TRUCKER ✦ HUSS

Benefits Report

JULY 2015

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New ACA Guidance on Requirement to Cover Preventive Health Services

TIFFANY N. SANTOS

On July 14, 2015, the Internal Revenue Service, Department of Labor and Department of Health and Human Services (the "Departments") jointly finalized interim final regulations issued in July 2010 regarding the Affordable Care Act's ("ACA") requirement to cover certain preventive health services without cost-sharing by non-grandfathered plans. They also finalized the process that "eligible organizations" must follow to object to covering contraceptive services on religious grounds (see: http://www.gpo.gov/fdsys/pkg/FR-2015-07-14/pdf/2015-17076.pdf).

The final regulations come on the heels of FAQs issued by the Departments on May 11, 2015 (FAQs About Affordable Care Act Implementation Part XXVI) regarding the requirement to cover BRCA testing, FDA-approved contraceptives, sex-specific recommended preventive services, certain well-woman preventive care for dependents, and anesthesia services provided in connection with a colonoscopy. This article focuses on the changes and clarifications announced in the final regulations and related FAQs and what plan sponsors must consider as they design their plans for the upcoming plan year. (*Note:* The complete list of preventive health services that a plan must cover may be found at: https://www.healthcare.gov/preventive-care-benefits/).

Background

Section 2311 of the Public Health Service Act, as amended by the ACA, requires non-grandfathered health plans to provide the following preventive health services without any cost-sharing:

- Evidenced-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"), except for USPSTF-recommended breast cancer screening, mammography, and prevention in guidance issued in November 2009;
- Immunizations recommended by the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention, for routine use in children and adolescents, and adults;

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Trucker ✦ Huss Attorneys Recognized as 2015 Northern California Super Lawyers and Rising Stars

Attorneys **Brad Huss**, **Lee Trucker**, **Barbara Creed**, **Charles Storke**, **Benjamin Spater**, **Robert Schwartz**, and **Clarissa Kang** were all selected as 2015 Northern California Super Lawyers, and **Angel L. Garrett** and **Matthew Gouaux** were both selected as 2015 Northern California Rising Stars by Super Lawyers Magazine. Only 5% of Northern California attorneys receive this honor. We are also very proud to announce that addition to earning Super Lawyer honors, **Brad Huss** again made the magazine's list of Top 100 Lawyers in Northern California for 2015. Super Lawyers compiles their list of top Northern California attorneys through a process in which peer nominations and third party research are combined with a final evaluation in which the top lawyers in the region confidentially evaluate their professional peers.

- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- For women, evidence-informed preventive care and screening provided in comprehensive guidelines supported by HRSA, including FDA-approved contraceptives, sterilization procedures, and patient education and counseling for women with reproductive capacity, as prescribed by a health care provider.

The Departments noted in the July 2010 interim final regulations that a plan or issuer may use reasonable medical management techniques to determine coverage limitations if a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service.

Final Regulations

The final regulations confirm or clarify the following:

- ***"Primary Purpose" Test Must Be Used to Determine If Cost-Sharing May Be Imposed:*** Affirming the July 2010 interim final regulations, the final regulations state that a plan may not impose cost-sharing for an office visit if a recommended preventive service is not billed separately (or is not tracked as individual encounter data separate) from the visit and the primary purpose of the visit is the delivery of the recommended preventive service. The preamble to the final regulations note that the Departments anticipate that the determination of a visit's "primary purpose" will be resolved through normal billing and coding activities.
- ***Certain Preventive Services Furnished by a Non-Network Provider Must Be Covered Without Cost-Sharing:*** The final regulations clarify that if a plan's network does not include a provider who can provide a particular recommended preventive service, the plan must cover the non-network-provided preventive service without any cost-sharing.
- ***Reasonable Medical Management:*** The final regulations adopt the guidance issued in FAQ, Part II, Q&A 8, permitting plans to rely on the relevant evidence base and established reasonable medical management techniques to determine the frequency, method, treatment or setting for the provision of a recommended preventive service where such limits are not provided for in the applicable recommendation or guideline.

