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April 2024 Agenda

- Washington Update
- STLDI and Fixed Indemnity Regulations
- Wellness Incentives/Surcharges: Benefits Areas of Concerns
- Updates to HIPAA Online Tracking
- Compliance Corner

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WASHINGTON UPDATE

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Health & Welfare Benefits
MONTHLY UPDATE

Regulatory Update

Recently Finalized Rules

- **STLDI, Independent, Non-Coordinated Excepted Benefits, Level Funded Arrangements** and Treasury Proposed Rule on **Tax Treatment of Certain Accident and Health Benefits** (July 12, 2023); comment period ended Sept. 11, 2023; Final Rule published in FR on April 3, 2024.
- HHS Final Rule **Notice of Benefit and Payment Parameters 2025 (Nov. 24, 2023);** comments period ended Jan. 8, 2024; Final Rule filed on April 5, 2024 and schedule to be published in the FR on April 15, 2024.

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MONTHLY UPDATE

Regulatory Update

Notice of Benefit and Payment Parameters 2025

- **Review:**
  - 2020 NBPP stated that copay assistance did not have to count toward the ACA MOOP if there was a generic alternative available. Did this mean that copay assistance had to count if there was not a generic alternative?
  - 2021 NBPP contained a non-enforcement policy allowing GHPs to not count copay assistance in the ACA MOOP in all instances—even when there was not a generic equivalent. This prompted a lawsuit arguing that not counting the copay assistance was inconsistent with the ACA definition of cost-sharing. The D.C. district court vacating the 2021 NBPP.

Health & Welfare Benefits
MONTHLY UPDATE

Regulatory Update

Notice of Benefit and Payment Parameters 2025

- **2025 NBPP**
  - Any drugs covered in excess of the EHB-benchmark plan are considered EHB and count towards annual cost sharing limitation. Applies to non-grandfathered individual and small group market plans.
  - Application of this policy to self-insured and large group market health plans were addressed in ACA FAQ Part 66.
    - "[T]he Departments intend to propose rulemaking that would align the standards applicable to large group market health plans and self-insured group health plans with those applicable to individual and small group market plans."
  - Exception: If (i) coverage is mandated by State action and (ii) is in addition to EHB, then drugs do not have to be considered EHB.
  - This policy will affect copay maximizer programs that exclude certain drugs from EHB.
  - Unclear how copay accumulator programs will be affected with regard to whether manufacturer copay must apply to annual cost sharing limits.

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Regulations Status Update

- Tri-agency Proposed Rules on **Federal IDR Operations** (Nov. 3, 2023); comment period ended Jan. 2, 2024
- Tri-agency Request for Information on **Coverage of OTC Preventive Services** (Nov. 3, 2023); comment period ended Dec. 4, 2023
- Tri-Agency Proposed Rules on **MHPAEA** (Aug. 3, 2023); comment period ended Oct. 17, 2023
- Tri-Agency Proposed Rules on **Federal IDR Process Administrative Fee and Certified IDR Entity Fee Ranges** (Sept. 26, 2023); comment period ended Oct. 26, 2023

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Regulations Status Update (cont.)

Currently under review by OMB

- DOL **Definition of "Employer"--Association Health Plan** Notice of Proposed Rulemaking to rescind 2018 AHP Rule (December 20, 2023); comment period ended February 20, 2024; received at OMB on March 22, 2024.
- DOL Proposed Rule on **Definition of an Investment Advice Fiduciary** and Proposed Changes to Related PTEs (Nov. 3, 2023); comment period ended Jan. 2, 2024; received at OMB on March 8, 2024.
- HHS Office of Civil Rights (OCR) Final Rule on the **HIPAA Privacy Rule and Reproductive Health Care** (Apl. 17, 2023); comment period ended June 16, 2023; at OMB since January 24, 2024.
- HHS-OCR Proposed Rule on **Nondiscrimination in Health Programs and Activities (1557)** (Aug. 4, 2022); comment period ended October 2022; at OMB since December 21, 2023.

