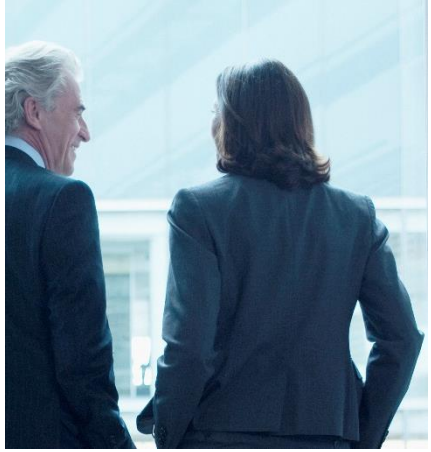

# Health Policy Year in Review

March 8, 2018

**John Barlament**
**Quarles & Brady LLP**
**John.Barlament@quarles.com**
**(414) 277-5727**

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# Agenda

- Health care reform – did it sneak by us already?
- Cadillac tax
- Miscellaneous changes
- Tax Cuts and Jobs Act
- Association health plans
- Disability claims procedures
- Litigation update

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# Available Regulatory Measures

- Regulatory Moratorium
  - Virtually every new president issues a freeze on new and pending regulations
  - The moratorium that President Trump issued has little impact on employee benefit plans because most regulations issued under the Obama administration are already final
- Eliminating Existing Regulations
  - The President cannot unilaterally overturn existing, final regulations by executive order
  - Revocation or modification of regulations requires public notice and a comment period
  - Executive orders
    - Cannot overturn existing regulations or law
    - Do not create new law
    - Are not enforceable in the courts

# Available Regulatory Measures

- Executive Orders (cont.)
  - Three Trump executive orders that potentially affect employee benefit plans
    - Minimizing the Economic Burden of the Patient Protection and Affordable Care Act
      - Directs agencies to take available actions to minimize burden of the ACA, including to waiver or defer related taxes and penalties
    - Reducing Regulation and Controlling Regulatory Cost
      - Directs agencies to identify two regulations for repeal for each new rule proposed
    - Enforcing the Regulatory Agenda
      - Direct agencies to establish task forces to evaluate existing regulations and identify regulations that eliminate or inhibit job creation, are outside or unnecessary, impose costs that exceed benefits or that create an inconsistency or otherwise interfere with regulatory reform
  - Little to no immediate impact on employers
- Recent order (Oct. 12) may allow for greater use of health reimbursement arrangements and association health plans
  - Association health plans discussed more, later

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# ACA Repeal and Replace Efforts

- First struggle: Repeal now, replace later? Repeal and replace at same time?
- Republicans decided to do it all at once
- March 2017: House tries to pass bill but fails
- May 2017: House passes bill
- Summer 2017: Senate struggles with what to do (e.g., start over?)
- July 2017: John McCain casts deciding vote to not proceed
- September 2017: Republicans try again but lack 50 votes
- December 2017: Moved to tax reform
  - Individual mandate penalty repealed (2019)
  - Several Republicans have promised to revisit it in 2018 and beyond
- March 2018: 20 states sue to eliminate ACA (again)
- Part of problem is that slogan ("repeal and replace") easy to say
  - But devil in details

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# American Health Care Act ("AHCA")

- What would a "replacement" look like?
- AHCA, introduced March 6, 2017 in House, instructive
- Tax credits to individuals to buy insurance
  - $2,000 - $4,000 per year, cap of $14,000 per family
  - Varies by age (e.g., under 30 is $2,000; 60+ is $4,000)
  - Begin phasing out at $75,000 single / $150,000 family
- Eliminate individual mandate (accomplished through Tax Cuts and Jobs Act in December 2017)
- Insurer age rating increases to 5-1 from 3-1
  - Protests from AARP and other lobbying groups
  - Mainly an issue for individual policies (not employer plans)
  - Being considered right now as part of "stabilization" bill

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# AHCA

- "Block-grant" Medicaid funding and roll back ACA expansion
- Eliminates $600B in taxes (high earners; tanning tax; medical device tax)
  - Essentially accomplished through TCJA
- Cadillac tax delayed until 2025
  - 2022 delay accomplished through TCJA
- HSAs boosted
  - Increase annual limit to out-of-pocket maximum limits under related HDHP ($6,550 for self-only; $13,100 for other) (effect. 1/1/2018)
    - Increase from current limits of $3,400 and $6,750
  - Both spouses can make catch-up contributions to same HSA
  - Not done yet, but Republicans still discussing it

