Proskauer

The ERISA Litigation Newsletter

December 2015

Editor's Overview

In this month's newsletter, we focus on the recent wave of guidance and case law related to the Affordable Care Act. We also discuss IRS Notice 2015-86, which provides guidance on the application of the U.S. Supreme Court's decision in *Obergefell v. Hodges* requiring states to allow same-sex marriage and to recognize lawful same-sex marriages performed in other states. In addition, the newsletter reviews legislation extending MAP-21 Pension Funding Relief and recent case law addressing attorneys' fees and standing.

Rulings, Filings, and Settlements of Interest

IRS Extends Deadlines for Affordable Care Act Reporting

By Damian A. Myers

> ???Today [Dec. 28, 2015], the IRS released Notice 2016-4, which extended the distribution and filing deadlines for the Affordable Care Act (ACA) reporting requirements set forth in Sections 6055 and 6056 of the Internal Revenue Code (the "Code"). Under Code Section 6055, health coverage providers are required to file with the IRS, and distribute to covered individuals, forms showing the months in which the individuals were covered by "minimum essential coverage." Under Code Section 6056, applicable large employers (generally, those with 50 or more full-time employees and equivalents) are required to file with the IRS, and distribute to employees, forms containing detailed information regarding offers of, and enrollment in, health coverage. In most cases, employers and coverage providers will use Forms 1094-B and 1095-B and/or Forms 1094-C and 1095-C.
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> The chart below shows the new deadlines.

	Old Deadline	New Deadl

Deadline to Distribute Forms to Employees and Covered Individuals	Feb. 1, 2016	March 31, 2(
Deadline to File with the IRS	Feb. 29, 2016 (paper) March 31, 2016 (electronic)	May 31, 20 June 30, 20

Notice 2016-4 brings welcome, albeit late, relief for employers and coverage providers that have been furiously working to meet the original deadlines. Importantly, the IRS explained that because the new deadlines are available to all filers and are more favorable than the extensions that were otherwise available, no additional automatic or permissive extensions will be granted.

The importance of filing by the new deadlines cannot be understated, as the IRS is applying a good faith compliance standard to all timely filed forms reporting 2015 information. Under this standard, the IRS will not assess a penalty for incomplete or incorrect information on the reporting forms as long as the forms were filed on time and the filer can show that it completed the forms in good faith.

Those that do not file by the new deadlines will be subject to penalties under Code Sections 6721 and 6722. The IRS stated in Notice 2016-4 that it would apply a reasonable cause analysis when determining the penalty amount for a late filer. According to the IRS, this analysis will take into account such things as whether reasonable efforts were made to prepare for filing (e.g., gathering and transmitting data to an agent or testing its own ability to transmit information to the IRS) and the extent to which the filer is taking steps to ensure that it can comply with the reporting requirements for 2016.

IRS Notice 2015-87 (Part 1) – IRS Issues New HRA Integration Rules

By Robert Projansky and Damian A. Myers

??? On December 16, 2015, the Internal Revenue Service issued Notice 2015-87 containing guidance on a wide-range of topics under the Affordable Care Act (ACA). In addition to providing guidance on affordability and COBRA matters (which will be described in subsequent blogs), Notice 2015-87 builds upon prior guidance to regulate further the use of health reimbursement arrangements to reimburse

premiums paid for individual market premiums.

By way of background, as described in IRS Notices 2013-54 and 2015-17, the IRS considers arrangements whereby employers reimburse employees (whether on a pre-tax or after-tax basis) for medical-related costs (including premiums) to be group health plans subject to the ACA's market reforms. The problem is that, by their very nature, these health reimbursement arrangements (HRAs) and premium payment plans cannot on their own satisfy certain market reforms, such as the required coverage of preventive services or prohibition on annual limits. Therefore, in order for HRAs to be ACA compliant, they must be "integrated" with a group health plan that meets the ACA's market reforms. Although the IRS allows an HRA to be integrated with a group health plan, including a group health plan not sponsored by the employer sponsoring the HRA, the IRS has unequivocally stated that an HRA cannot be integrated with an individual market plan (subject to the few exceptions described below).