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- ***Coverage of Additional Preventive Services:*** Plans are free to cover preventive services beyond those that are required by the ACA and can impose cost-sharing on such "non-recommended" services.

- ***Changes to Recommended Preventive Services:*** Consistent with the July 2010 interim regulations, the final regulations give plans until the first day of the first plan year beginning on or after the date that is one year after the date the relevant recommendation or guideline is issued to commence coverage of the preventive service. The final regulations, however, clarify that if a service or item ceases to be specified as a recommendation or guideline during the middle of a plan year, the plan must continue to provide coverage for the item or service through the last day of the plan year unless the item or service is downgraded from an "A" or "B" rating to a "D" rating, is subject to a safety recall, or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the service or item. If any of these exceptions apply, the plan may terminate coverage of the service or item immediately. For example, if the USPSTF downgrades a service from an "A" to a "C" rating on June 1, 2017, a calendar-year non-grandfathered plan would have to continue covering the particular preventive service without cost-sharing through December 31, 2017.

- ***Coverage of BRCA Testing:*** As provided in the FAQs issued on May 11, 2015, plans must cover recommended genetic counseling and BRCA genetic testing for any woman who previously had breast cancer, ovarian cancer, or other cancer if appropriate as determined by her attending provider, without any cost-sharing. The coverage requirement applies even if the woman was not diagnosed with a BRCA-related cancer (breast cancer susceptibility genes, BRCA 1 or BRCA 2).

- ***Requirement to Cover FDA-Approved Contraceptives:*** The HRSA guidelines recommend coverage for all Food and Drug Administration ("FDA") approved contraceptive procedures, sterilization procedures, and patient counseling for all women with reproductive capacity, as prescribed by a health care provider. The FAQs clarify that plans must cover without cost-sharing at least one form of contraception in EACH of the methods identified by the FDA for women in its current Birth Control Guide, including clinical services such as patient education and counseling. To date, the FDA recommendations include the following 18 methods: (1) sterilization surgery for women; (2) surgical sterilization implant for women; (3) implantable rod; (4) IUD copper; (5) IUD with progestin; (6) shot/injection; (7) oral contraceptives (combined pill); (8) oral contraceptives (or progestin only); (9) oral contraceptives extended/continuous use; (10) patch; (11) vaginal contraceptive ring; (12) diaphragm; (13) sponge; (14) cervical cap; (15) female condom; (16) spermicide; (17) emergency contraception (Plan B/ Plan B OneStep/Next Choice); and (18) emergency contraception (Ella).

  Reasonable Exceptions Process: The FAQs state that plans may use reasonable medical management techniques to determine the form of contraception that will be covered without cost-sharing within each method, but must provide for an easily accessible, transparent and expedient exceptions process that is not unduly burdensome on an individual or provider. For example, if an individual's attending provider recommends a specific FDA-approved item based on medical necessity (*e.g.,* severity of side effects, differences in permanence or reversibility, or ability to adhere to the appropriate use of the item), the plan must defer to the provider's determination and cover that service without cost-sharing.

  Some Cost-Sharing Permitted: The FAQs also clarify that plans may impose cost-sharing on some items or services to encourage the use of other specific items and services within the chosen contraceptive method. For example, a plan may impose cost-sharing on brand name pharmacy items versus generic pharmacy items or use cost-sharing to encourage use of one of several FDA-approved IUDs with progestin.

  Note: The above-described contraceptive guidance applies for plan years beginning on or after the date that is 60 days after May 11, 2015 (*i.e.,* January 1, 2016 for a calendar-year plan).

- ***Sex-Specific Recommended Preventive Services:*** The FAQs clarify that a plan may not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. Coverage for a medically appropriate service is determined by the individual's attending provider.

