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HHS Issues ACA Section 1557 Rules, Again

On May 24, 2019, the U.S. Department of Health and Human Services (HHS) proposed revised regulations under Section 1557 of the Affordable Care Act (ACA) that substantially rolls back the original Obama-era regulation. Among other changes, the new rule removes the redefinition of "sex" and certain administrative requirements, such as nondiscrimination notice and language tagline requirements.

Background

In 2016, the U.S. Department of Health and Human Services (HHS) and the Office of Civil Rights (OCR) published a final rule to implement Section 1557 of the ACA (2016 Rule). The 2016 Rule was not scheduled to go into effect until the first day of the first plan year on or after January 1, 2017, and prohibited discrimination in health coverage on the basis of race, sex, color, national origin, age, or disability. The 2016 Rule interpreted "on the basis of sex" to include gender "identity" and "termination of pregnancy." The 2016 Rule also required covered entities to provide nondiscrimination and accessibility notifications and taglines to inform participants that language assistance and auxiliary aids and services can be provided free of charge, if necessary.

The 2016 Rule only applied to those entities that:

- are principally engaged in providing or administering health services or health coverage;
- receive certain "federal financial assistance" with the primary objective to fund an employee health benefits program; or
- are not principally engaged in providing or administering health services or health coverage but operate an employee health program that receives certain federal financial assistance.

The 2016 Rule also clarified that federal financial assistance for these purposes included funding under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and The Age Discrimination Act of 1975.

Eight states and three health care providers sued HHS in the Northern District of Texas *(Franciscan Alliance, Inc. et. al. v. Burwell)* to challenge the 2016 Rule's inclusion of gender and termination of pregnancy in its interpretation of "on the basis of sex. "The parties argued that Section 1557 violated the Administrative Procedures Act and the Religious Freedom Restoration Act, and requested a preliminary injunction. On December 16, 2016, the Court issued a nationwide injunction blocking the challenged portion of the 2016 Rule, which included protections related to discrimination based on gender identity and termination of pregnancy in the interpretation on the basis of sex. This injunction remains in effect. The rest of the 2016 Rule went into effect on January 1, 2017.

The New Rule

On May 24, 2019, HHS proposed new revisions to Section 1557 (2019 Rule). HHS stated that the 2019 Rule would continue to enforce prohibitions of discrimination in healthcare as well as remove regulatory burdens. The 2019 Rule would retain the following provisions from the 2016 Rule:

- Protections for individuals with disabilities. The 2019 Rule would ensure that individuals with disabilities would have access to healthcare facilities and have appropriate technology and assistance to communicate, if necessary.
- Protections for individuals with limited English proficiency. The 2019 Rule would maintain the requirement to provide foreign language translators and interpreters for non-English speakers.
- Assurances of compliance. The 2019 Rule would require regulated entities to submit to HHS binding assurances of compliance with Section 1557.

The 2019 Rule also revised certain aspects of the 2016 Rule. Many of the revisions were in response to the preliminary injunction.

- Reaffirm that "on the basis of sex" does not include gender identity and termination of pregnancy. HHS would return to the original definition of on the basis of sex to only refer to binary sex assigned at birth. HHS also stated that it proposed to amend ten other regulations

issued by the Centers for Medicare & Medicaid Service (CMS), to make them consistent with the agency's traditional interpretation of on the basis of sex.