As described here and here, the IRS has already declared after-tax reimbursements for individual market insurance premiums impermissible and has provided guidance on integration with group health plans, Medicare and TRICARE. With Notice 2015-87, the IRS now provides the following additional guidance related to HRAs:

Notice 2015-87 reaffirms that HRAs limited to retirees may reimburse individual market insurance premiums (including Medicare supplement plans) and other medical-related costs. The rationale for this exception is that the Internal Revenue Code and ERISA contain a "retiree-only exception," stating that plans that cover less than two active employees are excepted plans that are not required to comply with the market reforms. This guidance is helpful given the current trend to replace traditional retiree group health plans with HRAs tied private individual insurance marketplaces.

Unless the retiree-only exception applies, unused amounts in an HRA cannot be used to reimburse premiums paid by former employees for individual market coverage even if the amounts were originally earned in the HRA when the HRA was properly integrated with a group health plan. To allow for post-termination reimbursements, an employer could presumably establish a separate payment plan or HRA program covering only former employees and credit this new HRA with the amount of the unused balance from the existing HRA for active employees.

The IRS reiterated statements in prior guidance that amounts credited to an HRA before 2014 may be used to reimburse medical expenses pursuant to the terms in effect before 2014 without violating the ACA market reforms.

An HRA that reimburses medical expenses for an employee and the employee's spouse and dependents cannot be integrated with self-only group health plan coverage provided by the employer. However, the IRS will not enforce this requirement until 2017.

Thus, starting in 2017, an HRA generally cannot reimburse medical expenses for a spouse or dependent not covered by the group health plan coverage sponsored by the employer. However, given that Notice 2013-54 clearly contemplates that an employee's HRA can be integrated with a group health plan sponsored by his or her spouse's employer, one would imagine that the HRA could still reimburse that spouse or dependent if he or she was covered by another group health plan (even if not one sponsored by the participant's employer).

An HRA that reimburses an employee for premiums paid for individual market coverage will not result in a violation of the ACA market reforms if the coverage solely provides excepted benefits. Thus, for example, an HRA could reimburse premiums for individual market dental or vision benefits.

An employer payment plan or HRA that is part of a cafeteria plan established under Section 125 of the Internal Revenue Code must be integrated with a group health plan to be ACA compliant. Some benefits consultants have advised that employers may reimburse employees for individual market premiums if the reimbursement is funded with employee salary deferrals or employer flex credits made to a cafeteria plan. Notice 2015-87 effectively ends this practice.

In order to be compliant with the ACA's market reforms, an HRA apparently must be in both documentary and operational compliance. For example, it is not enough that the HRA not actually reimburse employees for medical coverage purchased on the individual market. Instead, the terms of the HRA must explicitly state that individual insurance reimbursements are not permitted.

Considering the guidance issued over the past few years with respect to HRAs, and Notice 2015-87's apparent documentary compliance requirements, employers should review their HRA documentation to assess compliance with the ACA. Given the potential pitfalls, employers considering establishing an HRA should proceed carefully and consult with counsel. Additional blogs covering Notice 2015-87's other guidance will be forthcoming in the next few days.

IRS Notice 2015-86 — The Limited Effect of *Obergefell*

By Roberta Chevlowe and Damian A. Myers

> ???Last week, the Internal Revenue Service (IRS) issued Notice 2015-86, providing guidance on the application of the U.S. Supreme Court's decision in *Obergefell v. Hodges* to qualified retirement plans and health and welfare plans, including cafeteria plans. Importantly, and as expected, the IRS comments in the Notice that it does not anticipate that *Obergefell* will have a significant impact on the application of federal tax law to employee benefit plans.

By way of background, in 2013, the Supreme Court held in *United States v. Windsor* that Section 3 of the federal Defense of Marriage Act (defining marriage as being between opposite-sex partners for purposes of federal law) was unconstitutional, but the Court left intact the provision pursuant to which states could refuse to allow or recognize same-sex marriages. Two years later, the Court held in *Obergefell* that the Fourteenth Amendment's Due Process and Equal Protection Clauses required states to allow same-sex marriage and to recognize lawful same-sex marriages performed in other states. Following the *Windsor* decision, the IRS issued guidance recognizing, for federal tax and employee benefits purposes, same-sex marriages performed in states permitting such marriages, and providing guidance for plan sponsors.

