $2.17 per covered life for the plan year ending after September 30, 2015 and before October 1, 2016. The next PCORI fee must be paid by July 31, 2016.

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The IRS issued forms that health plans and insurers must use to annually report minimum essential coverage to the IRS and enrollees and that applicable large employers must use to report information related to their compliance with the play or pay requirements (**Forms 1094-B, 1095-B, 1094-C and 1095-C**).

The instructions clarify which forms to use and how to complete them, and provide guidance on reporting HRA coverage, offers of COBRA coverage, and multiemployer plan coverage.

Reporting is first required in 2016 (for 2015 coverage). The IRS **extended the due dates** for the first filings. The deadline to furnish 2015 forms to employees was extended from February 1 to March 31, 2016, and the deadline to file with the IRS was extended from March 31 to May 31, 2016 (or June 30, 2016, if filed electronically).

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PPACA originally required that certain large employers automatically enroll new full-time employees into the employer's health plan. In 2012, the Agencies advised that employers did not have to comply until final regulations were issued (which did not occur).

In November 2015, following lobbying efforts by business groups and bipartisan support in Congress, President Obama signed legislation that **repealed PPACA's automatic enrollment rule**.

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PPACA requires that health plans issue SBCs, a summary of benefits and coverage. The SBC is a 6-page template, which summarizes a health plan's benefits and limitations. It's delivered at open enrollment/annually, and updates are required 60 days before the effective date of a change.

In June 2015, the Agencies published amended final regulations on the **summary of benefits and coverage** requirement. The regulations incorporate prior FAQ guidance and provide instruction for insured plans on SBC timing and content.

The Agencies then issued new proposed model SBC documents on February 26, 2016, that will apply for plan years beginning in 2017.

http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html

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PPACA prevents plans from **discriminating against health care providers** who are acting within the scope of their license.

In 2013 FAQs, the Agencies advised that this rule does not require that plans accept all types of providers into their networks, or prevent plans from varying provider reimbursement rates based on market considerations.

The Senate Appropriations Committee objected, claiming that the Agencies were permitting the type of discrimination that PPACA was intended to prevent.

In May 2015 the Agencies rescinded their prior FAQs and announced that they will not take enforcement action against any plan that complies with a reasonable, good-faith interpretation of the nondiscrimination rule until further guidance is issued.

Who is impacted? Chiropractors, naturopaths, homeopaths, osteopaths.

In November 2015 the IRS, HHS, and DOL published **final regulations on many PPACA benefit mandates,** including grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits, rescissions of coverage, coverage of adult dependent children, claim and appeal procedures and patient protections.

Effective date: plan years beginning in 2017

Replaces: prior regulations issued in 2010

Incorporates: prior regulations and FAQ guidance

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In February 2015 the IRS issued transitional relief for certain **employer payment plans** not sponsored by applicable large employers, for Medicare premium reimbursement arrangements and Tricare-related health reimbursement arrangements, and for S-corporation health arrangements.

In 2015 the Agencies issued several notices on health reimbursement accounts, **HRA**s. An HRA is an employer-funded promise to pay for a health benefit. With some exceptions, an HRA cannot be used to purchase individual Exchange coverage and can be offered by an employer only in conjunction with an ACA-compliant group health plan.

One exception: A retiree-only HRA. However, a retiree-only HRA should be a separate, stand-alone ERISA plan that files its own Form 5500 and has a separate plan number and plan document.

Another exception: HRAs that pay only for ACA-excepted benefits such as limited scope dental or vision.

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In February 2016 a Federal District Court in New York refused to dismiss a case alleging that an employer violated ERISA 510 when it **reduced employee hours in order to eliminate "full-time" employee status under PPACA**.*

ERISA 510 prohibits an employer from taking employment action against an employee for exercising rights under a plan, or for the purpose of interfering with the attainment of rights under a plan.

The employer was attempting to avoid the play-or-pay tax, a tax which applies if an employer does not offer its full-time employees minimum essential health coverage that meets PPACA's minimum value standards, at an affordable price (less than 9.5% of the employee's household income).

* *Marin v. Dave & Buster's, Inc. (SD NY February 9, 2016)*

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Part II

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The deadline to implement **ICD-10** (the World Health Organization's set of diagnostic and medical procedure codes) was October 1, 2015.

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There were several developments with respect to the rights of **same sex spouses** and health coverage.

In 2013 the U.S. Supreme Court held in *U.S. v. Windsor* that the Defense of Marriage Act, DOMA, violated the 5th Amendment and so was unconstitutional. DOMA was the 1996 federal law blocking recognition of gay marriage. In 2015 the U.S. Supreme Court held in ***Obergefell v. Hodges*** that states must license marriages between two people of the same sex, and must recognize same sex marriages licensed out-of-state.

In 2015 the Equal Employment Opportunity Commission took the position that sexual orientation is protected under federal anti-discrimination law. Therefore, health plans that do not cover same-sex spouses may be targets for discrimination lawsuits.