- Comply with applicable civil rights laws. The 2019 Rule would add a regulatory provision stating that Section 1557 will be enforced in a manner that is consistent with the healthcare conscience laws of the ACA relating to abortion and assisted suicide as well as any other healthcare conscience laws and the First Amendment of the Constitution.
- Include language to protect religious entities from requiring them to pay for or perform abortions. The three health care providers who initially challenged Section 1557 were religiously affiliated and alleged that including termination of pregnancy in the interpretation of the basis of sex would violate the Religious Freedom Restoration Act. This 2019 Rule would attempt to address their concerns relating to paying for and performing pregnancy terminations.
- Remove the non-discrimination notice and taglines requirements. The 2016 Rule required health companies to distribute non-discrimination notices. Additionally, for any significant communications, health companies had to include taglines in at least fifteen languages to inform individuals with limited English language proficiency that they could receive free language assistance. The 2019 Rule would remove these requirements.
- Return to pre-2016 Rule enforcement structure. The 2016 Rule proposed a new and single enforcement structure for every type of discrimination claim under Section 1557. Some courts rejected some of those theories and the 2019 Rule returns to the previous enforcement scheme which only provides for the enforcement mechanisms found in the underlying civil rights statute.
- Revise and reduce the scope of HHS's enforcement. The 2016 Rule provided that Section 1557 would apply to all operations of an entity even if it was not principally engaged in healthcare. The 2019 Rule would only apply to an entity's health care activities to the extent that they are funded by HHS.

What this Means for Employers

The proposed 2019 Rule was published in the Federal Register on June 14, 2019 and the public will have until August 13, 2019 to submit comments. In particular, the 2019 Rule specifically requests comments addressing whether the proposed revisions strike the appropriate balance between the rights of individuals with disabilities and limited English proficiency under federal law and the burdens imposed on covered entities. Employers should assess whether they are subject to the Section 1557 requirements and prepare for any necessary changes to their plan documents and administrative practices. Employers should also continue to monitor the rule's development for additional changes.

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Court Vacates New Association Health Plan Rule, But It Won't Go Quietly

On March 28, 2019, the District Court for the District of Columbia ordered the Department of Labor (DOL) to vacate the Trump administration's new rule addressing "association health plans" (AHPs). The court's reasoning largely relies on the rule's clear intention to sidestep individual and small group market requirements imposed under the Affordable Care Act (ACA), as well as the DOL's "unreasonable" interpretation of the Employee Retirement Income Security Act of 1974 (ERISA).

The DOL subsequently released a policy statement disagreeing with the district court's ruling and notifying employers of its non-enforcement policy, which will be in place until the end of affected association health plans' current plan year or contract term. The U.S. Department of Justice (DOJ) also filed an appeal of the court's decision on April 26, 2019. On May 13, 2019, the DOL followed up on its initial statements by issuing additional guidance in the form of four FAQs.

The Background

Association health plans (AHPs) are a type of multiple employer welfare arrangement (MEWA) providing group health and welfare benefits through a professional or trade association to the association's members. Health plans offered by

these associations may qualify as a single plan offered by a single employer under Section 3(5) of ERISA. For decades, the DOL has interpreted these provisions narrowly as to allow only "bona fide" groups or associations of employers with close economic and representational ties to qualify as "employers" under the statute. Specifically, to constitute an AHP under the old MEWA rules, the association must be a bona fide organization with business/organizational purposes and functions unrelated to the provision of benefits (the "purpose" requirement) and employers must share some commonality and genuine organizational relationship unrelated to the provision of benefits (the "commonality of interest" requirement).

In 2017, President Trump issued an Executive Order directing the DOL to expand access to AHPs and "allow more small businesses to avoid many of the [ACA's] costly requirements." Accordingly, in 2018, the DOL issued a new final rule that loosened the requirements for associations to qualify as an "employer" and plan sponsor under ERISA by relaxing the purpose requirement and the commonality of interest requirement. Associations can satisfy the commonality of interest test under the new rule if their members are either in the same trade or business or in the same geographic area, including multi-state metropolitan areas. Before the new rule, geography alone was not sufficient to establish commonality. The new rule also allowed an association to qualify as "bona fide" even if its primary purpose is to offer and provide health coverage to its employer members and their employees, so long as the association has at least one substantial business purpose unrelated to the provision of health care. The new rule also added an entirely new provision allowing sole proprietors to qualify as both an employer and employee for certain ERISA purposes.