And still waiting on:

- HHS Office of Civil Rights (OCR) Proposed Rule on **Modifications to the HIPAA Privacy Rule To Support, and Remove Barriers to, Coordinated Care and Individual Engagement** (Jan. 21, 2021); (comment period closed in May **2021**)

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Final STLDI and Fixed Indemnity Regulations

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Proposed Rule for STLDI and Fixed Indemnity Coverage

Core purpose of proposed rule is to reduce confusing STLDI and fixed indemnity coverage with ACA-compliant coverage. Proposed rule published by federal regulators on July 12, 2023 would:

- Cut back the current 36-month max renewal limit on STLDI to three months with one month extension (also includes an anti-stacking provision);
- Redefine "excepted benefits" status for hospital indemnity and other fixed indemnity supplement benefits;
- Impose new notice requirements;
- Change the tax treatment of all fixed indemnity health policies, including specified disease coverage.

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Fixed Indemnity Coverage and "Excepted Benefits"

- Currently, certain benefits are "excepted" under HIPAA rules and excluded from the ACA requirements if:
  - the benefits are provided under a separate policy/certificate/contract;
  - no coordination of the benefits and exclusions under any plan maintained by same sponsor; and
  - benefits paid w/o regard to whether benefits are provided under plan maintained by same sponsor.
- If finalized, proposed rule would have
  - reinterpret and expand the meaning of "noncoordinated" benefits in group and individual markets
    - If read too broadly, coverage that complements/fill in gaps of other coverage offered by same plan sponsor (or same insurer in the individual market) might no longer be an "excepted benefit."
  - eliminate variation in the amount of benefits by services/items, severity of illness/injury, or any other characteristics particular to a course of treatment, for individual and group coverage alike.
    - Currently, individual coverage allows benefits to vary on a per service and/or per period basis; group coverage can vary on a per-period basis and vary the amount of benefit based on the triggering event.

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Proposed Rule Notice Requirements for Fixed Indemnity

- Proposed rule addresses the consumer confusion issue by adding a new notice requirement for fixed indemnity group coverage and amending the existing notice requirement for individual coverage.
- Notice states that coverage is not "comprehensive health insurance" and doesn't have to include Federal consumer health insurance protections.
  - Must be prominently displayed on first page of any marketing, application, and enrollment materials (paper or electronic) provided at or before enrollment or re-enrollment, and on first page of individual policies
  - Seeking comment on alternate language that would use the header "WARNING."

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Proposed Rule Tax Treatment for Hospital and Other Fixed Indemnity and Specified Disease

- Current understanding (see Rev. Rul. 69-154):
  - Premiums paid on after-tax basis: benefits received are tax-free.
  - Premiums paid on pre-tax basis (either employer contributions or employee pretax salary reduction): tax status depends on unreimbursed medical expenses.
    - Amounts not exceeding related unreimbursed medical expenses are tax-free.
    - Amounts exceeding related unreimbursed medical expenses are taxable.
- Proposed rule: If premiums are paid pre-tax (either employer-paid or pre-tax salary reduction), entire amount of benefit would be taxable income, regardless of the amount of the employee's unreimbursed medical expenses.
  - Benefits would also be subject to employment taxes.

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What if Proposed Reg was Finalized as proposed . . .

- Limits on types of fixed indemnity coverage
- All pre-tax health indemnity coverage creates taxable benefits
- Non-coordination and tax rules impact
  - Mini-MEC Coverage
  - Major-medical look-alike plans
  - Wellness income sheltering programs
  - HDHP indemnity combinations
- Requests comments on treatment of specified disease coverage
- Requests comments on level funded premium (LFP) plans

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Final Rule Published April 3, 2024

- Proposed STLDI changes adopted
- With exception of new Notice requirement (Eff 1/1/25) proposed fixed indemnity changes not adopted

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New Fixed Indemnity Notice Requirement

- Prescribed Notice required for all enrollments/renewals on/after January 1, 2025
  - Failure to satisfy notice requirement results in loss of excepted benefit status
- How is Notice provided?
  - For the group market, notice must be prominently displayed on all marketing, application, and enrollment (or reenrollment) materials. The notice must also be prominently displayed on websites that advertise or offer an opportunity to enroll (or reenroll) in group market hospital indemnity or other fixed indemnity excepted benefits coverage.
  - For individual market coverage, the revised individual market notice must be prominently displayed on the first page of the policy, certificate, or contract of insurance, as well as on all marketing, application, and enrollment (or reenrollment) materials. The notice must also be prominently displayed on websites that advertise or offer an opportunity to enroll (or reenroll) in individual market fixed indemnity excepted benefits coverage

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New Fixed Indemnity Notice Requirement

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.

Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?
Visit HealthCare.gov or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?
For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
If you have this policy through your job, or a family member's job, contact the employer.

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Wellness Program Abuse Scheme – CCA 202323006

- Employer provides comprehensive health and a fixed indemnity health insurance policy.
- Employees pay a monthly premium of $1,200 for the fixed indemnity policy through pre-tax salary reduction.
- The policy pays a monthly benefit of $1,000 triggered by certain health or wellness activities. The wellness benefit also offers full coverage of several triggering events, including wellness counseling, nutrition counseling, and telehealth benefits, at no additional cost.
- The wellness benefit "reimbursements" are paid by the insurance company to the employer. The employer then pays the "reimbursement" to the employee through their payroll system.
- The IRS concludes that the $1,000 wellness payments are taxable **and** subject to employment taxes (e.g., FICA, FUTA), because the payments are made automatically without regard to whether the employee has incurred any unreimbursed medical expenses. Rather, the "reimbursements" are tied to the amount of salary reduction and projected tax savings.

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If it looks too good to be true . . .

- **Step 1: The employee makes a salary reduction election**.
- *If the promised tax benefits are realized*, the salary reduction election reduces employee and employer FICA and FUTA payroll taxes and employee income taxes.
- The pre-tax salary reduction election purportedly reduces the employee's taxable paycheck.

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If it looks too good to be true . . .

- **Step 2: Bring the employee's paycheck back up to the pre-salary reduction level**.
- The employee receives purportedly tax-free payments ("wellness payments") equal to most of the employee's salary reduction amount. The amount of salary reduction returned to the employee is generally reduced by a promoter's fee. Part of the monies returned, which aren't paid directly to the employee, may be used to pay for a traditional fixed indemnity plan.
- To receive the benefit payment, the employee is required to take certain actions, also referred to as "benefit triggers." These include: calling a health coach, signing up for a newsletter, getting a flu shot

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If it looks too good to be true . . .

- The payments in Step 2 are taxable, which reduces the employee's take-home pay. For the payments in Step 2 to be tax-free, the payments must be reimbursements for an incurred medical expense. The benefit triggers, while perhaps health related, do not involve unreimbursed medical expenses as defined under federal tax rules. Thus, the purported tax savings evaporate.

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IRS News Release IR-2024-65

- "IRS alert: Beware of companies misrepresenting nutrition, wellness and general health expenses as medical care for FSAs, HSAs, HRAs and MSAs"
- The IRS rules
  - IRS preferences – e.g., offsetting interests for adjudication as in insured arrangements
  - "IRS Frequently asked questions about medical expenses related to nutrition, wellness, and general health"

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IRS News Release IR-2024-65

- **Q12: Is the cost of food or beverages purchased for weight loss or other health reasons a medical expense that can be paid or reimbursed by an HSA, FSA, Archer MSA, or HRA? (added March 17, 2023)**
- A12: Yes, but only if (1) the food or beverage doesn't satisfy normal nutritional needs, (2) the food or beverage alleviates or treats an illness, and (3) the need for the food or beverage is substantiated by a physician. The medical expense is limited to the amount by which the cost of the food or beverage exceeds the cost of a product that satisfies normal nutritional needs. If any of the three requirements is not met, the cost of food or beverages is not a medical expense.
- News release: "Notes from doctor's based on self-reported health information . . . Does not satisfy the requirement that it be related to a targeted diagnosis-specific activity or treatment"
  - Different standard for dual purpose?

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Wellness Incentives/Surcharges: Benefits Areas of Concern

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Wellness Incentives/Surcharges: Benefits Areas of Concern

- HIPAA Nondiscrimination Rules
  - Potential excise taxes of $100 per day per impacted individual under IRC §4980D and/or specific enforcement under ERISA
- Americans With Disabilities Act (ADA)
- Genetic Information Nondiscrimination Act (GINA)
- Recent tobacco surcharge litigation

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HIPAA Nondiscrimination Rules for Wellness Programs

Is the wellness program participatory or health contingent?

