ALSTON+BIRD LLP

Employee Benefits & Executive Compensation ADVISORY

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The Health & Welfare Benefit Year in Review

Well, 2011 was yet another busy legislative and regulatory year for health and other welfare benefits—keeping benefits practitioners and plan sponsors on their toes for most of the year. And not all of the activity related to health care reform. If you blinked, you almost certainly missed something. For those of you that may have blinked, or who just gain comfort from a retrospective review, we briefly outline below the major legislation, regulations and other federal guidance that either became effective or was issued in 2011 that had or will have a profound effect on health plans and other welfare benefits.

Over-the-Counter Drugs and Medicines

Under the Patient Protection and Affordable Care Act of 2010 (PPACA), over-the-counter drugs and medicines purchased on or after January 1, 2011, failed to qualify as "medical care" unless a state law-compliant prescription was first obtained from an authorized health care provider. This change impacted all group health plans, including health FSAs and health reimbursement arrangements (HRAs), and health savings accounts.

The IRS also issued helpful guidance on the use of debit cards to purchase over-the-counter drugs and medicines (see IRS Notice 2011-5). In particular, the guidance indicates that debit cards may still be used to purchase over-the-counter drugs and medicines at a pharmacy (including a web-based vendor) that uses the inventory information approval system (IIAS), so long as the pharmacist dispenses the drug, an RX number is assigned (without which the purchase may not be made) and the general IIAS data retention requirements are satisfied.

Practice Pointer: The "prescription" requirement applies only to "medicines or drugs" and not to over-the-counter supplies. While this is good news, the distinction between a "medicine or drug" and a "supply" can be difficult because we do not yet have a *working* definition of "medicine or drugs." Treasury regulations define "medicine or drugs" as items that are legally procured and "generally accepted as falling in the category of medicine or drugs" (see Treas. Reg. 1.213-(e)(2))—hardly a helpful definition, to say the least. Arguably, any item whose primary component is medication would be considered a drug or medicine.

HSA Non-Qualified Distribution Penalty Increases to 20 Percent

We can also thank PPACA for an increase in the excise tax applicable to nonqualified distributions from a Health Savings Account. Effective January 1, 2011, the excise tax for nonqualified distributions (i.e., distributions other than for "medical care" as defined in Code Section 223) increased from 10 to 20 percent.

Practice Pointer: Employers who have established an HSA contribution program for employees have likely communicated, as a convenience to the employee, the potential excise tax; however, it has been our experience that most employers did not alert employees to the increase. These employers should review communication materials and revise accordingly.

Mental Health and Substance Abuse Parity

The Departments of Labor, Treasury and Health and Human Services issued interim final regulations on the Mental Health Parity and Addiction Equity Act (MHPAEA) back in February 2010; however, they were effective for plan years beginning on or after July 1, 2010. Thus, health plans operating on a calendar plan year became subject to the final regulations on January 1, 2011.

Unlike the original Mental Health Parity Act of 1996, the MHPAEA requires true parity with respect to financial and treatment limits (e.g., the number of visits) imposed on mental health and/or substance abuse. The final regulations clarify many aspects of the MHPAEA, and they also set forth the manner in which the MHPAEA applies to *non-quantitative* treatment limits (e.g., pre-authorization) and how the MHPAEA rules apply to employee assistance plans (they don't, unless EAP visits must be exhausted before the health plan pays).

Practice Pointer: The agencies recently issued an FAQ that further clarifies the manner in which the MHPAEA applies to non-quantitative treatment limits. You can find the FAQ at http://www.dol.gov/ebsa/faqs/faq-aca7.html.

EEOC Regulations on Title II of GINA Take Effect

The EEOC's final regulations on Title II of GINA took effect on January 10, 2011. Title II of GINA regulates the collection of genetic information as part of the employer's employment practices and should not be confused with Title I of GINA, which regulates the collection and use of genetic information by health plans. The final Title I regulations issued by the Departments of Labor, Treasury and Health and Human Services were effective December 7, 2009.