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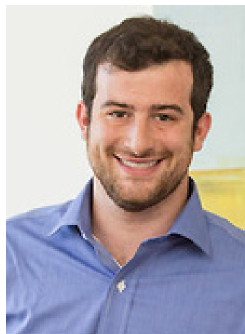
- ***Coverage of Well-Woman Preventive Care for Dependents, Including Recommended Preventive Care Related to Pregnancy, Such as Preconception and Pre-Natal Care:*** The FAQs clarify that if a non-grandfathered plan provides coverage to dependent children, the plan must cover the full range of recommended preventive services applicable to them (*e.g.,* age- and developmentally-appropriate) without cost-sharing. This means that if a dependent child is pregnant, the plan must cover any recommended preventive services related to the dependent's pregnancy, such as prenatal care, for that child.
- ***Coverage of Anesthesia Services in Connection with a Colonoscopy:*** The FAQs clarify that a plan must cover anesthesia services that are performed with a preventive colonoscopy without any cost-sharing, if the attending provider determines that such anesthesia is medically appropriate for the individual.
- ***Objection to Contraceptive Coverage on Religious Grounds:*** The final regulations allow entities to object to the contraceptive mandate and set forth the criteria for certain non-profit religious organizations to provide notice of their objection to the contraceptive coverage requirement.

Unless otherwise specified herein, the FAQs described above are for a calendar year plan, and the final regulations are applicable as of the first plan year beginning on or after September 1, 2015 (*i.e.,* January 1, 2016 for a calendar-year plan). Plan sponsors must review their plan documents and participant communications now to ensure they are able to timely comply. Plan sponsors may also wish to ensure that any third party administrators are aware of the new requirements and will administer the plan's preventive care benefit accordingly. If you have any questions, please contact the author of this article.



ACA Compliance Remains "Business as Usual" for Employers Following *King v. Burwell*

TIFFANY SANTOS AND MARSHAL HODA

In its much-anticipated June 25, 2015 decision in *King v. Burwell,* the United States Supreme Court upheld nationwide federal health care subsidies under the Affordable Care Act ("ACA"). *King* affirmed that the premium tax credit under Section 36B of the Internal Revenue Code (the "Code") is available to qualifying individuals, regardless of whether they obtain health insurance coverage on a State or Federal Exchange. While the ruling ensures that millions of Americans will continue to have access to affordable individual health insurance, for employers, the ruling confirms two major points: (1) employers with 50[1] or more full-time equivalent employees in a state whose Exchange is operated by the federal government will be subject to assessment under the employer shared responsibility provision under Code Section 4980H; and (2)

[1] As provided in the preamble to the final regulations implementing Section 4980H of the Code (http://www.irs.gov/irb/2014-9_IRB/ar05.html#d0e1288), employers with at least 50 full-time employees (including full-time equivalents), but fewer than 100 full-time employees (including full-time equivalents) in 2014, generally will be eligible for transition relief and will not be subject to any "employer shared responsibility payment" under Section 4980H(a) or (b) for any calendar month during 2015. This relief is set to expire for coverage months in 2016.

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the continuing endurance of the ACA despite two U.S. Supreme Court challenges and resulting need for plan sponsors to comply with its requirements.

Interpretive Uncertainty before *King*

King resolved an interpretive split between the Fourth Circuit Court of Appeals and the Court of Appeals for the District of Columbia regarding Code Section 36B. The provision defines the annual premium tax credit available to a taxpayer to purchase coverage by reference to the coverage months in which the taxpayer is enrolled in a health plan "through an Exchange established by the State". In issuing its implementing regulations, the Internal Revenue Service ("IRS") interpreted the statute to grant the credit to individuals who purchase health insurance through either a State Exchange or the Federal Exchange [see 26 CFR Section 1.36B-2(a)(1)].

Fourth Circuit: In *King v. Burwell,* the Fourth Circuit ruled that the aforementioned language was ambiguous and subject to multiple interpretations, and opted to apply deference to the IRS's interpretation. The court found that Section 36B permits the IRS to grant the credit to a taxpayer who enrolled in either a State or Federal Exchange, and further reasoned that the IRS's interpretation was consistent with the ACA's goal of expanding access to health insurance coverage, and subsidizing the purchase of insurance through federal exchanges helped to further that goal.