Qualified Retirement Plans

As expected, IRS Notice 2015-86 clarifies that, for federal tax law purposes, the Obergefell decision does not require the sponsor of a qualified retirement plan to change the terms or operation of its plan because these plans were already required to be amended (generally effective June 26, 2013) to reflect the Windsor decision and subsequent IRS guidance (i.e., recognizing same-sex spouses for federal tax purposes). However, the new Notice points out that a plan sponsor may decide to amend its plan following Obergefell to make certain optional changes or clarifications, such as to provide new rights or benefits with respect to participants who have same-sex spouses. As an example, a plan sponsor may adopt a plan amendment allowing a participant who began receiving a single life annuity prior to the date of the Windsor decision to make a new election of a qualified joint and survivor annuity with his or her same-sex spouse. The Notice also explains that a plan sponsor may still decide to amend its plan to apply Windsor (i.e., recognize same-sex spouses for plan purposes) retroactively to a period prior to the date of that decision, provided that the amendment otherwise complies with applicable plan qualification requirements.

The Notice also makes clear that, for single employer defined benefit plans that are subject to the restrictions contained in Internal Revenue Code (Code) Section 436(c) (i.e., limiting the ability to make plan amendments that increase liabilities if the plan's adjusted funding target attainment percentage is below a certain threshold), a discretionary plan amendment expanding benefits for participants with same-sex spouses in response to Obergefell is subject to the requirements of Code Section 436(c).

The deadline to adopt discretionary amendments contemplated in the Notice is generally the end of the plan year in which the amendment is operationally effective, or in the case of a retroactive amendment described above, the end of the plan year in which the amendment is approved.

Health and Welfare Plans

Notice 2015-86 also confirms that the Obergefell decision does not require any changes to the terms of a health or welfare plan, noting that if such a plan offers benefits to same-sex spouses of participants, the federal tax treatment of such benefits already has been addressed in prior IRS guidance. Nevertheless, the Notice further explains that Obergefell could require changes to the operation of a plan depending on the plan terms. For example, if a plan offers coverage to "the spouse of a participant as defined under applicable state law," and the plan administrator determines that applicable state law has expanded to include same-sex spouses as a result of Obergefell, then the terms of the plan would require coverage of same-sex spouses as of the date of the change in applicable state law.

Finally, the guidance clarifies the ability to permit election changes with respect to health and welfare plans that are offered through a cafeteria plan. The Notice explains that if a health or welfare plan did not permit coverage of same-sex spouses at the beginning of a plan year and the terms or operation of the plan change during the year to permit such coverage, the cafeteria plan may permit a participant to revoke an existing election and submit a new election, provided that the terms of the cafeteria plan allow a participant to make a change in coverage due to a "significant improvement in coverage" (or the plan is amended to allow such changes, as permitted by the Notice).

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Through various forms of guidance issued since the Windsor decision, the IRS and Department of Labor have provided detailed explanations regarding the impact of Windsor and Obergefell on employee benefit plans. Plan sponsors considering amending the plan to accommodate the Supreme Court decisions should consult with ERISA counsel.

Court Awards $11.7M in Attorneys' Fees in Fund Mapping Case

By Neil Shah

???The court in *Tussey v. ABB Inc.*, No. 2:06-cv-04305 (W.D. Mo. Dec. 9, 2015), a long-running suit alleging that ABB failed to monitor recordkeeping fees and improperly mapped participants' investments (previously reported on here), awarded class counsel $11.7 million in attorneys' fees and affirmed its earlier award of $2.28 million in costs and class representative awards. The court explained that the defendant, in its view, "was not merely negligent but rather motivated by self-

interest," and the case made a "significant, national contribution" towards educating "plan administrators, the Department of Labor, the courts and retirement plan participants about the importance of monitoring recordkeeping fees and separating a fiduciary's corporate interest from its fiduciary obligations." The court also rejected defendant's argument that the fee award was disproportionate to the $13.4 damage recovery because defendant had spent $42 million in attorneys' fees defending the case, and that "[t]ying Plaintiffs' counsel's fees to a percentage of the monetary recovery would unfairly deprive them of compensation for the time spent successfully litigating important claims and issues."