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# AHCA Employer Impact

- Over-the-counter ("OTC") medications, under ACA, cannot be tax-free under a Health FSA, HRA or HSA
- Employer shared responsibility rule drops to $0 (retroactive to 2016)
  - Neither accomplished yet but, again, ongoing discussions
- New idea: COBRA subsidy
  - Basically, take tax credits noted above ($2,000 - $4,000) and use them for COBRA

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# What Remains of ACA Under "Replacement"?

- Quite a lot – under most Republican bills there was not a full "repeal" or "replace"
- No annual / lifetime limits on essential health benefits
- No pre-existing conditions
- No excessive waiting periods
- Expanded claims / appeal rules
- Preventive care at first-dollar
- Cover children until age 26
- No rescissions
- SBCs
- Increased wellness plan discounts
- Section 1557 nondiscrimination rules
- Many other "suspended" or "ignored" ACA provisions, such as certification of HIPAA compliance; nondiscrimination rules for fully-insured plans
- Essentially, ACA remains in full force unless specifically noted

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# Other ACA Actions

- Some ideas have bipartisan support
  - March 2018: New push for a bill to simplify employer reporting under ACA (who is covered)
  - Negotiations to shore up individual market
- February 2018: DOL, HHS and IRS propose to expand short-term insurance policies
  - Previously capped at 90 days
  - Avoid many ACA rules
  - Now capped at 364 days
  - No direct employer impact (but if it destabilizes individual market, could "bleed over" to group plan market)
- September 2017: HHS eliminates cost-sharing reductions to insurers
  - Leads to higher individual premiums in 2018

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# Cadillac Tax

- "Cadillac tax" set to take effect in 2022
  - Already delayed – but no one likes it, so further delay likely
    - Will it ever be repealed?
  - 40% excise tax on "excess cost" of health plan
  - E.g., if total family coverage is $30,000 and "baseline" is $27,500, "excess" is $2,500
    - 40% of $2,500 = $1,000 non-deductible excise tax employer pays
  - IRS had promised guidance on it in 2018
    - But new delay by Congress may cause IRS to drag its feet

# Cadillac Tax

- Cost of coverage is based on "applicable premium"
- Statute refers to using COBRA method
  - But IRS guidance not very clear on how to determine COBRA cost of coverage
    - E.g., two former employees elect COBRA. One has a $1,200 HRA balance, the other has $2,400. COBRA rate probably based on "past cost" or an actuarial test
    - September 2017: IRS issues Information Letter discussing HRA COBRA premiums...but fails to add anything new

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# Cadillac Tax

- What coverage "counts" under the tax?
- Health FSA amounts which are reimbursed (including employee pre-tax contributions and employer credits)
- Employer contributions to an HSA
- HRAs in some manner (more difficult to address because of rollover features)
  - E.g., employer contributes $10,000 to HRA one day before tax applies. Is $10,000 exempt? Based on when it's used?

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# Cadillac Tax

- Some coverage is excepted
  - Accident, disability income insurance
  - On-site medical clinics if only offer "de minimis" care
  - Stand-alone dental and vision likely exempt (IRS exception likely)
  - EAPs likely in same category
- Some special rules for multiemployer plans and "high-risk" professions

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# Cadillac Tax

- Who is liable?
  - If fully-insured, carrier (will it be passed along?)
  - For HSA contributions, employer
  - For other coverage, "person that administers the plan benefits"
    - Unclear what that means – if it's the TPA, expect it to be passed along to employer

# 1094 / 1095 Forms

- These still remain (despite efforts to repeal)
- Generally require employers with self-funded health plans to report:
  - Which employees enrolled in health plan
  - Whether employer offered coverage to enough employees
  - Lots of tracking involved
- 2017 forms / instructions had very modest tweaks
  - Affordability test now 9.69% for 2017 plan year (was 9.66%)
  - Special rule for multiemployer plans still applies (employer can just contribute, not really monitor multiemployer plan)
    - But instructions state that it could be modified for 2018 reporting

