PROFESSIONAL GROUP PLANS

Specializing in Employee Benefits

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Your Guide to Health & Welfare Compliance

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HHS News

Final Rule Federal Conscience and Anti - Discrimination Laws

The Department of Health and Human Services, on May 2, 2019, outlined their final rule for conscience rights in healthcare. It should be noted that Congress has not passed any new law, but rather this is a rule change to enforce laws already on the books. Congress has recognized that “modern health care practices may give rise to conflicts with religious beliefs and moral convictions for payers, providers, and patients alike.” The final rule’s aim is to protect health care providers’ rights to refrain from participating in abortion and other services that violate the person’s or entities conscience or religious view. Roger Servino, the Director of the Office of Civil Rights said in a statement: “protecting conscience and religious freedom not only fosters greater diversity in healthcare, it is the law.” Last year, Servino said that this was one of his primary goals and he has now created within the Office of Civil Rights the Division of Conscience and Religious Freedom. While the laws governing religious freedom is not new, the enforcement and protections of these rights was thought to be inadequate and the final rule now ensures that the Department of Health and Human Services has the tools it needs for enforcement. The laws that the final rule enforce are:

- The Church Amendments.
- The Coats-Snowe Amendment.
- The Weldon Amendment.
- Affordable Care Act conscience protections regarding abortion coverage, assisted suicide, and provisions prohibiting the discriminatory denial of a religious exemption from the individual mandate.
- Section 1553 of the Affordable Care Act concerning the right to not participate in assisted suicide.
- Certain conscience protections under Medicare Advantage and Medicaid.
- Conscience protections concerning advance directives with respect to certain HHS-funded programs.
- Conscience protections for Global Health Programs administered by HHS or funded by HHS appropriations.
- Conscience exemptions for patients from certain specified health care services.
- Conscience protections for religious nonmedical health care institutions and patients who seek religious nonmedical care.

For more information please see the final rule and final rule fact sheet.

https://www.hhs.gov/sites/default/files/final-conscience-rule.pdf
https://www.hhs.gov/sites/default/files/final-conscience-rule-factsheet.pdf

ACA

One Stop Before the Supreme Court

The Fifth Circuit Court of appeals is expected to hear oral arguments in the case of Texas v. United States in July 2019. As you recall on December 18, 2018, a federal district court in Texas declared that the Affordable Care Act (ACA) was unconstitutional. The decision was reached because the Supreme Court had previously ruled in National Federation of Independent Business (NFIB) v. Sebelius, (2012), that Congress had the authority to pass the ACA under its taxing power. As they explained, the individual mandate was enforced by a penalty that "yield[ed] the essential features of any tax: it produce[d] at least some revenue for the Government". Id at 564.

Then along came the Tax Cuts and Jobs Act. Effective in 2019, Congress eliminated the penalty or revenue produced for the government if an individual fails to obtain health insurance coverage under the individual mandate. Therefore, the argument in Texas v. United States was no revenue, no tax, and no individual mandate.

Next, there was the question as to whether the rest of the ACA would crumble without the individual mandate and the Texas court said it would. Where and how did the Texas court reach this decision? By looking at the NFIB case from the Supreme Court. After all, historical case law reveals that when one provision in a statute is deemed unconstitutional, other provisions may be upheld only if they are constitutionally valid, capable of functioning independently, and consistent with Congress' objectives when the statute was enacted. Following this logic, the other sections of the ACA could not stand alone according to the Texas judge, after reviewing NFIB.

The individual mandate was premised on the fact that there would be guaranteed issue (no pre-existing condition requirements) and community rating (prohibition against issuers from charging higher premium based on an individual's medical condition). The ACA also established Marketplaces where plans that met minimum essential coverage could be sold. Individuals were required to have insurance for themselves and their tax families or face a penalty (tax). Congress concluded that healthy, young individuals would purchase insurance and offset the cost of the sick, thus allowing for guarantee issue and community ratings. In short, you can't have one without the other. As Justice Ginsburg stated: "without the individual mandate….guaranteed-issue and community-rating requirements would trigger an adverse-selection death spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market." NFIB. at 619.

So where do we stand? The appellant court apparently is going to hear oral arguments sometime in July after the court granted the United States' motion to expedite. If the court can reach a decision in the fall, this could very well then go to the Supreme Court in the 2019-2020 term which commences October 7, 2019 and will run through June 2020. If a decision is reached during this time, we should have resolution by the elections in November 2020. However, maybe this is just wishful thinking.

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Please check out the following link to read the government's full brief.

https://affordablecareactlitigation.files.wordpress.com/2019/05/5c-us-brief.pdf

ERISA Examiner

State Law Claims and Kickbacks

What happens when an insurance carrier indicates to an employer that they are providing the group health plan at cost, when they then paid the premiums to allow kickbacks? Is a fully-insured carrier liable under ERISA for violating fiduciary obligations? Can they be sued under state law or is this pre-empted under ERISA? These were the questions under Depot, Inc. v. Caring for Montana's, Inc., 915 F 3d 643 (Seattle Washington, 2019), a case that was recently decided.

The facts in this case are pretty straight forward. The insurance carriers (first Blue Cross Blue Shield of Montana and then Health Care Service Corporation) offered fully insured health plans to members of the Montana Chamber of Commerce. They marketed these plans as "Chambers Choice" and represented that the monthly premiums would reflect only the cost of providing benefits. It later became known that the premiums were padded with hidden surcharges used to pay kickbacks to the Chamber of Commerce and to buy unauthorized insurance products. Three employers filed suit.