AHPs under the new rule could be established as early as September 1, 2018, for fully insured health plans, and existing self-funded AHPs could expand within the context of the new AHP rule starting on January 1, 2019. All other associations were permitted to establish a self-funded AHP under the new rule starting April 1, 2019.

The Court Decision

Shortly after the issuance of the new rule, 11 states and the District of Columbia sued the DOL alleging that the final rule's interpretation of "employer" under ERISA stretches the definition beyond ERISA's text and purpose, exceeding the statutory authority delegated to the DOL by Congress. The court agreed, holding that (1) allowing employers linked only by geography to constitute a single employer is inconsistent with ERISA, (2) counting sole proprietors as both employers and employees is inconsistent with the text and purpose of ERISA, and (3) the new rule leads to absurd results under the ACA.

To illustrate that the DOL unreasonably interpreted ERISA and the ACA, the judge explained that the rule would treat business owners with no employees as both employers and employees, allowing a group of 51 working owners who employ no one to be treated as an association with 52 employers and 51 employees (the association counts as an additional "employer"). That definition would qualify the association as a large employer that is exempted from the ACA's individual and small-group market requirements. In the judge's words, this is "clearly an end-run around the ACA." "The court cannot believe that Congress crafted the ACA, with its careful statutory scheme distinguishing rules that apply to individuals, small employers, and large employers, with the intent that fifty-one distinct individuals employing no others could exempt themselves from the individual market's requirements by loosely affiliating through a so-called 'bona fide association' without real employment ties."

Accordingly, the court vacated the rule's bona fide association and working owner provisions and remanded the rule back to the DOL to determine what provisions of the rule (if any) will survive.

The DOL's Response

In response to the district court's ruling, the DOL issued a policy statement, which will remain in effect for existing AHPs until their current plan year or contract term expires. In the statement, the DOL states that many businesses and employees have obtained health coverage from AHPs in reliance on the final rule before the district court ruling, and accordingly, vacating the rule will cause substantial disruptions to these businesses and employees

(e.g., new coverage would impose new deductibles and out-of-pocket maximums without giving credit for prior participant out-of-pocket expenses paid). The statement specifically provides that

> . . . the [DOL] will work with affected parties, HHS, and the States to mitigate any disruptions or hardships that result from confusion regarding the status of the AHP rule and legal compliance requirements. The focus of the [DOL]'s efforts will be on ensuring that participants and beneficiaries get their health benefits claims paid as promised, and on reducing the risk of adverse consequences to affected employer associations, and their employer members, that relied in good faith on the rule.

Thus, during this interim period, the DOL will not pursue enforcement actions against parties for potential violations stemming from actions taken before the district court's decision in good faith reliance on the AHP rule's validity, provided that the AHPs continue to meet their responsibilities to association members and their participants and beneficiaries to pay health benefit claims as promised. The DOL's non-enforcement policy will remain in effect through the remainder of the AHP's plan year or contract term that was in force at the time of the district court's decision.

The DOL FAQs issued on May 13, 2019:

- Clarify that preexisting subregulatory guidance regarding the criteria for a group or association of employers to be considered an ERISA "employer" is unaffected by the court's ruling
- Indicate that AHPs formed under the old rules may rely on existing advisory opinions
- Indicate that AHPs formed under the new rules may not market or sign up new employer members, although existing employers may continue to enroll new employees pursuant to the special enrollment events defined in its plan
- Confirm that DOL enforcement relief extends through the remainder of the plan or contract year in effect at the time of the court's ruling (March 28, 2019)

What this Mean for Employers

For now, the final rule is on hold and employers and sole proprietors should not rely on it to form or join an association health plan under the Trump administration's expanded provisions. However, for those businesses that have already joined a fully insured AHP, the DOL will not enforce the court's decision to vacate the new rule before the end of the AHP's current plan year or contract term. Accordingly, disruption to participants' coverage should be minimal. However, employers that have joined AHPs since the new rules were issued should seek guidance from their ERISA counsel to assess whether the arrangement is still lawful and determine the risk associated with continuing to participate in the arrangement.