D.C. Circuit: In *Halbig v. Burwell,* the D.C. Circuit ruled that the language above "unambiguously restricts the Section 36B subsidy to insurance purchased on Exchanges 'established by the State'" and vacated the IRS's interpretation. In contrast to the Fourth Circuit, the Court concluded there was no evidence of Congressional intent to establish subsidies to purchase health insurance coverage on both Federal and State Exchanges.

In the past year, that split created a great deal of uncertainty for employers, because the ACA's 'employer mandate' — the provision requiring "applicable large employers" to offer affordable health insurance or pay substantial penalties under Section 4980H — uses employees' receipt of federal subsidies as the triggering mechanism for noncompliance assessments. Under Section 4980H, an "applicable large employer" may be assessed a payment depending on whether:

- The employer offers its full-time employees the opportunity to enroll in "minimum essential coverage" (for a discussion of these penalties, see our February 2014 newsletter); AND
- At least one full-time employee purchases individual Exchange coverage with a federal premium tax credit or cost-sharing reduction.

Because the federal Exchange operates in 34 states, if the Court had struck down the availability of subsidies to purchase coverage on the Federal Exchange, the employer mandate would not have applied to countless employers, and the ACA more broadly could have been severely compromised as millions of Americans would not have been able to obtain affordable coverage.

The Court Resolves the Split

In *King,* the Court held that the tax credit under Section 36B is available throughout the country via the State Exchanges and the Federal Exchange. The Court stated that because the ACA was intended to expand health plan coverage, Congress did not intend to limit the tax credits to coverage purchased through State Exchanges only. It concluded that Section 36B allows tax credits for insurance purchased on any Exchange created under the ACA, as such "credits are necessary for the Federal Exchanges to function like their State Exchange counterparts, and to avoid the type of calamitous result that Congress plainly meant to avoid," by denying access to affordable coverage to millions of Americans.

What Does *King* Mean to Employers?

King does not impose any new ACA obligations, but rather confirms that existing ACA provisions apply in full force. Employers that have implemented compliance strategies can now be assured that their time and efforts were well spent, and can focus on meeting the offer of coverage requirement that took effect in 2015 under Section 4980H (and the related reporting requirement under Sections 6056 via the Forms 1094-C and 1095-C) and other upcoming ACA requirements including the excise tax on high-cost employer-sponsored coverage (or "Cadillac" tax, Section 4980I) and nondiscrimination requirement for insured non-grandfathered plans. Those that had opted to 'wait and see' should recognize that

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significant legal challenges to the ACA have been exhausted, and should begin implementing compliance strategies immediately with respect to its requirements (for example, coverage for children up to age 26 and elimination of annual and lifetime dollar limits on "essential health benefits") and the above referenced "offer of coverage" and reporting requirements. If you have any questions, please contact the author of this article.

OTHER DEVELOPMENTS IN EMPLOYEE BENEFITS

Supreme Court's *Tibble* Decision Provides Little Guidance

The Supreme Court has issued a unanimous opinion in favor of plan participants in *Tibble v. Edison International,* 135 S. Ct. 1823 (2015), a case that raised an issue on the amount of time a plan participant has to bring a claim for breach of fiduciary duty under ERISA. The Court's decision, which reverses the earlier Ninth Circuit ruling from March 2013, found that plan fiduciaries have a "continuing duty — separate and apart from the duty to exercise prudence in selecting investments at the outset — to monitor, and remove imprudent, trust investments." Essentially, the Supreme Court's decision means that a valid claim for a continuing violation of the fiduciary duty to monitor plan investments creates a rolling six-year statute of limitations for bringing a breach of fiduciary duty claim under ERISA Section 413. (The Court did not discuss the possibly shorter three-year statute of limitations under ERISA based on actual knowledge of a fiduciary breach.)