So-Called Cadillac Tax Delayed until 2020

By Damian A. Myers

???On December 16, 2015, the House of Representatives struck a tentative deal on an appropriations bill that would fund the federal government through the 2016 fiscal year. Among other things, the 2016 Consolidated Appropriations Bill would delay the effective date of the controversial 40% excise tax on high-cost health plans (commonly referred to as the "Cadillac Tax") for two years. The bill would also make the Cadillac Tax a tax-deductible expense. The tax (which was described in detail here and here) was set to become effective in 2018, and many employers have already started implementing plan design changes in an effort to mitigate the impact of the tax. Assuming the bill is signed into law, employers and other health coverage providers can pause these efforts.

Congress is expected to vote on the bill as soon as December 17, 2015, with the President set to sign the bill into law the following week. Despite the two-year delay, the Cadillac Tax remains the subject of intense political scrutiny. With a bipartisan push to repeal the tax and nearly all presidential candidates expressing a similar desire, the future of the Cadillac Tax is uncertain at best.

Sub-Assignee Has Standing to Assert ERISA Claims

By Madeline Chimento Rea

???The Eleventh Circuit held that a sub-assignee's claim for payment of a chiropractor's bills against Blue Cross and Blue Shield of Florida were within the scope of ERISA and thus determined that the district court properly declined to remand the case to state court. In so holding, the Court explained that the sub-assignee could have brought its claims under ERISA § 502(a) because each count was based on an alleged wrongful denial of coverage under the plan. The Court also concluded that the sub-assignee had standing to assert its claims because it

acquired derivative standing through an assignment of rights and determined that there is nothing in ERISA prohibiting non-healthcare providers from obtaining derivative standing through a sub-assignment. Moreover, in the court's view, permitting such an exception furthers the goals of ERISA and protects plan participants. The case is *Gables Ins. Recovery, Inc., v. Blue Cross & Blue Shield of Fla., Inc.*, No. 15-cv-10459, 2015 WL 7729474 (11th Cir. 2015).

DOL Proposes to Bring ERISA Disability Denials in Line with the Affordable Care Act

By Neil Shah

- ???On November 18, 2015, the Department of Labor (the "Department") published a notice of Proposed Rulemaking at 80 Fed. Reg. 222 (the "Proposed Rule") to amend ERISA's claims procedures (29 C.F.R. 2560.503-1) as they apply to claims for disability benefits. One of the purposes of the Proposed Rule is to make ERISA's claims procedures for disability claims consistent with the Affordable Care Act's claims procedures for group health plans. The Proposed Rule contains several components.

First, the Proposed Rule expands a disability plan's duty to ensure that claim decisions are free from conflicts of interest. To that end, the Proposed Rule amends subsection (b) of the claims procedures to require that a disability plan's claims procedures must "ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision." The amendment further provides that "decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits."

Proskauer's Perspective: *Even prior to the proposed amendment, many plans had already taken affirmative steps to ensure the independence and impartiality of the persons involved in the decision-making process. The Proposed Rule therefore likely will not present an additional burden to plans.*

Second, the Proposed Rule amends subsection (g)(1) of the claims procedures to expand the types of information that a plan must include in an adverse benefit determination of disability benefits. Specifically, it requires a plan to include: (i) a discussion of the decision, including the basis for disagreeing with the views of a treating physician or determinations by the Social Security Administration; (ii) the specific criteria relied upon in making the adverse benefit determination or a statement that no such specific criteria exist; and (iii) a statement that the claimant is entitled to receive "reasonable access" to all documents and information relevant to his or her claim, upon request and free of charge.

Proskauer's Perspective: *The Department noted that several courts previously held that the failure to provide a discussion of the decision or the specific criteria relied upon in making the adverse benefit determination could make a claim denial arbitrary and capricious. The Proposed Rule therefore appears to be an effort to extend this standard across other jurisdictions.*

Third, the Proposed Rule replaces subsection (h)(4) of the claims procedures to require a plan to provide a claimant any additional evidence, information, or additional rationales for denying the claim developed during the course of an appeal, and to allow the claimant a reasonable opportunity to respond before the plan issues a final decision. Because these rules conflict with the detailed timing rules contained in subsection (i) of the claims procedures, the Department has requested comments on "whether, and to what extent, modifications to the existing timing rules are needed."