Title II of GINA prohibits employers from discriminating against applicants and employees on the basis of genetic information and from requesting or requiring an employee's genetic information (including the employee's family medical history). The regulations carve out some important exceptions to the general prohibition against requesting or requiring genetic information, including genetic information obtained as part of the employee's "voluntary" participation in a wellness program and where the employee's advance authorization is obtained. The regulations go on to indicate that participation in a wellness program is not voluntary if participation in the program is conditioned on providing the genetic information or the employee is penalized for failing to provide the information. Moreover, financial inducements for providing genetic information are not permitted. However, financial inducements for completing a health risk assessment with questions regarding family medical history or other genetic information may be permissible, as long as the assessment clearly indicates that the financial inducement will be provided without regard to whether the participant answers the family medical history questions or not. For more information on the EEOC's final regulations on Title II of GINA, please click here.

Practice Pointer: The EEOC indicates that they intend to prevent Title II causes of action being asserted for Title I violations by a health plan; however, there is practical overlap. For example, if an employer amends its self-insured health plan to require genetic information, the employer may have violated Title II. If the plan requires the genetic information as a result of the amendment, then the plan may have violated Title I. Although the "plan" is a separate legal entity, it is the employer who pays the penalty for both the Title II and Title I violations.

NOTE: *On June 24, 2011, the EEOC issued an informal information letter confirming its prior position regarding the definition of "voluntary." You can find the letter at* http://www.eeoc.gov/eeoc/foia/letters/2011/ada_gina_incentives.html.

The "Seff Case": ADA Relief for Wellness Programs?

The Americans with Disabilities Act (ADA) generally prohibits employers from requiring employees to undergo a medical examination or answer medical inquiries (the "ADA Prohibition"). An important exception exists for wellness programs that are considered to be voluntary under ADA guidance. Based on current informal guidance from the EEOC, a wellness program will only be considered to be *voluntary* if it neither requires participation nor penalizes employees who do not participate.

In 2011, a district court in Florida ruled in favor of Broward County in a suit brought by participants under the ADA with respect to Broward County's wellness program, which imposed a surcharge on employees who declined to participate (see *Seff v. Broward County*, U.S. District Court for the Southern District of Florida, Case No. 10-61437-CIV-Moore/Simonton). Ruling in favor of Broward County, the court stated that the county's wellness program did not violate the ADA Prohibition because the program comes under ADA's "safe harbor" underwriting exception to the ADA Prohibition.

Practice Pointer: Only one other court has applied the approach adopted in *Seff*, and that decision was under a fully insured program. It is unclear whether the EEOC, as the ADA enforcement agency, will follow this ruling. We are aware of several EEOC challenges where the EEOC has disputed the validity of employer wellness programs that offer financial incentives based on the "voluntariness" of the arrangement. Nonetheless, *Seff* provides employers some breathing room, and an alternate approach to support the validity of their wellness programs.

Relief for Certain HRAs from Medicare Reporting

In late 2007, Congress enacted the Medicare, Medicaid and SCHIP Extension Act of 2007, which amended the Social Security Act to add new mandatory Medicare coordination reporting requirements ("MSP Reporting Rules") for third-party administrators and insurers of group health plans. Health Reimbursement Arrangements (HRAs), but not Health FSAs or HSAs, are considered "group health plans" for this reporting purpose. The nature of HRAs posed unique reporting problems. Although reporting was originally required to begin for coverage provided on or after January 1, 2009, CMS initially delayed the reporting date for HRAs until the last quarter in 2010. In addition, CMS initially exempted HRAs that had a maximum annual reimbursement amount of less than $1,000.

In 2011, CMS issued additional reporting relief for HRAs. For new accounts or renewals (e.g., the beginning of a plan year) on or after October 3, 2011, reporting is no longer required for HRAs with a maximum annual reimbursement of less than $5,000. In addition, if the balance of a reportable HRA is exhausted during the year, then the administrator would report an HRA as terminated (until coverage begins again).

Practice Pointer: The exemption applies to HRAs with a maximum annual reimbursement of *less than* $5,000. However, if the maximum annual reimbursement is equal to or exceeds $5,000, at any time during the year, the reporting requirements apply. Moreover, amounts carried over from a prior year are considered in determining whether the HRA has an annual reimbursement equal to or greater than $5,000.