The Ninth Circuit's *Tibble* decision had held, in part, that a breach of fiduciary duty claim based on the selection of higher-cost retail-class mutual funds, when identical lower-cost institution-class mutual funds were available, over six years prior to the filing of the suit would be barred by the six-year statute of limitations under ERISA Section 413, unless a plaintiff could show that a significant change in circumstances had occurred, which would cause a fiduciary to reexamine the fund's inclusion in the plan. (See our March 2013 Special Alert for further discussion.) In October 2014, the Supreme Court granted the plaintiffs' petition for writ of certiorari in *Tibble* to solely address whether such a claim is barred by ERISA Section 413, when fiduciaries initially chose the higher-cost mutual funds as plan investments more than six years before the claim was filed.

In addressing this question, the Supreme Court relied on trust law principles to determine that the Ninth Circuit erred in applying a statutory bar to the claim for breach of fiduciary duty without considering the nature of the particular duty at issue. The Supreme Court found that, instead of focusing exclusively on the act of selecting an investment, the Ninth Circuit also needed to consider a fiduciary's continuing duty to monitor investments to determine if and when a breach occurred. The Court noted that under trust law, a fiduciary is required to conduct a regular review of its investments, with the nature and the timing of the review contingent on the circumstances. The Supreme Court therefore remanded the case back to the Ninth Circuit to decide what the fiduciary duty to monitor plan investments requires within the context of trust law, but it did not provide the Ninth Circuit with any guidance for making this determination. This lack of guidance on what the duty to monitor entails may result in conflicting opinions from the lower courts.

While the *Tibble* decision sheds little light on the scope of the ERISA fiduciary duty to monitor plan investments, fiduciaries should examine their plan procedures for reviewing investments to ensure that a regular review (optimally on a quarterly basis) is in place. This review process should include matters such as investment performance, investment expenses, compliance with any investment policy statements and any significant changes as to the investment vehicles. The review should be thoroughly documented as well. If you have any questions on the *Tibble* decision or on fiduciary issues under ERISA, please contact us.

— MICHELLE S. LEWIS

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Significant Changes to Qualified Plans Determination Letter Program Underway

On July 21, 2015, the Internal Revenue Service ("IRS") released Announcement 2015-19, announcing a significant curtailment of the IRS determination letter program for individually designed retirement plans. Announcement 2015-19 eliminates the five-year remedial amendment cycle for individually designed retirement plans and restricts the IRS determination letter program to limited circumstances.

The IRS determination letter program, which was last significantly overhauled in 2007, permits (but does not require) plan sponsors of individually designed retirement plans to submit the plan document for review by the IRS to confirm that the plan maintains tax-qualified status under Section 401(a) of the Internal Revenue Code ("Code") and the related trust is tax exempt under Section 501(a) of the Code. Filing for an IRS determination letter also extends the remedial amendment period provided by the Code, which is the period during which a plan sponsor can retroactively adopt plan amendments to comply with the tax qualification rules. Receipt of a favorable determination letter is significant in that if the plan sponsor operates a plan according to the terms of a plan document that has received a favorable determination letter, the plan itself will also satisfy the law in operation. This helps assure the plan sponsor that plan contributions can continue to be tax-deductible, participants can defer taxation on amounts contributed to the plan, and all contributions can continue to grow tax-deferred until distribution.

During the 2007 overhaul of the determination letter program, the IRS placed individually designed plans on a staggered five-year remedial amendment cycle, permitting plan sponsors to apply for favorable determination letters once every five years and extending the remedial amendment period for the plan to the end of the applicable cycle. As a general rule, the plan's staggered cycle is based on the last digit of the sponsor's employer identification number (EIN). Upon receipt of a favorable determination letter, the plan sponsor can rely on the favorable letter until the end of the next five-year period.