Proskauer's Perspective: *Many plans already provide claimants an opportunity to respond to new evidence during the appeals process; the Department's request for comment underlines its interest in ensuring that plans and participants will have adequate time to engage in a dialogue concerning the evidence presented during the administrative review process.*

Fourth, the Proposed Rule allows a party to deem a plan's administrative remedies exhausted if the plan fails to adhere to the claims procedures. The Proposed Rule also provides an exception for certain types of violations that are: (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond a plan's control; (iv) in the context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of noncompliance. If a court determines that any of these exceptions apply, the Proposed Rule requires the plan to re-route the underlying claim through its internal appeals process and to provide the claimant notice of the resubmission.

Proskauer's Perspective: *The Proposed Rule on when administrative remedies are deemed exhausted mirrors the existing standard adopted by the courts, and the safe harbor is similar to the "substantial compliance" doctrine that many courts had previously adopted to excuse minor digressions from the claims procedures.*

Fifth, the Proposed Rule expands the definition of "adverse benefit determination" for disability claims to include "any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time)." The Department noted that many rescissions of coverage (*e.g.*, as part of an internal audit) do not trigger the procedural protections in the ERISA's existing claims procedures, and that this gap may make participants and beneficiaries "face dangerous and unwanted lapses in disability coverage without their knowledge, and without knowing how to challenge the rescission."

Proskauer's Perspective: *Plans should consider the effect of this proposal on their arrangements with claims administrators and third-party vendors. By way of example, many claims administrators contract with outside vendors to identify factors that warrant rescinding disability coverage. Coupled with other provisions in the Proposed Rule, the outside vendor's determination may constitute an adverse benefit determination and the information it considered in rendering its determination may have to be produced to the claimant.*

Sixth, the Proposed Rule requires that notices and disclosures be both culturally and linguistically appropriate for claimants who reside in a county where 10% or more of the population are literate in only one non-English language. Affected individuals must be provided access to a customer assistance process (*e.g.*, telephone hotline) to answer questions and assist them with filing claims and appeals in the non-English language.

Proskauer's Perspective: *The Department identified 225 affected counties in the United States, the overwhelming majority of which contained Spanish-language speakers. Information on these counties is available on the Department's website, and plans should assess whether their customers reside in the affected counties.*

Seventh, the Proposed Rule seeks comments on a requirement that plans be required to prominently identify any contractual limitations period both in the plan and in any adverse benefit determination, and to provide updated notices should that date change. The Department noted that the federal circuit courts to have considered the issue are split, and that "plans may be in a better position than claimants to understand and to explain what those provisions mean."

Proskauer's Perspective: *In response to the current split in authority, and in an abundance of caution, many plans have already amended participant communications to prominently include this information. Plans should nevertheless consider whether their voluntary efforts comply with the Proposed Rule.*

Lastly, the Proposed Rule makes a technical correction to subsection (i)(3)(i) of the claims procedures clarifying that the extended time frames for deciding disability claims only apply to multi-employer plans.

Comments to the Proposed Rule are due by January 19, 2016.

Proskauer's Perspective

Many plans already have implemented procedures that are consistent with the Proposed Rule's requirements in light of existing case law and developing "best practices." Nevertheless, plan administrators should not rush to amend their plan documents until the Proposed Rule is finalized and approved for implementation. In the meantime, administrators should begin to review their existing policies and procedures and assess their ability to comply with the newly added provisions.

Supreme Court Agrees to Hear Contraceptive Mandate Cases

By Benjamin Saper

- ???As part of its requirement that non-grandfathered group health plans provide benefits for certain preventive care without cost sharing, the Affordable Care Act ("ACA") requires these plans to cover at least one form of women's contraception in

each of the 18 methods identified by the Food and Drug Administration. The U.S. Supreme Court previously ruled in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S.Ct. 2751 (2014) that the contraceptive mandate was invalid with respect to *for-profit*, closely held corporations whose owners objected to providing the insurance coverage on religious grounds.