# Transgender Benefits

- Transgender benefits
  - ACA Section 1557 requires that health plans of certain "covered entities" must pay for gender reassignment surgery
  - Impacts entities receiving "federal financial assistance":
    - Health care providers; universities (because student loan = "federal financial assistance"); employers who receive Medicare Part D subsidies
  - On 12/31/2016, Texas federal judge stopped some of it from taking effect on 1/1/2017
  - HHS initially fought judge (under President Obama) – now says it is reconsidering whether to scrap requirement altogether
  - Notice rules still apply today
    - Likely need a "tagline" in many of your benefit communications (e.g., EOBs; notice of privacy practices)

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# Transgender Benefits

- Same may be playing out for Title VII "sex" discrimination
  - Client sued recently by EEOC because health plan failed to cover gender reassignment surgery
  - Jeff Sessions, in 2017, said that Title VII does not apply to transgender individuals
    - Will courts agree?
    - Seventh Circuit, Hively v. Ivy Tech. Community College (2017) – Employment discrimination on basis of sexual orientation violates Title VII

# Transgender Benefits

- New Second Circuit case, Zarda v. Altitude Express
  - Male skydiving instructor commented to female customers that they should not feel uncomfortable because he was gay
  - Employer fired Zarda after complaint
- Recent case (Tovar v. Essentia Health) clarified that employee's child not protected by Title VII
  - Child had sought health plan coverage for gender dysphoria
- Baker v. Aetna (Texas 2018) – Title VII does not require plan to cover breast augmentation for male transitioning to female (other options available under plan)

# Other Health and Welfare Changes

- Some changes proceed
  - E.g., new "summary of benefits and coverage" ("SBC") must be used, generally 1/1/2018
  - Changes are not too difficult
- Recent changes made it easier for employers to claim a religious exemption from offering birth control under health plan
  - Part of ACA's "preventive care" mandate for "non-grandfathered" health plans
- December 20, 2016 update on various women's preventive care benefits
  - Apply for plan years starting on or after December 20, 2017
  - Includes breast cancer screening, breastfeeding supplies and services; well-woman preventive visits

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# Other Health and Welfare Changes

- EEOC issued final wellness plan regulations May 2016
- Beware! Many traps for the unwary
  - 30% of self-only coverage maximum limit
    - Can sometimes add another 30% for spouse
  - Does not coordinate with HIPAA wellness limit of 50%
  - Requires new forms (e.g., spousal authorization) and new security procedures for medical information
- In a twist, AARP sued and just got court to order regulations to be reviewed
  - Proposed rules likely by August 2018
  - Very unclear when final (or "interim final") regulations will be issued

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# Other Health and Welfare Changes

- Court was displeased with EEOC's proposed date for final regulations to apply (2021)
- Directed it to be faster
- And stated that May 2016 regulations vacated as of 1/1/2019
- What does that mean?

# Other Health and Welfare Changes

- If gather biometric data in 2018 and give reward in 2019, is that illegal?
- Maybe structure plan so no gathering of biometric data (or other "disability-related inquiries")?
- "Hedge" in wellness communications
  - E.g., say "We intend to provide a 30% premium discount in 2019, if allowed by applicable law. If not, we may need to decrease your premium discount to a level allowed by law"
- Some case law (Orion) favorable to employers
  - 100% surcharge on non-participating employees "voluntary"

# Other Health and Welfare Changes

- Health plan identifier requirement ("HPID") likely will be going away
  - Not that anyone remembers it anyways....
- Similarly, in October 2017 HHS withdrew proposed regulations on certifying compliance with HIPAA "Standard Transactions"
- Forum selection clauses gaining in popularity
  - Force plan participants to bring a lawsuit only in certain jurisdictions (e.g., WI courts)
  - Several recent cases have approved of this

# Data Privacy and Security Issues

- Office for Civil Rights ("OCR") begun stricter enforcement of HIPAA Privacy and Security Rules
  - E.g., "desk audits" and some "on-site" audits
- Most common problem is lost laptops, lack of training and failure to conduct security risk assessment
  - Feb. 2017: $5.5M penalty against hospital for breach of 115,000 records (fail to terminate log-in privileges)
- Sample audit letter on HHS web site
  - "Best practice" to review and do "mock audit"
- "Ransomware" guidance also