Extension of COBRA for PBGC/HCTC recipients

On October 21, 2011, the president signed into law the Trade Adjustment Assistance Extension Act of 2011, Pub. L. No. 112-40 (TAAEA). The TAAEA will retroactively increase the Section 35 health care tax credit that is available to certain individuals receiving trade adjustment assistance, or certain PGBC recipients, from 65 percent (previously 80 percent for coverage months beginning prior to February 13, 2011) to 72.5 percent. This increase will not extend beyond January 1, 2014. The IRS is currently working on the process for applying the credit retroactively.

The TAAEA also entitles COBRA qualified beneficiaries by virtue of a termination of employment/reduction in hours of employment, who are also (i) PBGC recipients (or survivors of PBGC recipients) or (ii) TAA-eligible individuals, to continuation of COBRA coverage periods under their former employer's plans through January 1, 2014, or, if later, the maximum COBRA period. Fortunately, the COBRA extension is applied prospectively—it will only apply to coverage months that would end (absent the extension) on or after the date that is 30 days after the bill was enacted, which was October 21, 2011. Thus, the extension only applies to those whose coverage would otherwise lapse naturally on or after November 20, 2011.

Practice Pointer: The Omnibus Trade Act of 2010 extended coverage for such PBGC recipients or TAA-Eligible Individuals until the later of the maximum COBRA period or February 12, 2011. Since the new extension under the TAAEA is presumably not retroactive, those PBGC recipients or TAA-eligible individuals whose statutorily extended coverage ended in February 2011 would not be entitled to re-elect coverage.

HIPAA Privacy and Security Enforcement

On November 8, 2011, the Department of Health and Human Services' Office for Civil Rights (OCR) published on its website the details of a new audit program targeted at covered entities. Under the program, OCR will perform up to 150 audits of covered entities for compliance with the privacy, security and breach notification standards adopted under HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

You can find more details regarding the audit program at http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/index.html.

Practice Pointer: This would be a good time for sponsors of group health plans to ensure that they have updated privacy and security policies and procedures, including "breach" procedures as required by the HITECH Act.

First Wave of PPACA's Health Insurance Reforms Apply to Health Plans with Calendar Plan Years

The first wave of health insurance reforms added by Sections 1001 and 1201 of PPACA (you know, the ones that require coverage of a child until age 26, prohibit lifetime or annual limits on essential benefits and require a four-page summary of your benefit plan options—yeah, those) went into effect for plan years beginning on or after September 23, 2010. Thus, the health insurance reforms applied to calendar year plans on January 1, 2011, and all other plans that were not already required to comply in 2010.

The agencies were very busy this year issuing regulations and guidance regarding the health insurance reforms. The following is a brief overview of that guidance:

• Nondiscrimination rules for fully insured plans	The IRS delayed the application of the new nondiscrimination rules applicable to fully insured, non-grandfathered health plans, and then requested comments. See IRS Notice 2011-1, which you can find at http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6.
• New well-woman preventive care guidelines adopted by HHS on August 1, 2011	Applicable only for non-grandfathered plans and is not effective until the first plan year beginning on or after the date the guidelines were issued. Thus, the first effective date is for plan years beginning on or after August 1, 2012. You can find a fact sheet from HHS at http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html. You can also find a more detailed summary here.
• HHS issues guidance on waiver process	HHS issued guidance regarding the process for obtaining waivers from the restricted annual limit rule. First, HHS indicated that the waiver application process closes September 22, 2011. Also, HHS granted a class exemption from the waiver process for HRAs otherwise subject to the annual limit prohibition, so long as the HRA was in effect prior to September 23, 2010. Such HRAs are still subject to certain recordkeeping and notice requirements. For more detail, please click here.
• Guidance on new claims review procedures, including external review	Amended regulations and guidance issued by agencies provide clarification and relief regarding the new internal and external claims review procedures applicable to non-grandfathered plans. For example: • Urgent care determination and notice period changed from 24 hours to 72 hours. • The scope of external reviews requested after September 20, 2011, under the federal external review program (e.g., for self-insured plans) was limited to claims involving medical judgment or rescission of coverage. • Notices were required to be sent in a culturally and linguistically appropriate manner. For a more detailed summary regarding the internal and external claims review guidance, see: Department of Labor Extends Enforcement Grace Period for Certain Internal Claims and Appeals Requirements So What Are My Internal and External Claim Review Requirements? A Question Every Group Health Plan Is Asking

• Regulations and guidance on Summary of Benefits Coverage (SOBC)	The agencies issued regulations regarding the four-page, 12-point font "summary" of benefits coverage required to be distributed during the plan's applicable enrollment period. The new SOBC was originally slated to be effective on March 23, 2012; however, recent FAQs from the agencies have delayed the effective date until a later date yet to be determined. For a more detailed summary of the SOBC rules, see: When Is a Summary More than a Summary: Agencies Issue Long-Awaited Guidance on the ACA's Uniform Summary of Benefits and Coverage Requirement

The various FAQs from the agencies can be found at http://www.dol.gov/ebsa.