Shifting its focus to non-profit organizations, the Supreme Court has now agreed to hear arguments on whether the application of these requirements to *non-profit* organizations with faith-based objections violates the Religious Freedom Restoration Act ("RFRA") notwithstanding a regulatory "accommodation" provided to these organizations. See Order Granting Certiorari, *Zubik v. Burwell* (No. 14-1418); *Priests for Life v. Burwell* (No. 14-1453); *Roman Catholic Archbishop of Washington v. Burwell* (14-1505); *Little Sisters of the Poor Home for the Aged v. Burwell* (15-105), *Southern Nazarene University v. Burwell*; (15-119); *Geneva College v. Burwell* (15-191); *East Texas Baptist University v. Burwell* (15-35).

The "accommodation" allows non-profit organizations holding themselves out as religious organizations to avoid covering contraception under their health plans if, on account of religious objections, they oppose providing the coverage. In order to avail itself of the accommodation, an organization must notify its insurer or third party administrator of its eligibility for the accommodation or notify the federal government of its religious objection and provide information so that the government can set up the coverage with the insurer or third party administrator. Once this occurs, the insurer or third party administrator must provide coverage for the women's contraceptive services at no cost to the participant/dependent or the religious organization.[1]

At issue in the seven cases in which the Supreme Court will hear argument, is whether the notice requirement to elect an "accommodation" to the contraceptive coverage requirement substantially burdens the nonprofits' religious exercise in violation of RFRA, whether the government has a compelling interest, and whether there is a less restrictive way to achieve the goal of providing women free contraceptive coverage. The Administration has argued that this accommodation takes the entities themselves out of having to provide coverage in violation of their beliefs, while still allowing the government to meet its interest in providing access to free birth control. Several circuit courts had aligned in agreeing with the Administration's view. In September, however, the Eighth Circuit issued a contrary ruling and held that, although the interest in universal free contraception was legitimate, the government did not meet this interest by the "least restrictive means" as required by RFRA. The Eighth Circuit listed less restrictive alternatives to the current accommodation such as the government providing birth control itself; making it available through the ACA insurance marketplaces; or providing it through health centers, clinics, and hospitals.

It is anticipated that the Supreme Court will now resolve the circuit split.[2] The cases are expected to be argued in March, with a decision likely being issued in late June.

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[1] As a result of Hobby Lobby, the regulatory agencies extended this accommodation to closely held for-profit corporations that adopt a resolution establishing that the corporation objects to some or all contraceptive services on account of the owners' sincerely held religious beliefs. See 45 CFR §147.131 (b)(2)(ii).

[2] The Eighth Circuit cases, while creating the circuit split, are not before the court.

New Affordable Care Act FAQs Provide Guidance on Preventive Services, Wellness Programs and Mental Health Parity

By Damian A. Myers

??? On October 23, 2015, the Departments of Labor, Health and Human Services and Treasury (the "Agencies") jointly released their twenty-ninth (XXIX) set of Frequently Asked Questions (FAQs) about Affordable Care Act (ACA) implementation. This latest set of FAQs generally (1) clarify that certain services performed ancillary to various preventive services must also be covered without imposition of cost-sharing, (2) explain that in-kind incentives provided through

wellness programs are also subject to limitations under HIPAA and (3) state that medical necessity guidelines related to mental health and substance abuse benefits must be provided to participants upon request. Additional detail is provided below.

Preventive Services

The ACA generally requires that non-grandfathered group health plans provide services designated as preventive care without the imposition of cost-sharing. If a group health plan provides a preferred network of service providers, this requirement generally applies only to in-network services. Since the enactment of the ACA, the agencies have released numerous guidelines regarding coverage of preventive services. The new FAQs provide the following additional guidance:

- **Lactation Counseling.** The new guidance states that group health plans must provide participants with a list of in-network lactation counseling providers. This information can be included in other in-network provider directories. Additionally, the FAQs note that if there are no lactation counseling providers within the preferred network, group health plans must cover without cost-sharing lactation counseling services obtained outside of the network. The Agencies recognized the general rule that prohibits cost-sharing for in-network services only, but explained that this rule is contingent on a particular service being available within the network. Also, if a state does not license lactation counselors, a group health plan must cover counseling services provided by another provider (such as a registered nurse) acting within the scope of his or her license or certification. Group health plans are not permitted to limit coverage of lactation counseling without cost-sharing to services provided on an inpatient basis. Although plans may apply reasonable medical management techniques, requiring cost-sharing for outpatient (but not inpatient) lactation counseling services is not reasonable. Finally, coverage of breastfeeding equipment cannot be limited to a specific time period following birth. Instead, breastfeeding equipment must be covered with no cost-sharing for the duration of breastfeeding (as long as the covered individual remains enrolled in the plan).