A case was filed in Florida, alleging that assisted reproductive technology should be a deductible medical expense under Code Section 213 for same sex male couples.* A surrogate female carried the plaintiffs' twin boys. Code Section 213 does permit single females and heterosexual couples to deduct fertility expenses.

**Morrissey v. United States (November 23, 2015 DC MD Fla).*

In an effort to limit benefit lawsuits, some plans and SPDs now have a **deadline for participants to sue the plan**.

These deadlines are generally enforceable.

The 3rd Circuit Court of Appeals joined the 5th and 6th Circuits in holding that benefit denial notices (explanation of benefits, or EOBs) must mention the plan's deadline to file a lawsuit challenging the benefit denial, in order for the deadline to be enforceable.*

* *Mirza v. Insurance Adm'r of America, Inc.*, 800 F.3d 129 (3d Cir. 2015).

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In *M&G Polymers USA, LLC v. Tackett,* the U.S. Supreme Court ruled that courts should not infer a **lifetime health care benefit for retirees** when a collective bargaining agreement promises employer-paid retiree health benefits, is silent on duration of the benefits, and the agreement has a general durational clause.

The Court struck down an inference applied for 30 years in the 6th Circuit, originating from a case known as "Yard-Man." The Court explained that Yard Man places "a thumb on the scale in favor of vested retiree benefits in all collective-bargaining agreements," and that instead, ordinary principles of contract interpretation should apply to determine an employer's obligation to provide permanent health coverage to retirees.

New guidance was issued on **wellness programs**:

- Under HIPAA nondiscrimination rules, wellness programs must be reasonably designed to promote health or prevent disease. In April 2015 guidance, the DOL, IRS and HHS identified several types of programs that may not meet this requirement and will be subject to scrutiny, including programs that collect a substantial amount of personal health information without helping individuals make behavioral changes or that are designed to discourage sick individuals from enrolling in the employer's health plan.

- The EEOC published proposed amendments to its Americans with Disabilities Act regulations. The proposed changes would allow wellness programs to provide rewards or impose penalties. However, these are more limited rewards and penalties than are allowed under the HIPAA nondiscrimination rules.

- The EEOC also issued proposed changes to its Genetic Information Nondiscrimination Act regulations, to clarify when wellness programs may offer rewards in exchange for a dependent's health information.

- The EEOC appealed its loss in *EEOC v. Flambeau* to the 7th Circuit.

Under the **Mental Health Parity and Addiction Equity Act ("MHPAEA")**, if a Plan covers mental health or substance use disorder benefits, it may not impose financial requirements or treatment limitations on those benefits that are more restrictive than the predominant financial requirements/treatment limitations applied to substantially all medical and surgical benefits. Several MHPAEA cases are making their way through the courts.

The 2nd Circuit Court of Appeals allowed participants to bring a fiduciary breach claim against a third-party administrator for allegedly applying more restrictive **medical necessity, preauthorization and concurrent review procedures** to the plan's mental health benefits.* A district court in the 2nd Circuit upheld a plan's ability to require psychiatric treatment be recertified as medically necessary, since the plan applied the medical necessity requirement equally to all benefits.**

* *N.Y. State Psychiatric Ass'n v. UnitedHealth Group*, 2015 WL 4940352 (2d Cir. 2015)

** *Tedesco v. IBEW Local 1249 Ins. Fund,* 2015 WL 6509039 (SDNY 2015)

…also under the **MHPAEA**

In early 2016 the District Court of Oregon issued new rulings that permitted continued litigation of certain factual matters without disturbing its earlier 2014 ruling that a plan's refusal to pay for **ABA therapy** (used to treat autism spectrum disorder) per the plan's exclusion for developmental disability coverage violated the MHPAEA because that exclusion is a treatment limitation that only applies to mental health benefits.* The plan did cover certain other autism spectrum disorder services.

Two courts recently addressed claims against plans that provided limited or no **residential treatment facility** services for mental health and substance abuse conditions otherwise covered by the plans. Those courts permitted MHPAEA claims.** Microsoft successfully defended a similar claim, however there the court dismissed the case because the plaintiff's treatment was in 2013 and MHPAEA did not require coverage of residential treatment centers until the effective date of final regulations, July 2014.***

* *Legaard v. Providence Health Plan, 201*6 WL 81796 (D. Oregon 2016)

** *Craft v. Health Care Serv. Corp*., 84 F. Supp 3d 748 (ND Ill. 2015) and *Joseph F. v. Sinclair Servs. Co*., 2016 WL 309787 (D. Utah 2016)

****S.S. v. Microsoft Corp. Welfare Plan* (WD WA February 11, 2015)

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Some health plans include **anti-assignment language**, for example, "plan benefits may not be assigned. The payment of benefits to a health care provider are a convenience and not an assignment." This is done to prevent providers from suing the plan under ERISA for benefits.