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# Mental Health Parity

- If your health plan is self-funded, consider opting out of these rules if you are a governmental employer
- If not, comply with stringent new regulations
- Monitor litigation in this area
  - E.g., many cases on autism coverage; eating disorder guidance; residential restrictions; wilderness therapy

# Tax Cuts and Jobs Act

- Main ACA provisions not impacted
- Elimination of individual mandate penalty (2019) predicted to cause millions of Americans to not have health insurance
- Loss of paying customers (and increase in bad debts) could cause providers to make up difference with other payors (e.g., employers)
- Exchanges still up and running

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# Tax Cuts and Jobs Act

- Subsidies in Exchanges still available
  - And subsidies trigger Employer Shared Responsibility Rule penalties...so penalties still possible in 2019 and beyond
- No change in ACA reporting
  - But one reason for employer reporting is for IRS to enforce individual mandate, which is basically gone
  - Will / can IRS offer some relief to employers?

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# Tax Cuts and Jobs Act

- New paid leave tax credit
- For companies that offer up to 12 weeks of paid family leave
- Some "strings" attached, though:
  - Need written policy providing at least 2 weeks of annual paid leave for full-time employees (pro rata for part-time)
  - Paid at rate of at least 50% of wages normally paid
  - Employer cannot interfere with any paid leave right
  - Only lasts two years

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# Tax Cuts and Jobs Act

- Other limits apply too:
  - Employee employed for 1+ years and who had compensated that did not exceed 60% of limit ($120,000 in 2018)
  - Certain leaves (e.g., vacation and personal) not "family and medical leave"
  - Credit is 12.5% of amount of wages paid to qualifying employees during family and medical leave (with some adjustments)

# Tax Cuts and Jobs Act

- Changes to qualifying moving expense reimbursements
- Previously, could generally excluded such reimbursements from income
- From 1/1/2018 – 12/31/2025, such reimbursements are included in employee's gross income
- Above the line deduction for moving expenses is suspended for same time period

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# Tax Cuts and Jobs Act

- Some changes for employer deductions for transportation benefits
- Before, employers could deduct up to $255 per month in benefits (transit passes, parking)
  - Repealed as of 1/1/2018
- But, employees continue to receive paring, transit passes and vanpooling benefits tax-free

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# Association Health Plans

- Lot of history relating to employers banding together to purchase insurance on joint basis / self-fund on joint basis
- Many "scam" health plans set up
  - ERISA preempted ability of states to regulate them
  - Many went bankrupt, leaving millions in unpaid claims
  - Congress modified rules to allow states to regulate "multiple employer welfare arrangements" ("MEWAs")
- Many states do – often treat MEWAs as a "mini-insurance company" subject to burdensome rules

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# Association Health Plans

- Rules apply if employers are "unrelated" (as defined in Internal Revenue Code Section 414)
- Related employers not considered MEWAs
  - So, if Parent Co. owns 100% of Subsidiary, both can be covered by same plan without creating a MEWA
- Employers in same industry / city / association / chamber of commerce generally not "related enough" to band together to buy / self-fund health insurance
  - Would be considered a MEWA

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# Association Health Plans

- Is possible that they could band together, but DOL rules make it somewhat difficult
  - Check if there is a "bona fide association"
  - Many MEWAs do exist, though – e.g., auto and truck dealers in WI; recent dairy co-op approved in MN / WI
- Bona fide association (pre-2018) –
  - Have purpose other than to provide benefits
  - Commonality of interest
  - Participating employers exercise control

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# Association Health Plans

- Proposed regulations issued per President Trump's order
- Association may exist solely to provide health benefits to members
- At least one employee covered
- Formal structure / by-laws
- Controlled by employers
- New nondiscrimination rules

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# Association Health Plans

- "Commonality of interest" – e.g., trade, industry, line of business or profession
  - Principal place of business in same geographic area
  - But, appears that employees in other states would enable that other state to subject it to that state's foreign insurer laws
- Big catch – it's still a MEWA
  - And no reduction in ability of states to regulate MEWAs
  - So, states can still make it difficult for MEWAs
    - For fully-insured MEWA, likely not a big deal
    - For self-funded MEWA, states likely to still regulate