Announcement 2015-19 provides that the IRS will eliminate staggered five-year remedial amendment cycle for individually designed plans, effective January 1, 2017. Plan sponsors whose plans are currently "on cycle" (generally sponsors of plans with EINs ending in 5 or 0) have until January 31, 2016 to file a determination letter application. Plan sponsors whose plans fall in the remedial amendment period beginning February 1, 2016 and ending January 31, 2017 (generally sponsors of plans with EINs ending in 1 or 6) will have until January 31, 2017 to file a determination letter application. The IRS was also clear that as of the date of the Announcement, it will no longer accept determination letter applications filed "off-cycle".

The decision to eliminate the five-year remedial amendment cycle is largely the result of budget and time constraints on the IRS, meaning that individually designed retirement plans may no longer be able to apply for determination letters on a regular basis. Announcement 2015-19 carves out a special exception for new individually designed plans, explaining that such plans will be able to apply for an initial determination letter. It also notes that determination letters may remain available under limited circumstances, to be determined by the IRS. Plan sponsors will still be able to apply for determination letters upon termination of a plan under a separate existing determination letter program for terminating plans.

Understanding that Announcement 2015-19 results in many questions for sponsors of individually designed plans, the IRS has requested comments from the public on the changes to the determination letter program by October 1, 2015. We anticipate significant additional guidance following the comment period and will provide further updates and be in communication with our clients as they become available.

— ROBERT R. GOWER

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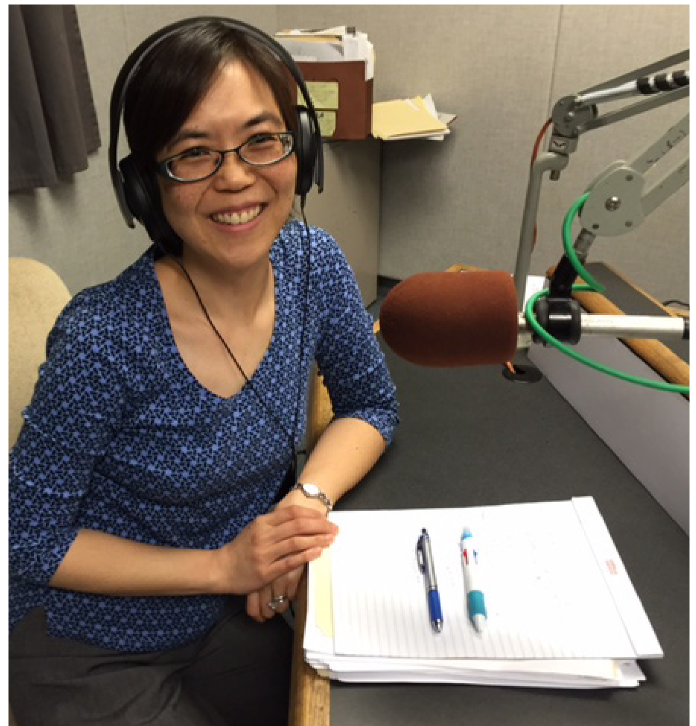
FIRM NEWS



On June 24, **Clarissa Kang** (right) discussed same-sex marriage and employee benefit issues on San Francisco's public radio station KALW 91.7 FM program, "Your Legal Rights."

On July 21, **Tiffany Santos** gave a presentation at the 2015 Western Pension Benefits Conference in San Francisco entitled, *HIPAA Privacy and Security Issues*.

On July 23, **Tiffany** acted as moderator and panel speaker on a webinar sponsored by the Joint Committee On Employee Benefits entitled, *Same-Sex Marriage After Obergefell: What Employee Benefits Lawyers Need To Know Now.*

On August 18, **Jahiz Agard** will speak on the new ACA reporting requirements for the Presidio Benefits Group's ACA Reporting Workgroup.

Brad Huss presented an ERISA litigation update to the Phoenix Chapter of the Western Pension & Benefits Council in January and to the Western Benefits Conference in San Francisco in July. He will be speaking on Record Retention for Benefit Plans at the Bechtel Benefits Conference in Scottsdale in August.

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this *Benefits Report*.

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