- Participatory programs are available to all employees regardless of health status
- If participatory then no limit on the "reward" under HIPAA rules (includes *both* an incentive or absence of a surcharge) if the program is available to similarly situated individuals.
  - *But see below re: ADA/GINA*
- If health contingent, then there are limits on the "reward" and other requirements.
- Two types of health contingent wellness programs.
  - Activity only
  - Outcome based

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HIPAA Nondiscrimination Rules for Wellness Programs

Health Contingent: HIPAA Nondiscrimination Rules apply if the following conditions present

- Program provides a "reward"
  - Reward includes not only incentive but absence of a surcharge such as a premium discount, lower benefits, or any other financial incentive
- To individuals covered by a group health plan
- In exchange for achieving a specific health outcome or completing a health-related activity
  - "Activity based" requires an individual to perform or complete an activity related to a health factor to obtain a "reward" such as a walking program
  - "Outcome-based" requires an individual to attain a specific health outcome such as not smoking or attaining specific BMI or cholesterol level.

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HIPAA Nondiscrimination Rules for Wellness Programs

- Requirements for a non-discriminatory health contingent program:
  - For programs not related to nicotine/tobacco use, total Reward cannot exceed 30% of the total costs of single coverage (or family coverage if dependents are allowed to participate)
    - Total reward includes all other non-smoking related rewards
    - Cost of coverage is COBRA premium w/o 2% fee
    - Up to 50% for programs related to tobacco/nicotine use prevention/cessation
    - Potential ADA/GINA issues
  - Qualify for the reward at least once per year
  - Provide a reasonable alternative standard for obtaining the reward
    - ***Full reward must be available if reasonable alternate standard is satisfied***
  - Notice that a reasonable alternative will be provided must disclosed "***in all plan materials describing the terms***" of the wellness program.
  - Must be reasonably designed to promote health or prevent disease

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EEOC Regulations for Wellness Programs

- Title I of the ADA prohibits disability-related medical examinations and inquiries with two exceptions:
  - Medical examinations or inquiries if they are "job-related and consistent with business necessity"
  - Voluntary medical examinations, including medical histories and disability-related inquiries, that are part of an employee health program
- May 17, 2016 - EEOC published regs addressing wellness programs under ADA and GINA
  - Effective for plan years beginning in 2017
- Regs state ADA applies to both health contingent and participatory programs under HIPAA
- Regs allowed wellness programs that make disability-related inquiries or require an employee to take a medical exam to offer an incentive up to 30% of the cost of self-only health coverage and still qualify as "voluntary"
  - Did not allow the additional 20% incentive for programs that are designed to prevent or reduce tobacco use
- Regs under GINA provided a similar 30% limitation on incentives for providing a spouse's medical history (*i.e.*, the employee's genetic information)

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EEOC Regulations for Wellness Programs

- AARP challenged the incentive portions of the EEOC regulations
  - AARP – EEOC has authority to limit incentives under wellness programs but limits in regs are arbitrarily assigned and too high
  - August 22, 2017, district court held that EEOC had failed to provide a reasoned explanation for the limits in the regs. *AARP v. EEOC*, 267 F. Supp. 3d 14 (D.D.C. 2017).
  - EEOC withdrew the incentive portions of the regulations
  - EEOC announced proposed regulations in January 2021 that would have changed wellness program incentives permitted under the ADA & GINA
    - Would have limited rewards for wellness programs that include a medical examination or disability-based inquiry to a *de minimus* amount, with higher incentives permitted under certain circumstances for health contingent programs that are or part of a group health plan.
    - With certain exceptions, an employer would only have been permitted to offer a de minimis incentive to an employee whose family member (not limited to spouses) provides information to a wellness program about a disease or disorder manifested by the family member.
  - EEOC withdrew proposed regs prior to publication in the Federal Register
  - Where are we now?

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ADA & GINA

- In interim the statutes will require wellness programs subject to ADA to be "voluntary" – but not clear what this means
  - In particular, not clear if large incentive renders the program involuntary
  - *EEOC v. Orion Energy Sys., Inc.*, 208 F. Supp. 3d 989 (E.D. Wis. 2016) said amount of incentive does not affect whether voluntary
    - Decided under standard that is currently in effect
    - But, just one district court case
  - Kwesell v. Yale University complaint filed in 2019 and settled in 2022 for $1.3 million, employees argued that wellness program violated ADA and GINA because surcharge for not participating of $25/week made the program involuntary.

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Secretary of Labor v. Macy's Inc. et al.