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# Employer Shared Responsibility Rule Penalties

- In November 2017, IRS began sending out penalty notices with respect to 2015
- Letter 226J sets out time periods for employers to respond / appeal
- Penalties often in the hundreds of thousands of dollars
  - And, it's a non-deductible excise tax
- Common error – employer checked the wrong box in 2015 filing (and said "No" health plan coverage offered, when it was)
  - Should appeal penalty, of course, in that situation

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# Employer Shared Responsibility Rule Penalties

- Some employers likely to challenge IRS assessment on a technical ground
  - ACA says that employer must receive a "certification" that employee received subsidy
  - Federal government did not generally send them out in 2015
- Lesson even if you do not receive a letter
  - Look at what IRS is seeking – e.g., proof that you "offered" "minimum value", "minimum essential" health plan coverage to every "full-time" employee and "dependent"
  - Do you have records recording all that?

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# New Disability Regulations

- December 2016: DOL released final claims procedure regulations for ERISA-covered plans which base eligibility for (or amount of) benefits on a disability
- Generally effective 1/1/2018
- July 2017: DOL announces a review of them for "law and policy"
  - In combination with President Trump's other orders, expected that regulation would be delayed / modified / scrapped

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# New Disability Regulations

- 11/24/2017: DOL delays applicability date to 4/1/2018
  - DOL took more comments on regulations
- January 2018: DOL, in a surprise, proceeds with final rules, but delays effective date to 4/2/2018
  - This is for claims filed from that date – NOT based on "plan year" (so, calendar year plans comply on 4/2/2018)

# New Disability Regulations

- What plans are impacted?
- First, ERISA must apply
  - Non-ERISA plans (e.g., governmental plans) avoid rules
  - Also, certain short-term disability plans meet "payroll practices" exception
    - Self-funded
    - Maximum 6 months or less
    - Must not pay more than normal compensation
    - No employee contributions
    - Stop when employment terminates

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# New Disability Regulations

- Clearly impacts long-term disability plans
- Can also impact defined contribution, defined benefit, executive compensation and health plans
  - So, oddly, certain short-term disability plans are among the most likely to avoid these new disability rules!
- Plan sponsors should review all their plans and determine what needs to change

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# New Disability Regulations -- Requirements

- New rules intended to provide "full and fair review" of disability claims
- Decision must avoid any conflicts of interest
- Enhanced disclosure requirements (e.g., discuss why claim was denied and what standard used to make decision)
- Denial must include internal rules, guidelines, protocols, etc. plan relied upon in denying claim or state that none existed

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# New Disability Regulations

- If initial adverse determination based on experimental or medical necessity criteria, provide explanation of scientific or clinical judgment the determination was based upon, applying terms of plan to claimant's medical circumstances
  - Or state that such explanation will be provided free of charge upon request
- Right to review and respond to any new information before final claim determination
  - Big change

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# New Disability Regulations

- Right to access and, upon request, obtain copies of documents / records related to claim
- If you fail to do this, claims and appeal process is deemed exhausted (i.e., individual can immediately sue)
- Rescission is an "adverse benefit determination"
- Culturally and linguistically appropriate notices
  - If 10%+ of population where claimant resides are literate only in same non-English language
  - State prominently that language services available

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# New Disability Regulations

- If plan is fully-insured (e.g., LTD), can we ignore it?
  - Perhaps. At a minimum, may want to obtain in writing that insurer is handling it and compliant
- If plan is self-funded (e.g., STD, health plan, executive compensation plan) work with TPA to make sure it follows
  - Does contract indemnify you if TPA makes a mistake?
  - Ask for examples of proof (e.g., new letters) from TPA?
  - If no TPA (i.e., self-administered) is your staff trained on new rules? Update form letters?
- If you modify the plan, may need to notify participants about changes

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# Other Benefit Changes

- This week, IRS changed 2018 maximum HSA contribution
  - Had previously announced it was $6,900; now it's $6,850 (retroactive to 1/1/2018)
  - If already contributed $6,900, extra $50 should come out
    - Avoid excise tax if do so by April 15, 2019
- New IRS guidance clarifies that male sterilization / male contraception is not "preventive care" under HSA rules
  - Some transition relief provided (because some states require insurance policies to include it as "preventive")