The first question was whether or not the insurance companies breached a "fiduciary duty" under ERISA. The court, The United States Court of Appeal for the Ninth Circuit, said they did not as the carriers were not fiduciaries under ERISA. First off, they were not a named fiduciary in the plan documents as outlined in 29 U.S.C.S. §1102(a) (2); and second they were not what is sometimes referred to as a "functional fiduciary". A functional fiduciary exercises discretionary authority or control over the management of the plan or the disposition of assets. A functional fiduciary also renders investment advice for a fee or compensation, direct or indirect, with respect to any moneys or other property of the plan. The court ruled that merely negotiating fees upfront before the sale of the plan did not rise to the level for the insurance carriers to become functional fiduciaries. In fact, under the fully-insured plans, there were no plan assets.

Next, the court had to answer whether or not the Montana Consumer Protection Act that prohibited fraudulent inducement, constructive fraud, negligent misrepresentation or unfair trade practices could stand or whether or not ERISA's pre-emption of State laws would apply. While ERISA expressly pre-empts "any and all state laws insofar as they may now or hereafter relate to any employment benefit plan (29 U.S.C. §1149a), the United States Supreme court has rejected an "uncritical liberalism in applying it given its potentially never ending reach". BCBS v. Travelers Ins. Co. 514 U.S. 645, 656. In order to properly apply ERISA exemption or allow a State law to move forward the court looks to see whether the state law claim have a reference to an ERISA plan or whether claims have an imperishable connection to an ERISA plan. In a reference claim, the court looks to see if the existence of the ERISA plan is essential to the claims survival. In an impermissible connection argument the claim must govern a central matter of plan administration. Here the court found that ERISA pre-emption did not apply, under either standard. The court found that since the misrepresentations occurred prior to any plan existence, the ERISA plan is not essential to the claims survival. When reviewing the impermissible connection argument the court said that "preventing sellers of goods and services, including benefits plans, from misrepresenting the contents of their wares is certainly an area of traditional state regulation that is quite remote from the areas with which ERISA is expressively concerned-reporting, disclosures, fiduciary responsibilities and the like."

Therefore, always beware of state law and whether ERISA preemption may apply!

Compliance

Cafeteria Plans and Mid-Year Election Changes

This area of the law creates a lot of confusion and anxiety for plan administrators. Section 125 of the Internal Revenue Code requires that a cafeteria plan be in writing and adopted by the Employer. As a result, provisions regarding mid-year election changes must be included within the plan document. When we encounter questions about applying mid-year election changes from a plan administrator, we always refer to what was written into the plan document. There are several instances where a plan can be written to permit certain election changes mid-year, it can prohibit mid-year election changes, or the language could be omitted altogether. Below is a brief overview of the permission an administrator can design.

Change in Status

Through the Change in Status rule, a cafeteria plan may be written to permit an employee to revoke an election mid-year and make a new election for the remainder of the year if;

- a specific change in status event, as listed below, occurs; and
- the election change satisfied the consistency rule, as further described below.

What are the Change in Status Events?

- Change in legal marital status.
  - Marriage, divorce, death of spouse, legal separation, and annulment.
- Change in number of dependents.
  - Birth, adoption, placement for adoption, and death.
- Change in employment status.
  - Where change in employment status affects eligibility: termination or commencement of employment; strike or lockout; commencement or return from unpaid leave; change in worksite.
- Dependent satisfies or ceases to satisfy dependent eligibility requirements.
  - Attaining a certain age; gain or loss of student status; marriage; similar circumstances affecting dependent eligibility.
- Residence change.
  - Where a change in residence affects the employee's eligibility for coverage.
- For adoption assistance provided through a cafeteria plan, the commencement or termination of an adoption proceeding.

Consistency Rule

If a change in status event occurs, the plan administrator can only permit employees to make election changes that are consistent with the event. The regulations provide that an election change satisfies this requirement "if the election change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's plan."

Other Permitted Changes

Plans may be drafted to permit mid-year election changes for the following reasons:

- Cost changes with automatic increases/decreases in elective contributions.
- Significant cost changes during a period of coverage (although not a change in cost of Exchange coverage).
- Significant coverage curtailment (with or without loss of coverage).
- Addition or significant improvement of a benefit package option.
- Change in coverage under other employer plan.
- Loss of group health coverage sponsored by governmental or educational institution.
- HIPAA special enrollment rights.
- COBRA qualifying events.
- Judgments, decrees, or orders (QMCSO).
- Medicare or Medicaid entitlement.
- FMLA.
- Pre-tax HSA contribution election changes.
- Reduction of hours.
- Exchange enrollment.
- USERRA.
- Mistakes with clear and convincing evidence.

Cafeteria plan elections are required to be irrevocable for the period of coverage unless the plan permits in writing, and the employee has experienced, one of the above events.

HIPAA Huddle

HIPAA BAND FINES

We are often asked what the fines are for HIPAA violations. On April 26, 2019, the Office of Civil Rights (OCR) made some adjustments to the fines in order to apply what they believe is a better reading of the Health Information Technology for Economic and Clinical Health Act (HITECH).

Under the tier penalty approach, OCR now states the penalty per occurrence are:

Culpability	Minimum Penalty/Violation	Maximum Penalty/Violation	Annual Limit
No Knowledge	$100	$50,000	$25,000
Reasonable Cause	$1,000	$50,000	$100,000
Willful Neglect - Corrected	$10,000	$50,000	$250,000
Willful Neglect - Not Corrected	$50,000	$50,000	$1,500,000

Therefore, this in fact means that organizations that take steps to meet the HIPAA requirements will face a much lower maximum penalty than those who do not.

Self-funded health plans should make sure they are HIPAA compliant with the Privacy and Breach notification requirements. If they create, receive, use, or maintain electronic personal health information.