The 7th Circuit held that ERISA's claim and appeal procedures do not apply to a payment dispute between an insurer and its network provider if the plans have anti-assignment clauses. Instead, the dispute is governed by the terms of the PPO contract between the insurer and the provider.*

The 3rd Circuit found that a patient's assignment of ERISA rights to a provider permitted the provider to sue a plan under ERISA for benefits.** The Court did not mention whether that plan had anti-assignment language.

The 2nd Circuit found an assignment was insufficient to permit a provider to sue under ERISA.***

* *Pa. Chiropractic Ass'n v. Independence Hosp. Indem. Plan, Inc., 2015 WL 5853690 (7th Cir. 2015).*
** *NJBSC v. Aetna,* 801 F. 3d 369 (3rd Cir. 2015)
*** *Rojas v. Cigna Health and Life Ins. Co.,* 793 F. 3d 2153 (2d Cir. 2015)

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In October 2015 the DOL, IRS and HHS issued an FAQ that if a participant requests documents which are subject to disclosure under ERISA, the plan administrator **cannot refuse to provide the documents on the basis that they are proprietary**.

The FAQ specifically mentions the plan's medical necessity criteria as a document to be disclosed.

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In January 2016 the U.S. Supreme Court ruled in *Montanile v. Board of Trustees of Nat. Elevator Industry Health Benefit Plan* that the plan could not sue a participant to recover **third party liability** settlement funds. In that case the plan advanced $121,000 in accident-related claims, and the participant recovered $500,000.

The participant had signed a reimbursement agreement. The settlement funds were deposited into the attorney's trust account. The participant's attorney refused to reimburse the plan and after 14 days' notice, disbursed the funds which the participant then spent.

Because the plan would have been forced to collect from the participant's general assets rather than a specific fund, the Court ruled that equitable relief under ERISA 502(a)(3) was not available.

In November 2015 the DOL issued proposed amendments to ERISA's **claims procedures for disability benefits**. The changes would apply to health benefits coverage conditioned upon a showing of disability.

Example: coverage after age 26 for a disabled child

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Part III: Issues to watch in 2016

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More MHPAEA litigation. *Do non-quantitative treatment limitations in the regulations exceed statutory authority?*

Continued efforts to repeal the Cadillac Tax and raise the threshold

Ramp-up for new benchmark plans effective in 2017

Continued expansion and discussion of preventive care services

More suits by out-of-network providers against plans that limit reimbursement to an "allowed," "UCR," or similar amount

The Supreme Court will decide *Zubik v. Burwell*, a case involving religious organization and the contraceptive coverage mandate of PPACA (*The Little Sisters of the Poor* case*).* In 2014, the Supreme Court decided the *Hobby Lobby* case, finding that closely-held companies may claim exemption from the PPACA mandate to provide birth control free-of-charge. Employers must file with the government and insurers to obtain that exemption. The *Little Sisters* argue that the requirement they file violates the Religious Freedom Restoration Act.

Nondiscrimination testing regulations for insured, non-grandfathered plans?

Plan sponsors, insurers and administrators should pay attention to….

Exchange notices. PPACA requires that Exchanges notify employers if an employee enrolls in Exchange coverage and qualifies for a subsidy (this can happen if the employee attests that he/she is not enrolled in employer-provided coverage and was not offered affordable, minimum value employer coverage). The federal Exchange will start providing the notice beginning in 2016. Many state-based Exchanges have already been doing so.

Employers that receive a notice should evaluate whether the employee may have received the subsidy in error and, if so, consider filing an appeal, both to protect against potential penalties and to prevent the employee from incurring tax penalties for wrongfully receiving a subsidy.

Form 5500. The IRS added compliance questions to the 2015 Form 5500, and in late February 2016 announced that the questions should be "skipped."

And don't forget to pay those state and local taxes:

State child immunization taxes based on headcount (e.g., AK, CT, ID, MA, ME, VT)

Taxes based on claims paid (e.g., MA, ME, MI, NY, VT)

Taxes based on headcount (e.g., ME, NY, VT).

Not to be confused with states that require health insurers report payments related to health care claims and other health care information to the State of Vermont for compilation in a state data base: preempted by ERISA in *Gobeille v. Liberty Mutual Insurance Co (2016).*

At Song Mondress, all of the attorneys focus their practice on just one area of law, employee benefits.

Ellen Mondress serves as lead counsel for clients in a full spectrum of retirement plans, such as 401(k), 403(b), pension, annuity, money purchase, defined contribution, and deferred compensation plans; and of health and welfare plans, such as VEBA-funded, uninsured and insured plans, and training, educational and vacation funds. Her clients are in industries ranging from retail to energy to construction, and include plans maintained by Fortune 50 and 500 companies, nonprofits, and regional Taft-Hartley boards of trustees.

This outline is a selection of legal updates of interest to the author and her audience. It is not intended as legal advice.

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