



# 2019 Compliance Issues and Takeaways for Self-Funded Employers

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# Topics for Today

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- Health care reform update
- Association health plans
- Proposed HRA regulations
- Wellness update
- Mental health parity update
- Fiduciary issues relating to cost control
- HIPAA update
- Recent benefits case law and its potential impact on plan drafting
- Cross-plan offsetting

# Health Care Reform (ACA) Update

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- Republican efforts to "repeal and replace" ACA have halted
  - Dramatic "thumbs down" by Senator McCain in July 2017 ended up being last, best chance for Republicans to remove it legislatively
  - Had been some discussion (e.g., Sen. Cruz) of trying to repeal and replace in current lame-duck session but not enough support
- Cadillac tax was delayed until 2022 by Continuing Appropriations Act
- Individual mandate reduced to \$0 for months starting 1/1/2019
  - *Texas v. U.S.* – 20 state plaintiffs say that removing the individual mandate removes the justification for entire ACA, so entire ACA must be deemed void by court
  - Judge agreed with plaintiffs. But decision on hold pending appeal
  - Mind-boggling effects if decision is enforced

# ACA Update

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- Will Congress change the ACA?
- Democrats fighting on whether to "fix" ACA versus go for "Medicare for All"
- Republicans quiet – hoping that Texas decision forces Democrats to bargain?
- So, ESR Rules (and 1094 / 1095 reporting) remain in place
  - Double-check your 1095 / 1094 filings – make sure that you checked "yes", that you met 95% test (if that is true)

# Association Health Plans Historical Overview

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- Concept of banding together is not new
- DOL has allowed it for a number of years
- After ERISA was passed in 1974, a number of marketers began promoting AHPs
- They were self-funded, usually
- For some, when high claims occurred, the plan disbanded, leaving employees / providers in a lurch

# AHP Historical Overview

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- States could not regulate self-funded plans due to ERISA preemption
- This led Congress to modify ERISA
- States could now regulate "multiple employer welfare arrangements" ("MEWAs")
- Most states did regulate them
  - Require them to be "mini-insurers" with assets set-aside
  - Some flat-out prohibited them
  - Some states ok with them if they were fully-insured
- There remained a way for AHPs to avoid stringent MEWA rules
- Under DOL guidance, a "bona fide group or association of employers" could be a single "employer"
  - If it's a "single" employer, it's not a MEWA (which requires "multiple" employers)

# "Bona Fide" Association

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- DOL looks at various factors to determine if a "bona fide" association exists
- How members are solicited
- Who is entitled to participate and who actually participates
- Process by which association was formed
- Purposes for which it was formed and what, if any, were the pre-existing relationships of its members
- Powers, rights and privileges of employer-members
- Who actually controls and directs activities / operations of benefit program
- Employer-members must, either directly or indirectly, exercise control over program, both in form and substance
- "Inherently factual issue" – meant to be "rare" but some exist

# Overview

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- June 2018 – Department of Labor ("DOL") released final rule on definition of "employer" under ERISA
- Intent / goal is to expand "association health plans" ("AHPs")
  - Per President Trump's executive order (October 2017)
- May allow employers (especially smaller employers) to "band together" to purchase health insurance / self-funded health benefits
- Big attraction: For smaller, fully-insured plans the banding together may result in group being a "large" (not "small") group
  - May avoid some state and federal (e.g., ACA) coverage mandates
  - Avoiding mandates may result in "worse" coverage (i.e., cheaper)
- Can go under "old rules" (prior slides) or "new rules" (upcoming slides)
  - For newly-formed groups, "new rules" may be only / most feasible option
- Effective dates:
  - 9/1/2018 – Fully-insured AHPs
  - 1/1/2019 – Existing self-insured AHPs
  - 4/1/2019 – New self-insured AHPs under new rules