- Action brought by the DOL against Macy's, Macy's group health plan and plan's two TPAs in August 2017 in federal court in Ohio.
  - Pending over four years before motions to dismiss were decided.
- Decision on the motions to dismiss in November 2021 and DOL's motion for reconsideration on February 10, 2022.
- No findings of any liability at this point, simply letting limited claims go forward with some claims dismissed.
- Two claims—
  - Discriminatory wellness program under HIPAA/ERISA §702 (against Macy's alone),
  - Failure to follow out-of-network reimbursement methodology as stated under the plan document (against all defendants).

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MONTHLY UPDATE

Secretary of Labor v. Macy's Inc. et al.

Wellness Program:

- DOL alleged that Macy's tobacco cessation program was discriminatory because Macy's failed to provide a reasonable alternative standard.
- Different allegations for different time periods:
  - 2011 to 2012-- had to be tobacco free for six months even if you completed a smoking cessation course,
  - 2013 had to complete a smoking cessation course and did not have to be tobacco free-- ***but*** did not provide the "full reward" for completing the course (i.e. the affidavit itself stated the tobacco surcharge would "not be changed retroactively and no refunds or credits [would] be issued."),
  - 2014 forward—Only had to complete the course and 2013 language was deleted from the affidavit, but DOL still alleged "upon information and belief" that the full reward was not provided in all circumstances (i.e. refund of the tobacco surcharge on completion of the course).

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Secretary of Labor v. Macy's Inc. et al.

For the wellness program DOL alleged:

- Violation of §702 of ERISA for a discriminatory wellness program.
  - Section 702 of ERISA incorporates the HIPAA nondiscrimination provisions into ERISA.
  - Breach of fiduciary duties under ERISA.
  - Self-dealing prohibited transaction under ERISA because the surcharge allowed Macy's to pay less in employer contributions.
- Ruling on the motion to dismiss the Court permitted:
  - The allegations of a direct violation of ERISA §702 for 2011-2013
  - For 2013 there was an issue on whether the "full reward" was required prior to the 2013 amendment to the wellness regulations but the Court let the claims for 2013 go forward.
  - The Court dismissed the §702 claim for 2014 forward, with leave to amend, because DOL's "upon information and belief" allegations were not sufficient.
  - The Court dismissed the fiduciary breach and prohibited transaction claims because the Court ruled Macy's was acting as a settlor and not a fiduciary in designing the wellness program with the allegedly deficient reasonable alternative standard.

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Secretary of Labor v. Macy's Inc. et al.

- DOL moved for reconsideration on the fiduciary breach claim alleging that even if Macy's was acting as settlor in designing the wellness program it breached its fiduciary duty in ***administering*** the plan under ERISA §404(a)(1)(D) because ERISA only requires adherence to plan documents "insofar as such documents and instruments are consistent with [ERISA's] provisions."
- Court concluded that requiring a fiduciary to administer plan documents insofar as the plan documents are consistent with ERISA ***does not*** mean that the inverse is true –(i.e. it is a fiduciary breach to administer a plan that is inconsistent with ERISA). It said DOL's argument relied on a logical fallacy called "denying the antecedent" or "the fallacy of the inverse."

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Secretary of Labor v. Macy's Inc. et al.

- DOL filed a second amended complaint in March of 2022.
- Macy's moved to dismiss that complaint in May of 2022 and fully briefed by July 2022.
- Reassigned to another judge in December 2022 and no action since then.

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MONTHLY UPDATE

Recent Tobacco Surcharge Litigation

Platt v. Sodexo, S.A., complaint filed in the Central District California on December 8, 2022, alleging:

- Violation of §702 of ERISA for a discriminatory wellness program.
- Breach of fiduciary duties under ERISA.
- Self-dealing prohibited transaction under ERISA because the surcharge allowed Solodex to pay less in employer contributions.
- Health plan requires each tobacco user to pay $23.08 weekly/ $1,200 yearly surcharge.
- No full reward: Employees could prospectively stop the surcharge by attending a cessation program but there was no reimbursement of amounts previously deducted as stated by program Q&A.
- Complaint seeks class certification.

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Recent Tobacco Surcharge Litigation

Platt v. Sodexo, S.A.