The DOJ has already appealed the district court's decision, and if the appeal is not successful, we expect the DOJ to take the issue all the way to the Supreme Court. Thus, it may be a while before we see final resolution on this issue. Employers should stay tuned to see how the issue unfolds in the higher courts. Though, importantly, the district court's ruling does nothing to upset MEWA guidance issued prior to the now-vacated final rule. The old MEWA rules are still in effect and can still be relied upon to form a single health plan under ERISA.

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Court Finds CBA Created Vested Retiree Health Benefits

Unlike pension benefits under the Employee Retirement Income Security Act of 1974 (ERISA), the right to retiree health insurance benefits do not automatically vest. As a result, there have been numerous cases of retirees suing their former employers over reduced or eliminated health benefits, alleging that retiree health care benefits provided for in their collective bargaining agreements (CBAs) were vested, lifetime benefits that could not be revoked.

Over the past few years, much of this litigation has generally gone in the employer's favor, finding no vested retiree health benefits. However, a federal judge in the Northern District of Illinois recently ruled in favor of retirees, finding that the terms of the applicable CBA required the employer to provide lifetime health benefits to the retirees.

The Controversy over Vested Retiree Health Benefits

The Supreme Court awarded a victory to employers just last year in the context of vested retiree health benefits *(CNH Industrial N.V. v. Reese).* In rejecting the Sixth Circuit's pro-vesting stance, the Court held that CBAs must specifically provide for vested lifetime benefits, and that simply failing to address the duration of health benefits isn't enough to imply lifetime benefits. The Court reasoned that a CBA's "silence" on the duration of health care benefits is not an ambiguity that justifies reliance on facts existing outside the written contract (like oral communications between the union and management). Instead, because there was no provision in the CBA specifying that health care benefits were subject to a different durational clause, the CBA's general durational clause governed, and the retirees' rights to health benefits expired when the CBA expired. Though importantly, the court acknowledged that "[i]f the parties meant to vest health care benefits for life, they easily could have said so in the text."

In line with the Supreme Court's acknowledgement, on March 13, 2019, a federal judge ruled in *Stone v. Signode Indus. Grp., LLC* that the terms of the CBA specifically provided for vested lifetime health benefits. In Stone, two retirees sued their former employer claiming entitlement to lifetime health benefits based on the terms of the applicable CBA, which the employer's successor announced it was terminating in 2015. Specifically, the CBA provided that:

> Any Pensioner or individual receiving a Surviving Spouse's benefit who shall become covered by the Program established by the Agreement shall not have such coverage terminated or reduced (except as provided in this Program) so long as the individual remains retired from the Company or receives a Surviving Spouse's benefit, notwithstanding the expiration of this Agreement, except as the Company and the Union may agree otherwise.

The employer argued that the right to health benefits terminated when the CBA terminated, but the court disagreed. The court found that the CBA's general durational clause did not serve to limit the duration of the retirees' health benefits because "[t]he agreement does not provide for the right to terminate the benefits" and "[t]he provision of lifetime benefits without provision for their termination constitutes vested benefits." Thus, because the CBA's language provided for lifetime benefits without providing specific limitations on the duration of those benefits, the court found that the two employees had vested rights to lifetime health benefits.

What This Means for Employers

The *Stone* decision provides a cautionary tale for employers that, despite recent favorable decisions at the Supreme Court level, it is still important to closely scrutinize language in plan documents and CBAs to protect against the possibility of retiree claims for lifetime health care benefits. In particular, employers should include reservations of rights provisions and other durational language in plan documents, summary plan descriptions (SPDs), and participant communications to clarify that the employer retains the right to alter or terminate retirees' future health benefits.