# New Rules

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- "Commonality of Interest" test
  - Employers are in same trade, industry, line of business or profession OR
  - Each employer has principal place of business in same region that does not exceed boundaries of a single state / metropolitan area
- Each employer member must have someone covered
- Must have at least one "substantial business purpose" unrelated to offering / providing health coverage
- Need formal organization structure with governing body and bylaws
  - Facts and circumstances include election of directors, officers, etc.; whether employers can remove them; whether employers can approve decisions relating to plans
- Association cannot be controlled by health insurance issuer
- Nondiscrimination rules apply
- State laws can still apply (MEWA rules)

# Account Based Plans (HRAs)

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- Under ACA, health reimbursement arrangements ("HRAs") could not be used to purchase individual health insurance policies
  - Concern is that HRA by itself would not meet annual and lifetime limits and that HRA could not be "integrated" with individual policy
- October 2018 proposed regulations would reverse this
- But proposed regulations somewhat-complicated and may be changed
- Allow for "individual coverage HRAs" ("ICHRAs")
- Also allow for stand-alone HRAs so employees can pay for out-of-pocket medical expenses and certain premiums ("Excepted Benefit HRAs")

# ICHRAs

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- Individual covered by ICHRA must be enrolled in health insurance coverage purchased in individual market
- Employer cannot offer the same class of individuals covered by the ICHRA and a "traditional" health plan
- Employer must offer the ICHRA on same terms to all employees in a "class"
- Employees must have ability to opt out of receiving the ICHRA (in order to receive a premium tax credit through an Exchange)
- Employers must provide detailed notice to employees of ICHRA terms

# Excepted Benefit HRAs

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- Most ACA rules do not apply to "excepted benefit" plans (like dental or vision)
- Excepted-benefit-only coverage also does not prevent an employee from receiving an Exchange subsidy
- Excepted Benefit HRA requirements:
  - Employer must offer other, non-account based medical coverage to employees that is not an excepted benefit
  - Amount of new employer contributions each year cannot exceed indexed amount (initially set at \$1,800)
  - Cannot be used to reimburse medical expenses and premiums or contributions for COBRA or excepted benefits coverage
    - But can be used to reimburse for other individual or group coverage
  - Made available on a uniform basis to all similarly situated employees
  - Employer cannot offer this and an ICHRA to same group of employees

# Wellness Update

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- Law remains jumbled
- Had certainty due to EEOC, IRS, DOL and HHS all issuing wellness regulations (even though some variance in requirements)
- But, EEOC's 30% wellness discount was challenged by AARP and EEOC lost
- Effective 1/1/2019, 30% maximum is no longer the law
- Leaves it unclear what IS the law – presumably prior, muddled law
  - EEOC final regulations might still be years away
- Some employers are not doing any physical examinations which could trigger EEOC rules applying
- Others are comfortable taking some risk (because risk is similar to what it was for 20+ years when EEOC was silent)

# Mental Health Parity Update

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- Mental health parity rules updated in 2013
- New rules very difficult to apply
- Bipartisan political pressure to enforce rules
- In last year, about ½ of all DOL audits and penalties related to mental health parity

# Mental Health Parity

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- Lawsuits somewhat-frequent
  - "Wilderness therapy" cases are hot now. Cases are mixed
- Seen arguably abusive practices involving drug testing clinics "on the beach"
  - Can it be limited through amendment?
- As a practical matter, many TPAs / PBMs won't do the test
  - May run the "quantitative treatment limitations" test but won't touch the "non-quantitative" test
  - Even if TPA does, may not be right

# Mental Health Parity

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- Wit v. United Behavioral Health (March 2019)
  - UBH adopted mental health guidelines drawn from national standards – but NOT identical to those standards
  - UBH had fiduciary discretion to interpret plan and ensure guidelines "consistent with ... accepted standards of care"
  - Court ruled that UBH had "conflict" and its care guidelines resulted in breach of "duty of loyalty, duty of due care and its duty to comply with plan terms by adopting Guidelines that are unreasonable and do not reflect generally accepted standards of care"
    - Court arguably is wrong on this – seems like a "settlor" activity