- No decision yet on the merits
- Solodex sought to dismiss the case arguing that the employees must use arbitration to challenge the company's practice.
  - Arbitration clause was added to the SPD in 2021
  - Employees received an e-mail with a link to the SPD w/o any mention of updated arbitration provision
- Court ruled that the arbitration provisions was not binding in *Platt v. Sodexo, S.A,* 2023 WL 4832660 (C.D. Ca Jul.25, 2023).
- Solodex appealed to the 9th Cir. and the DOL submitted a brief in support of the employees' ability to litigate their claims in court.

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Recent Tobacco Surcharge Litigation

Su v. Flying Food Group, LLC (N.D. Ill Aug. 30, 2023)

- DOL filed a complaint against Flying Good Group, LLC (FFG) and its group health plan alleging FFG improperly charged participants deductibles for outpatient diagnostic services and wrongly imposed a tobacco surcharge from 1/01/2011 through 4/30/2018.
- For the tobacco surcharge, the DOL was seeking reimbursement of improper surcharges.
- DOL alleged that FFG violated the discrimination provisions in ERISA §702 because it systematically administered the plan to charge higher premiums, $20 per month, to plan participants who reported using tobacco products than those who did not use tobacco products.
- FFG did not offer any alternative standard or provide notice of an alternative standard.
- DOL also alleged that FFG violated its fiduciary duties under ERISA § 404 (a)(1)(B) (duty of prudence) and § 404 (a)(1)(D) (solely administer benefits in interests of participants and beneficiaries);
- FFG entered into a settlement with the DOL on August 31, 2023, and agreed to refund $96,440 in surcharges to participants.
  - Settlement agreement lists ERISA §406 violation too.

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MONTHLY UPDATE

Recent Tobacco Surcharge Litigation

- *Wiederhold v. Res-Care, Inc.* complaint filed in the Southern District Indiana on January 8, 2024.
- Complaint alleges:
  - Violation of §702 of ERISA/HIPAA for a discriminatory wellness program, breach of fiduciary duties under ERISA, and self-dealing
  - Tobacco users must pay a surcharge of $50 per month per tobacco user ($600 per year/$1,200 for employee and spouse)
  - No full reward: Upon completion of tobacco cessation program, surcharge ends for future months only –there is no refund of amounts already paid.
  - Seeking class certification

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MONTHLY UPDATE

Recent Tobacco Surcharge Litigation

Gates v. Lippert Components, Inc., complaint filed in the Northern District Indiana on January 4, 2024, and alleges:

- Violation of §702 of ERISA/HIPAA for a discriminatory wellness program, breach of fiduciary duties under ERISA, and self-dealing
- Employees could self-certify tobacco use during open enrollment
  - Any employees who certified as non-tobacco users were tested for nicotine use once per year
- Tobacco users, self-certified or those who tested positive, had an $18 week/$936 annual surcharge added to their medical plan premiums
- No full reward: Surcharge could only be removed upon completion of a smoking cessation program on a prospective basis only – no retroactive adjustments were made.
- Seeking class certification.

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Recent Tobacco Surcharge Litigation

- Lipari-Williams V. Missouri Gaming Company, LLC et al. Complaint filed in the Western District of Missouri in 2020.
- Class action—ERISA claims regarding a smoking surcharge as well as other wage and hour claims.
- No full reward—surcharge only removed prospectively.
- Settled in 2023 for $5.5 million for all claims. Settled for approximately 62% of the surcharges assessed.

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Update to March HIPAA Online Tracking Updates

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MONTHLY UPDATE

Online Tracking Technologies and the Health Insurance Portability and Accountability Act (HIPAA)

- On December 1, 2022, OCR/HHS issued the bulletin "Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates"
- On March 18, 2024, OCR/HHS updated this guidance to "increase clarity"

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Online Tracking Technologies and HIPAA: When is it PHI?

- Information collected by tracking technologies is considered PHI when it is both:
  - individually identifiable health information; and
  - collected for a purpose related to an individual's past, present, or future health care.
- This largely depends on the website or app user's subjective purpose in using a HIPAA Covered Entity's or their Business Associate's website or app, which is difficult to assess.