- **Obesity.** The FAQs state that plans are not permitted to impose general exclusions on weight management services for adult obesity. The US Preventive Services Task Force (USPSTF) has designated screening for adult obesity as a preventive service. In addition to screening, plans must cover with no cost-sharing weight management programs for individuals with certain risk factors.

- **Colonoscopy.** The USPSTF has designated a colonoscopy as a preventive care service for certain individuals. The FAQs state that a consultation by a specialist prior to a colonoscopy screening must be covered without cost-sharing if the attending provider determines the consultation is medically appropriate. Additionally, the FAQs expand colonoscopy coverage to include post-screening pathology exams. The agencies consider a pathology exam of a polyp biopsy to be an integral part of a colonoscopy, and thus, this type of exam must be covered without cost-sharing beginning 60 days after the publication of the FAQs.

- **BRCA Testing.** Following-up on previous guidance related to BRCA testing, the FAQs state that women found to be at an increased risk of BRCA mutations using a family history screening tool must receive coverage without cost-sharing of genetic counseling and BRCA mutation testing.

- **Religious Exemptions for Contraceptive Coverage.** The FAQs provide instructions on how religious organizations can avoid paying for contraceptive coverage.

Wellness Programs

The new guidance also contains one FAQ regarding wellness programs. As previously reported, the Department of Labor and Equal Employment Opportunity Commission are currently crafting guidelines that will describe, among other things, when a wellness program is a group health plan for purposes of the HIPAA wellness regulations and future EEOC regulations (a description of the HIPAA wellness regulations and the EEOC proposed regulations can be found here and here). In general, the HIPAA wellness regulations provide that certain wellness programs will not be considered discriminatory based on a health factor if the incentives offered under such programs are limited to 30% (50% in the case of tobacco-related program) of the cost of coverage. The EEOC proposed regulations contain similar, though by no means identical, rules.

The newest FAQs clarify that in-kind incentives, such as gift cards, sports gear or other items, must also be considered when determining whether the incentive limitation has been reached. Both the HIPAA wellness regulations and EEOC proposed regulations indicate that the incentive limitations apply only to those wellness programs that are, or are part of, group health plans (note that HIPAA in general only applies to group health plans). Many employers offer wellness programs that do not involve premium discounts, rebates or surcharges to their entire workforce. For example, an employer might offer its employees the opportunity to get a free wearable fitness tracker upon completing a nutrition course or walking program. The prevailing understanding has been that this type of program is not a group health plan and, thus, is not subject to HIPAA or the EEOC proposed regulation's incentive limitations. Unfortunately, the new FAQs do not address when in-kind incentives are connected to a group health plan. Additional Agency guidance would be helpful.

Mental Health Parity

The Mental Health Parity and Addition Equity Act of 2008 requires that group health plans provide mental health and substance abuse benefits in parity with medical and surgical benefits. Although the requirements are complex (a summary can be found here), the basic structure of the law is that both quantitative limitations (e.g., dollar and visit limits) and nonquantitative limitations (e.g., medical management techniques) applied to mental health and substance abuse benefits must be the same or better than the limitations applied to comparable medical and surgical benefits.

The new FAQs contain clarifying guidance related to disclosure of nonquantitative limitations. In particular, the Agencies stated that the criteria for medical necessity determinations with respect to both mental health and substance abuse benefits and medical and surgical benefits must be provided to current or potential participants or beneficiaries upon request. Plan administrators may not withhold medical necessity criteria on the basis that it is proprietary. However, plan administrators may offer participants a summary document describing the criteria in layperson's terms. Nevertheless, this summary document cannot substitute for the actual guidelines, so the detailed criteria still must be provided when requested.

Employers and plan administrators should review their group health plan practices and procedures carefully in light of this new guidance.