# Fiduciary Duties in Plan Design / Cost Control

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- Refresher: ERISA provides that only certain activities are subject to ERISA's fiduciary duty provisions
  - Fiduciary duty rules include a requirement to act in "best interests" of participants
- "Settlor" activities are not subject to ERISA's fiduciary duty rules
  - So, an employer generally can raise deductibles / premiums without violating rule to act in best interests of participants
  - Usually includes actions to design plan

# Fiduciary Duties in Plan Design / Cost Control

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- "Fiduciary" activities generally include actions to administer the plan
- Per 2015 DOL publication "Understanding Your Fiduciary Responsibilities Under a Group Health Plan", plan administrator must verify that service provider's fees are "reasonable"
  - And must monitor them on an ongoing basis
  - Ask provider for all sources of compensation (including from third parties)

# Fiduciary Duties in Plan Design / Cost Control

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- If plan sponsor receives any benefit, raises issues
  - E.g., Emory University prohibited transaction exemption (1993) dealt with what rates Emory's self-funded health plan would pay Emory's hospital
  - 2017 Montana case alleging that hospital plan sponsors received \$20M in revenue by giving 6-year contract to a Blue Cross entity (HCSC)
  - Charlotte-Mecklenburg Hospital Authority ("Atrium") sued (2018) over whether it improperly used an affiliated third-party administrator for health plan

# Fiduciary Duties in Plan Design / Cost Control

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- More likely scenario for employers to be sued is if fail to monitor service provider fees
- DOL is aggressive in forcing employers to monitor and report service provider fees on retirement plan side
  - Under Obama administration, was some thought to increased disclosure for health and welfare plans, as part of Form 5500 changes
  - Proposed 5500 changes issued in July 2016
  - Supposed to be effective in 2019, but that seems doubtful

# Fiduciary Duties in Plan Design / Cost Control

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- Risk for plan sponsors is not understanding (or documenting) what fees vendors are charging
- Per-employee-per-month fees are easy
- But some are more difficult to quantify
  - E.g., PBM fees can sometimes be difficult to quantify or compare among PBMs
  - TPAs, too -- BCBS of MI successfully sued over "hidden" fees
    - Added a "mark-up" to hospital cost; paid hospital lesser cost and kept the difference
    - Could participants sue fiduciaries?

# HIPAA Update

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- HIPAA Privacy and Security Rule penalties reached record amount last year
- Always a good idea to make sure your documents and training are in place
- In December 2018, HHS proposed possible changes to HIPAA regulations
  - May impact providers the most
  - No immediate action steps needed from employers

# Impacts of Recent Benefit Litigation on Plan Drafting

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- Recently there have been a number of benefits-related cases that may impact the provisions plan sponsors choose to include in plan documentation, including:
  - Anti-Assignment Provisions
  - Mandatory Arbitration/Class Action Waivers
  - Venue Selection Provisions
- In 2018, the United States Court of Appeals in the 3rd and 9th circuits upheld anti-assignment clauses included in employee benefit plans that were governed by ERISA

# Anti-Assignment - Background

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- Health care providers oftentimes have individuals who receive medical services "assign" their right to benefits under their health care plans to such health care providers so that the providers can pursue the health plan directly to recover any fees incurred
- To mitigate the risk of increased claims from health care providers, plan sponsors have started including anti-assignment language into their plan documents



# Anti-Assignment - Recent Cases

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- *Eden Surgical Center v. Cognizant Technology Solutions Corp.* (9th cir., 2018)
- *American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield* (3rd cir., 2018)
  - Both upheld the anti-assignment provisions contained in the plan documents
  - This is consistent with the approach most other circuits have taken with respect to anti-assignment provisions
- Tough to measure benefit, exactly, of this provision

# Arbitration/Class Waiver - Background

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- In *Epic Systems Corp. v. Lewis* (2018), the Supreme Court ruled that class action waivers in employment arbitration agreements do not violate federal law and are in fact enforceable
- Previously, there had been a circuit split as to whether it was a violation of federal labor laws for employers to require employees to agree to arbitrate any work-related claims and waive their rights to participate in class action lawsuits pursuant to a mandatory arbitration policy
- Supreme Court resolved circuit split by ruling that such agreements are enforceable