Additionally, employers should push-back on language in their labor contracts that imply continuing benefits with no end date (e.g., terminology indicating that retiree health benefits are granted on a "lifetime" or "for life" basis, extending beyond the duration of the CBA). Finally, employers should always have their plan documents and labor contracts reviewed by experienced counsel to minimize the risk of inadvertently providing vested retiree health benefits.

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HHS Reduces Maximum Annual Civil Penalty Limits for HIPAA Violations

On April 30, 2019, the U.S. Department of Health and Human Services (HHS) announced that civil penalties for many violations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be subject to substantially reduced annual limits. After a record year of enforcement, it appears that HHS has cut covered entities some slack by reducing penalty limits for less culpable violations. HIPAA generally covers healthcare providers, healthcare clearinghouses, and group health plans. Accordingly, many employers with group health plans (particularly self-funded plans) are required to comply with HIPAA's privacy and security requirements and should take note of HHS's new guidance.

Background

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 expanded the obligations of covered entities and their business associates under HIPAA and changed the way that civil monetary penalties (CMPs) could be imposed for violations of the HIPAA privacy and security rules. Specifically, the HITECH Act authorized increased minimum and maximum potential CMPs for HIPAA violations and established four categories for HIPAA violations with increasing penalty tiers based on the level of culpability associated with the violation: (1) the person did not know (and, by exercising reasonable diligence, would not have known) that the person violated the provision; (2) the violation was due to reasonable cause, and not willful neglect; (3) the violation was due to willful neglect that is timely corrected; and (4) the violation was due to willful neglect that is not timely corrected. The applicable CMP per violation increased based on the level of culpability associated with a violation, with a blanket annual penalty limit of $1.5 million for violations of the same requirement.

When the enhanced penalty provisions of the HITECH Act were implemented, HHS' view at the time was that "the most logical reading" of the law was to apply the highest annual limit of $1.5 million to all violation types regardless of the level of culpability, and that this was "consistent with Congress' intent to strengthen [HIPAA] enforcement." However, many industry participants disagreed, asserting that imposing the $1.5 million penalty cap for all violations was inconsistent with the HITECH Act's establishment of different penalty tiers based on culpability.

The New "Enforcement Discretion"

On April 30, 2019, HHS issued a "Notification of Enforcement Discretion" stating that a "better reading" of the HITECH Act is to apply tiered annual limits, ranging from $25,000 to $1.5 million, depending on the level of culpability. The new penalty limits are effective immediately and will be used until further notice. A chart summarizing HIPAA's CMP provisions and comparing the prior annual limits with the new annual limits, is provided below.

What this Means for Employers

The new guidance is good news for employers with group health plans subject to HIPAA. As we previously noted, CMPs are assessed per HIPAA violation (e.g., unauthorized disclosure of 15 individuals' protected health information (PHI) constitutes 15 separate violations). With this in mind, it's easy to see how quickly CMPs can add up, and how often penalties can creep toward the annual limit. Thus, employers should take swift action to correct any known HIPAA compliance problems to avoid larger penalties and higher annual limits.

HHS has clearly stepped-up its enforcement of the HIPAA rules, ending 2018 with an all-time record for HIPAA-enforcement (including the largest individual HIPAA settlement in history, totaling $16 million). Thus, it's more important now than ever for employers to consult with their broker or ERISA counsel to ensure that they understand their HIPAA obligations. Employers should also regularly assess their HIPAA compliance and maintain updated HIPAA policies and procedures.

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LEVEL OF CULPABILITY	MINIMUM PENALTY PER VIOLATION	MAXIMUM PENALTY PER VIOLATION	PRIOR ANNUAL LIMIT	NEW ANNUAL LIMIT
No Knowledge	$100	$50,000	$1.5 million	$25,000
Reasonable Cause	$1,000	$50,000	$1.5 million	$100,000
Willful Neglect - Corrected	$10,000	$50,000	$1.5 million	$250,000
Willful Neglect – Not Corrected	$50,000	No Maximum	$1.5 million	$1.5 million

All amounts are adjusted annually for inflation.