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Online Tracking Technologies and HIPAA: "increase[d] clarity" about unauthenticated pages

- User data collected from visits to unauthenticated pages that have nothing to do with treatment – for example, pages related to hospital visiting hours or job postings – is not PHI.
- Other visits to unauthenticated pages *might* be PHI depending on subjective intent:
  - "If a student were writing a term paper on the changes in the availability of oncology services," letting pixels collect info from his visit to a healthcare website does not share PHI, "even if the information could be used to identify the student."
  - However, if "an individual were looking at a hospital's webpage listing its oncology services to seek a second opinion on treatment options for their brain tumor," then letting pixels collect that user's "IP address, geographic location, or other identifying information" results in a disclosure of PHI.

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Online Tracking Technologies and HIPAA: "increase[d] clarity" about unauthenticated pages (continued)

- For unauthenticated webpages and mobile apps, companies typically have no way of knowing who a user is or why they are visiting specific web pages. As HHS notes, a user viewing a hospital's pages on COVID treatment options could be:
  - A student writing a term paper,
  - A parent using the family computer to find out if his kids have COVID symptoms, or
  - A COVID patient.
- Thus, connecting IP address of a user's device might or might not be IIHI – it depends if the visit was for the past, present, or future health or, health care, or payment for health care

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Online Tracking Technologies and HIPAA: "increase[d] clarity" about enforcement

- Although OCR/HHS intent is unknowable, its practical effect might be to move Covered Entities toward the assumption that every visitor is a potential patient looking at the site for options on their own treatment or diagnosis.
- This updated guidance suggests that OCR may treat disclosures of PHI to tracking technologies as data breaches
- HHS added a section on its "enforcement priorities" stating "OCR is prioritizing compliance with the HIPAA Security Rule in investigations into the use of online tracking technologies."

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Online Tracking Technologies and HIPAA: Impact to Health Plans/Issuers and Business Associates

- Use of tracking technologies on the plan's or business associate's webpage and apps may be problematic.
  - Risk of class action by private litigants asserting state law privacy actions.
- What can a CE or BA do if a vendor won't sign a BAA? OCR/HHS has you "covered", entity:
  - Put a "Customer Data Platform"-style vendor in between the CE/BA and the Vendor that won't sign a BAA
  - Have the Customer Data Platform deidentify PHI
  - Send only deidentified data to the Vendor
- NOTE: HIPAA deidentification standard is often different than "hashing" or encryption techniques offered by companies that facilitate data-sharing for marketing or advertising:
  - CE/BA must scrutinize the deidentification techniques offered by intermediaries to confirm they will meet HIPAA deidentification standard.

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Compliance Corner

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MONTHLY UPDATE

Mandated Commuter Benefits

- Two states and several cities have mandated some form of commuter fringe benefits:
  - States: Illinois and New Jersey
  - Cities:
    - California:
      - Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, southwestern Solano and southern Sonoma Counties)
      - Berkeley, CA
      - Richmond, CA
      - San Francisco, CA
    - New York, NY
    - Philadelphia, PA
    - Seattle, WA
    - Washington, D.C.

Health & Welfare Benefits
MONTHLY UPDATE

Mandated Commuter Benefits

- IRC §132(f) allows employers to offer "qualified transportation fringe benefits" on a tax-free basis. Current qualified benefits for 2024 include qualified parking, transit passes, and vanpooling. Certain bicycle commuting expenses will also be eligible under §132(f) for plan years starting on and after January 1, 2026.
- General requirements:
  - Most of these mandates require the employer to maintain its own §132-compliant plan to provide transit passes and/or vanpooling.
  - Some laws allow employers to register for an existing local transit plan.
  - Some laws have recordkeeping and disclosure (posters) requirements.
  - Most of these laws have fines/penalties for noncompliance.
- **Parking is generally excluded**. While these laws generally align with IRC §132(f), a commuter fringe benefit plan that offers qualified parking only will not be in compliance with most of these local laws, which encourage the use of mass transit or vanpooling.

Health & Welfare Benefits
MONTHLY UPDATE

State Law Compliance Requirements

- State law reporting
  - ACA-like reporting: New Jersey, D.C., Rhode Island, California
  - 1099-HC in Massachusetts/HIRD Form in Massachusetts
  - HCSO contribution reporting in San Francisco
- State Law Requirements
  - Vermont Health Care Contribution Fund
  - Washington Partner Access Line Assessment
  - San Francisco HCSO contribution requirements
  - Illinois EHB disclosure

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Questions