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# Cross-Plan Offsetting

- "Cross-plan offsetting" – something you probably have not heard of but might be largest fiduciary risk (if your major medical plan is self-funded)
- Some larger insurers / TPAs engage in CPO
- E.g., John participates in the ABC health plan, administered by Big Insurer. Sally participates in the DEF health plan, administered by Big Insurer. ABC is fully-insured; DEF is self-funded
- John goes to out-of-network provider whose bill is $500. Big Insurer pays $500 immediately, then later reviews claim and determines only $300 should have been paid

# Cross-Plan Offsetting

- Provider says $500 was appropriate and refuses to refund $200. Big Insurer sends nasty letters but no action
- Sally goes out of network to same provider. Sally's bill was $1,000. Big Insurer requests $1,000 for bill. DEF sends $1,000 to Big Insurer
- Big Insurer forwards $800 (not $1,000) plus a note that the $200 relating to John is "forgiven" – claims it's a $1,000 "payment in full"
- Provider may dispute that and send Sally a $200 balance bill – even though DEF sent $1,000 and even though Sally may have received an EOB saying claim was paid in full

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# Cross-Plan Offsetting

- 2016: AT&T (and its fiduciaries) sued over UHC's CPO
- March 2017: Court finds that UHC's practice violates plan terms of dozens of plans and likely violates ERISA
- September 2017: DOL files amicus brief, agreeing that practice violates ERISA
- UHC's brief disclaims responsibility and notes that their employer clients "directed" them to do it
- Other large insurers / TPAs also seem to do CPO
- Consider whether to "opt out" or stay in
- If stay in, monitor pending cases and seek contractual protection

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# Retiree Health Coverage

- Recent Supreme Court case, CNH Indus. N.V. v. Reese, dealt with this issue (2nd time in 3 years)
- 6th Circuit had adopted "Yard-Man" inference that retiree health care more easily vests per a written agreement (such as a collective bargaining agreement)
- Here, CBA expired in 2004
- But, some language clearly extended beyond 2004 (such as life insurance benefits)

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# Retiree Health Coverage

- Generally courts must apply "ordinary principles of contract law" in determining vesting
- 6th Circuit gave that phrase a broad reading
- Supreme Court again rejected it – CBA must be very clear that a benefit is vested
- Generally helpful for employers

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# Emergency Room Care

- ACA requires that non-grandfathered health plans treat emergency room care in a special manner
- May not require preauthorization, including for emergency services provided out-of-network;
- Must provide coverage regardless of whether the provider is in- or out-of-network;
- May not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and
- Must comply with certain (complicated) cost-sharing requirements (e.g., out of network treated as in-network)

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# Emergency Room Care

- What is "emergency care" that triggers this?
  - Acute symptoms of sufficient severity so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts
- Prudent layperson standard is a problem for TPAs and insurers

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# Emergency Room Care

- An earache or sore throat not usually an "emergency"
  - But, for some people it could be
  - How to examine each and every claim? Or perhaps just cover all ER visits as an "emergency"?
- 2017: Magnacare insurer / TPA sued by DOL over this
- Agreed to go back and re-process all claims which could meet standard (and seek input from claimants)
- Also paid $16M penalty (other issues too)
- Check with your TPA to see how handled

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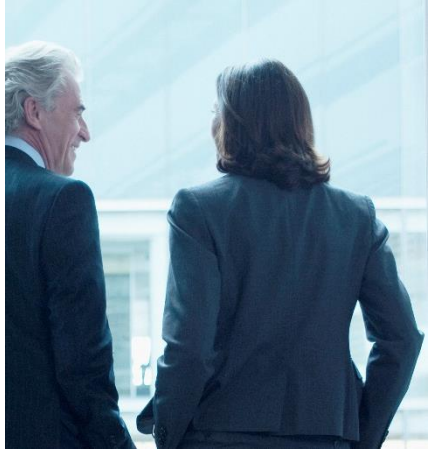

# Questions? Thank you!

March 8, 2018

**John Barlament**
**Quarles & Brady LLP**
**John.Barlament@quarles.com**
**(414) 277-5727**



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