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EMPLOYEE BENEFITS LAW

Legal Developments Impacting Health and Welfare Plans
(Other than Health Care Reform)

2016 Year-End Update

1. In 2016, the IRS, DOL and HHS (the "Agencies") issued additional guidance on the federal **mental health parity** law. They confirmed plans cannot impose different "non-quantitative treatment limitations" (such as preauthorization requirements) on mental health and substance abuse benefits, unless the limits resulted from the same "processes and strategies" used to determine limits on the plan's medical benefits.

   Also in 2016, three federal district courts considered whether mental health parity requires covering treatment received at **residential treatment centers**, such as rehab facilities. Each court came to a different conclusion. The cases involved facts that predated the 2013 final mental health parity regulation, and the courts did not indicate whether the cases would have been decided differently under the final regulation.

2. HHS issued several pieces of guidance on the **HIPAA privacy and security rules**, including:

   - FAQs confirming that a cloud computing provider storing protected health information ("PHI") is a business associate—even if the provider is unable to access the PHI.
   - A Fact Sheet on preventing and recovering from ransomware attacks.
   - FAQs on participants' rights to access their PHI.

   In addition, the HITECH Act required HHS periodically audit health plans and their business associates for HIPAA compliance. In 2016, HHS performed a small number of audits under a pilot program. HHS will use the results to develop a permanent audit program.

3. In May 2016, the EEOC published a final regulation under the Americans with Disabilities Act ("ADA"), which addressed the extent to which employers can incentivize participation in **wellness programs** that involve disability-related inquiries or medical exams (such as biometric screenings). Contrary to several prior court cases, the regulation also provides that the ADA safe harbor for "bona fide benefit plans" cannot apply to wellness programs. Several months later, a federal district court deferred to the EEOC's interpretation of the safe harbor.[1]

[1] *EEOC v. Orion Energy Sys., Inc.*, No. 14-CV-1019, 2016 WL 5107019 (E.D. Wis. Sept. 19, 2016).

4. In July 2016, the IRS and DOL issued proposed guidance that, if adopted, would make sweeping changes to **Form 5500 filing requirements** starting in 2019. Of particular note for health and welfare plans, the proposed changes would eliminate the Form 5500 filing exemption for small (fewer than 100 participants) fully insured and/or unfunded plans, and add a new Schedule J requiring detail on claim payments, stop loss coverage, employee premium sharing, employee and dependent eligibility, and various benefit designs.

   The IRS and DOL also added new "compliance questions" to the 2015 and 2016 Form 5500s and supporting schedules that were intended to uncover legal violations. However, in response to widespread concern, they subsequently stated that these questions should not be answered.

5. Federal law does not expressly require that ERISA health plans cover **same-sex spouses**. However, in 2015 the EEOC took the position that sexual orientation is protected under federal anti-discrimination law (Title VII). As a result, health plans that do not cover same-sex spouses are targets for discrimination lawsuits. For example, in December 2016 Walmart paid $7.5 million to settle a class-action lawsuit.

6. At least 30 different state and local laws require employers provide **paid sick or family leave**, with several more such laws passed in 2016 and effective in 2017. The requirements differ widely as to eligibility, accrual, carryovers, cash-outs, and recordkeeping—making administration of leave programs increasingly complex for multistate employers.

7. In general, health plans must offer a **HIPAA special enrollment opportunity** to employees and dependents who lose other health coverage. In December 2016 FAQs, the Agencies confirmed this could include loss of coverage under an Exchange insurance policy.

8. Many ERISA health plans will pay accident-related medical expenses so long as the participant promises to reimburse the plan out of the participant's settlement or other recovery (for example, a car insurance settlement). However, when the participant spends the settlement without reimbursing the plan, federal courts had disagreed about whether the plan could seek reimbursement from the participant's general assets. In January 2016, the U.S. Supreme Court resolved the conflict, ruling that **a plan generally cannot seek reimbursement from a participant's general assets**. The Court was unmoved by arguments that its decision would encourage participants to violate their reimbursement obligations and spend settlements as quickly as possible.[2]

9. In *House of Representatives v. Burwell,* a federal district court ruled in favor of the U.S. House of Representatives regarding **PPACA subsidies to insurance companies**. More specifically, the court held that PPACA's "cost-sharing reductions" payments to insurers are unconstitutional because Congress never appropriated funds to cover them. Without these payments—totaling about $150 billion over 10 years—the health insurance Exchanges could become highly destabilized or collapse entirely. The Obama

[2] *Montanile v. Bd. of Trs. of Nat'l Elevator Indus. Health Benefit Plan*, 136 S.Ct. 651 (2016).

Administration had appealed the court's decision, but the Trump Administration put the appeal on hold.[3]

10. There were several noteworthy court decisions regarding **preemption** of state laws that impact self-funded ERISA plans:

    - In *Gobeille v. Liberty Mutual*, the U.S. Supreme Court invalidated a Vermont law requiring third-party administrators to report claim payments, information about individuals' eligibility for coverage, and other information to a state agency. The Court considered this to be direct regulation of a fundamental function of a health plan, and thus preempted by ERISA when applied to self-funded plans (as opposed to insurance companies, which have always remained subject to state regulation).[4]
    - In *Health Care Service Corp. v. Methodist Hospitals*, the Fifth Circuit rejected a Texas prompt-pay law with respect to self-funded ERISA plans.[5]
    - In *Self-Insurance Institute of America v. Snyder*, the Sixth Circuit held that Michigan's tax on health plan claims is not preempted by ERISA. The ruling was consistent with the Supreme Court's long-standing approval of taxes that apply to self-funded as well as insured plans and impose only "incidental" burdens.[6]
    - Two federal district courts in California disagreed about whether a state law could limit a self-funded plan's "discretion" to decide benefit claims. Some uncertainty on this issue will remain in California unless the federal district courts come into agreement or the Ninth Circuit resolves the dispute.[7]

11. The DOL increased the **penalties** for certain ERISA violations. For example, the maximum penalty for failure to file a Form 5500 increased from $1,100 to $2,063 per day, and the maximum penalty for failure to provide an SBC increased from $1,000 to $1,087 per affected person.

12. For 2017, the **annual dollar limit** on employee contributions to a health FSA increased from $2,550 to $2,600. The limit on HSA contributions for self-only coverage increased from $3,350 to $3,400, but the limit for family coverage remains at $6,750.

From all of us here at MMPL, your employee benefits law firm.

Not intended as legal advice.

[3] *House of Representatives v. Burwell*, 2016 WL 2750934 (D.D.C. 2016).
[4] *Gobeille v. Liberty Mut. Ins. Co.*, 136 S.Ct. 936 (2016).
[5] *Health Care Serv. Corp. v. Methodist Hosps. of Dallas*, 814 F.3d 242 (5th Cir. 2016).
[6] *Self-Ins. Inst. of Am., Inc. v. Snyder*, 827 F.3d 549 (6th Cir. 2016).
[7] *Thomas v. Aetna Life Ins. Co.*, No. 215CV01112JAMKJN, 2016 WL 4368110 (E.D. Cal. Aug. 15, 2016); *Martin v. Aetna Life Ins. Co.*, No. CV 15-7355-RSWL-FFMX, 2016 WL 6997484 (C.D. Cal. Nov. 30, 2016).