Other PPACA-Related Items

- Federal Courts of Appeal grapple with PPACA constitutionality: D.C. and 6th Circuit holds individual mandate under PPACA constitutional; 11th Circuit holds individual mandate unconstitutional.
- IRS issues guidance on reporting the value of health coverage on the employee's W-2 (which was delayed; reporting is not required for coverage beginning prior to January 1, 2012). See IRS Issues Guidance on Form W-2 Reporting for Health Coverage Costs. Further guidance and clarification is provided in IRS Notice 2012-9.
- IRS requests comments on pay-or-play rules, CER fees and premium tax credit. See http://www.irs.gov/newsroom/article/0,,id=220809,00.html?portlet=6 for more information.
- HHS issues guidance on establishing exchanges. See http://cciio.cms.gov/ for more information.

Transit Parity and Delay in IRS "Smart Card Ruling" Expire December 31, 2011

On December 31, 2011, the current parity between the monthly limitation for parking ($230) and the monthly limitation for transit ($230) expires. Beginning January 1, 2012, the monthly limitation for parking will be $240 and the monthly limitation for transit will decrease to $125. Also, every indication is that the delay in IRS application of its 2006 transit "smart card" ruling (See IRS Notice 2010-94) will not be renewed for 2012.

THE ROAD AHEAD!!!!

The question on everyone's mind—will there be any relief in 2012 or should we expect an equally busy year? You should expect an equally busy year. First, three PPACA-related laws go into effect in 2012 or will have an impact in 2012:

- ***Comparative clinical effective research fees (applicable to plan years ending after September 30, 2012).*** This fee for the first year is $1 multiplied by the average number of covered lives and $2 multiplied by the average number of covered lives for years thereafter. No fee is due for policy years ending after September 30, 2019.

- ***Collection of information for W-2.*** The first W-2 on which the value of "applicable employer sponsored coverage" must be reported is the 2012 W-2, which is due no later than January 31, 2013.
- Health FSAs that have a plan year beginning on or after January 2, 2012, should amend their plans to comply with the new rule that limits Health FSA salary reductions elected during the 2013 calendar year to $2,500.

It is also expected that the Supreme Court will issue its ruling on the constitutionality of the individual mandate (and perhaps PPACA as a whole) during 2012.

Benefit plan practitioners and plan sponsors must also begin to prepare for the expiration of the following benefit plan-related tax provisions at the end of 2012:

- ***The educational assistance tax exclusion under Code Section 127***. Unless extended, the tax exclusion otherwise made available under Code Section 127 for employer-provided "educational assistance" will cease to exist in 2013. However, an income tax exclusion for employer-provided educational assistance may still apply under Code Section 132 (e.g., for education required to maintain your job).
- The deemed earned income amounts increased under EGTRRA for dependent care assistance plans (and the dependent care tax credit under Code Section 21) will expire (as will the increased amounts that may be taken into account to determine the Code Section 21 credit). If the increased amounts are not extended, the deemed earned income amounts for a disabled or full-time student spouse will decrease from $250 (for one child) and $500 (for two or more children) to $200 (for one child) and $400 (for two or more children).

In 2012, we also may see regulations and/or guidance with respect to the following:

- final cafeteria plan regulations
- fully insured plan nondiscrimination rules
- final SOBC rules
- rules regarding the pay-or-play penalty, including guidance on calculating "full-time employee" status
- guidance on "essential benefits"
- final HITECH regulations
- the $2,500 cap on FSA salary reductions
- guidance on debit cards used for transportation plans
- guidance on the tax treatment of rebates under the MLR rules

Buckle up!! If history is our guide, 2012 will prove to be busier than ever.

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