New Jersey Gives Employers Guidance on Individual Mandate Reporting Requirements

The end of 2017 was marked with the passage of the Tax Cuts and Jobs Act (TCJA), which effectively repealed the individual mandate under the Affordable care Act (ACA) by reducing the tax penalty to zero. Thus, while the ACA still requires individuals to obtain health insurance, there is no tax penalty for ignoring the law. Importantly, however, the penalty was not eliminated until 2019, so individuals could still be assessed taxes under the ACA for failing to maintain coverage through 2018.

Seeking to uphold one of the major foundational pillars of the ACA, some states are enacting their own state-wide health care individual mandates. Massachusetts has had its own health coverage mandate since 2006, which continues to remain in effect. But new states, including New Jersey, have passed their own state-wide mandates and even more states (including California, Connecticut, Maryland, Minnesota, and Washington) are considering implementing their own laws. It is unclear at this point what employer reporting obligations will look like under many of the new state laws.

Background

The original purpose of the individual mandate was to motivate individuals, sick and healthy, to obtain health coverage so that the risk associated with insuring sicker individuals could be spread across a more diverse population, resulting in reduced premiums for everyone. Accordingly, once the individual mandate penalty was nullified by the TCJA, states naturally became concerned that healthier individuals would drop health insurance coverage and that the remaining pool of insureds in the marketplace would cause health insurance premiums to rise.

Last year, New Jersey and the District of Columbia joined Massachusetts as the second and third state/district to enact an individual health insurance mandate. Both laws were effective January 1, 2019, and closely parallel the federal individual mandate in terms of the penalty amount and available exemptions. Vermont has also enacted a state-level individual mandate that will be effective in 2020, but details regarding the penalty's operations have not been finalized.

Enforcement of the state individual mandate penalties will certainly subject employers to new reporting obligations at the state or district level. However, up until this point, employers have had very little guidance from state agencies. For example, the District of Columbia and Vermont have not yet released guidance addressing employer reporting requirements or forms. However, New Jersey has finally released information for employers regarding the state's individual mandate reporting.

New Jersey Employer Reporting Requirements

New Jersey has provided initial guidance for employers on its "NJ Health Insurance Mandate" website. The guidance explains that the state expects employers to use the current IRS ACA reporting Forms 1095-C, 1094-C, 1095-B, and 1094-B for the state-level reporting. If the IRS discontinues or substantially changes the ACA Forms, the state has indicated that it will deploy similar forms and require that they be sent to the state and to New Jersey taxpayers. The state has also instructed that employers will file the forms through New Jersey's W-2 filing system.

Coverage information for 2019 must be filed electronically by February 15, 2020. Filing instructions are anticipated sometime in mid-2019. The new guidance does not specify a date for providing reporting forms to employees under the state mandate, but the deadline will likely be on or before February 15, 2020. The reporting requirements apply to employers within the state, as well as out-of-state employers that withhold and remit New Jersey gross income tax for New Jersey residents.

What this Means for Employers

Employers with operations in Massachusetts, New Jersey, Vermont, and the District of Columbia should review the individual mandate requirements imposed by their respective state or district and assess whether changes to their administrative practices and procedures are needed. Although we are still awaiting guidance from Vermont and the District of Columbia, New Jersey employers should review the state's recent guidance posted to the "NJ Health

Insurance Mandate" website and stay tuned for filing instructions later this year.

With the growing popularity of state-level individual mandate laws, all employers should keep an eye on their state agencies and lawmakers and track any proposed or enacted individual mandate legislation. Many of the state-level individual mandate laws are designed to mirror the provisions of the now nullified federal mandate. However, it's unclear at this point to what extent states will subject employers to varying state reporting requirements. Employers with operations in multiple states should pay particularly close attention and seek guidance from their broker or ERISA counsel to assess opportunities for integrating and streamlining their state reporting obligations.

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