Bipartisan Budget Act Extends MAP-21 Pension Funding Relief and Increases PBGC Premiums

By Mary Bresnan

- On Monday, November 1, 2015, President Obama signed into law the Bipartisan Budget Act of 2015 (the "BBA") which brings familiar changes for sponsors of defined benefit pension plans. Similar to the Moving Ahead for Progress in the 21st Century Act in 2012 ("MAP-21"), the BBA provides relief from pension funding obligations while increasing PBGC premiums. The following summarizes the two major changes under the BBA that affect pension plans.

  - **Extension of MAP-21 Rates** – Under the BBA, plan sponsors of single employer defined benefit plans may continue to measure pension liability using the 25-year average of segment rates plus or minus a 10% corridor (i.e., the MAP-21 rates) through 2020, with a 5% increase applying to each year thereafter through 2023. The corridor will remain at 30% after 2023. Prior to enactment of the BBA, the 10% corridor was scheduled to increase by 5% each year beginning after 2017 through 2020, and would have remained at 30% after 2020. With interest rates at historical lows, limiting the rates based on the 25-year average tends to increase the interest rates, and therefore lowers the minimum funding requirements. Of course, the benefit to a plan sponsor from the decreased funding obligation resulting from the BBA extension of the MAP-21 rates will be offset by the increased PBGC premiums.

  - **Increased PBGC Premiums** – The BBA increases both the annual fixed premiums and variable rate premiums that sponsors of single employer defined benefit pension plans are required to pay to the Pension Benefit Guaranty Corporation (the "PBGC") effective for plan years beginning in 2017 through 2019. The fixed premium is a per participant fee and the variable rate premium is based on the plan's level of underfunding.

The increased premiums contained in the BBA are even higher than the amounts originally proposed and reported. The increased rates are as follows:

Plan years beginning in...	Increased Fixed Premium	Variable Rate Premium I Inflation and Increased b
2017	$69	Additional $3

2018	$74	Additional $4
2019	$80	Additional $4

The BBA provides that after 2019, the fixed premium will be indexed for inflation. The BBA also accelerates the due date for PGBC premiums by one month for plan years beginning in 2025. Unlike Map-21, the BBA does not affect PBGC premiums for multiemployer plans.

ACA Automatic Enrollment Mandate Repealed by Bipartisan Budget Act

By Damian A. Myers

??? On Monday, November 2nd, the President signed the Bipartisan Budget Act of 2015 (BBA). Some legislators had hoped that a budget deal would at least include a repeal of the controversial 40% excise tax on high-cost health care (the so-called "Cadillac Tax"). However, the BBA left the Affordable Care Act (ACA) largely intact, with the ACA's automatic enrollment mandate being the only casualty.

The ACA added Section 18A to the Fair Labor Standards Act requiring employers with 200 or more full-time employees to automatically enroll new full-time employees in a health benefit plan and to automatically continue coverage during open enrollment. The statute also required that any full-time employee who was automatically enrolled be given notice and an opportunity to opt-out of the coverage. Ostensibly, the automatic enrollment requirement was included in the ACA as a way to encourage health coverage (similar to design features allowing automatic enrollment in defined contribution retirement plans).

Given the nature of most employer health benefit programs, the statute left open a large number of questions. For instance, who constitutes a full-time employee for this purpose? Would dependents also need to be enrolled? Which benefit option must an employee be enrolled in? Is a refund necessary for an employee who opts-out? Recognizing the need for implementing regulations, the Department of Labor issued guidance delaying the effective date of the automatic enrollment mandate until regulations were released. No such regulations were ever proposed.

Critics of the automatic enrollment mandate largely viewed it as unnecessary. The ACA's employer shared responsibility mandate already requires that employers with more than 50 full-time employees (including full-time equivalent employees offer adequate coverage to 95% (70% in 2015) of their full-time workforce. Also, many of employer health programs already provide for automatic continuance of health coverage during open

enrollment (absent, of course, an affirmative election otherwise). Finally, with the individual mandate requiring enrollment in health coverage to avoid a tax penalty, individuals already have an incentive to enroll in health coverage. Therefore, the policy justifications (i.e., encouraging enrollment) present in the retirement plan context simply did not apply to health care.

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