# Arbitration/Class Action - Trends

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- Mandatory arbitration for ERISA disputes is not necessarily always in plan sponsor's interest
  - Can be expensive
  - Arbitrators can get it "wrong" and review may be more difficult
- If arbitration policy/agreement covers plan-based ERISA claims, it will need to be carefully coordinated with plan documents
- We have not seen too many clients trying to include mandatory arbitration provisions

# Venue Selection

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- Venue relates to where litigation will occur
  - E.g., suppose you have an employee who retires and moves to Florida. The employee then brings a claim under one of your plans and files a lawsuit in Florida. Can you force the employee back to a WI court?
- A recent case in the 7th Circuit upheld a venue selection provision in a employee benefit plan governed by ERISA
- The court followed a similar decision from the 6th Circuit that held venue selection provisions in ERISA plans are generally enforceable

# Venue Selection - Background

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- Under ERISA's venue provision, a claim must be brought in the district court where:
  - the Plan is administered
  - the breach or violation took place; or
  - a defendant resides or may be found

# Venue Selection – Trends

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- The 7th Circuit court ruled that there is nothing in the ERISA venue provision language that prohibits a plan from contractually narrowing down the venue options so long as they select a venue that is permissible under ERISA
- It is currently unclear whether other circuits will follow suit and uphold venue selection provisions in ERISA plans
- Could also try to limit other state rights, too, perhaps

# Cross-Plan Offsetting

- Some recent controversy over seemingly-arcane concept called "cross-plan offsetting" ("CPO")
- Basic concept is that some TPAs have been using relationship with one employer's health plan to benefit another employer (or benefit the TPA, if it's also an insurer)
- For example, suppose John is a participant in the Quarles & Brady health plan. John goes to an out-of-network provider (Provider Inc.) and has a \$1,000 charge for a service
  - CPO is only an issue for out-of-network charges, so it's a small % of claims
  - Quarles sends \$1,000 to TPA
  - TPA for Quarles plan pays the \$1,000 to Provider Inc.
  - Then, TPA determines that Provider Inc. should have charged only \$700, not \$1,000
  - Provider Inc. disagrees and refuses to return the \$300
  - TPA writes a demand letter but it's ignored
  - \$300 dispute just sits there

# Cross-Plan Offsetting

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- Sally at Client Inc. goes to Provider Inc. and has a \$2,000 charge (also out of network)
- Client Inc. also uses same TPA
- TPA asks for \$2,000 from Client and Client sends it to TPA
- TPA does NOT send the \$2,000 to Provider. Instead, TPA sends \$1,700 and a "note" which "forgives" Provider for the \$300 "owed" with respect to Quarles & Brady health plan. TPA may keep \$300 (or some portion of it) or refund all (or some) of it to Quarles & Brady
- Provider may view Sally as still owing \$300 (because only \$1,700 of \$2,000 bill was paid)
- Provider may write off \$300 or may pursue (balance bill) Sally
- Client Inc. and Sally may be very surprised if Provider pursues Sally because they were told to pay \$2,000 and they did
  - Also TPA likely sent EOB stating amount was paid in full



# Cross-Plan Offsetting

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- Some dollar amounts have gotten to be large enough where Provider Inc. will bring a lawsuit
- A major case now is *Peterson v. UHC*
- In September 2017 DOL weighed in on case and said that UHC's CPO practice likely violated ERISA
- Some prior lawsuits have brought claims against employers for failing to monitor CPO practice / TPA
  - And we just saw this asserted against a client a few months ago – also ties into fiduciary concerns
- January 2019: *Peterson* court rules against UHC, but ERISA analysis a bit light
- Two main options for employers: (1) Try to opt out (if possible); (2) Ensure that contractual language offers adequate protection and "beef up" SPD, EOBs, other documents

# Questions?

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