Employee Health & Benefits

COMPLIANCE CENTER OF EXCELLENCE

COMPLIANCE NEWSLETTER

IN THIS EDITION:

Automatic Enrollment Given a Boost

U.S. Department of Labor (DOL) Issues Letter Indicating ERISA Preemption Applies to State Payroll Withholding Laws

On December 4, 2018, the DOL issued a letter in response to an inquiry from the American Council of Life Insurers (ACLI) about the interaction of ERISA and state wage withholding laws that require an affirmative written election before payroll deductions may be taken as contributions toward coverage in an employer-sponsored benefit plan.

ACLI's inquiry related to employer-provided disability coverage, but the DOL responded more broadly and indicated that ERISA preempts (overrides) such a state law. This generally means that, unless an employee has waived coverage, an employer with an ERISA-covered benefit plan may automatically enroll employees in coverage and deduct the required contributions from employee paychecks. This letter does not actually represent a change in the DOL's position or introduce any new guidance, but it is a welcome clarification that allows employers flexibility to increase group plan participation, spreading risk, and expanding protection for their workers.

In support of its position for the preemption of state wage withholding laws in connection with enrollment in an ERISA plan, the DOL cited various court cases and previous Advisory Opinions addressing circumstances in which state laws have been found to relate to an ERISA benefit plan. To the extent an applicable state law is interpreted to regulate or limit an employer's ability to enroll employees or to make plan-related payroll deductions, it is the DOL's position that such state law will be preempted and will not apply to the employer's ERISA plan.

ERISA Preemption Primer

Basically, the legal doctrine of ERISA preemption provides that a benefit plan subject to ERISA may generally ignore any conflicting state law that may relate to the benefit plan with certain limited exceptions. The most significant exception allows states to regulate insurance within their borders, and state laws regulating insurance are "saved" from ERISA preemption. This is why state insurance mandates apply to fully-insured ERISA plans while self-insured ERISA plans may choose to ignore them.

Note: The DOL's letter did not address any of the exceptions to ERISA preemption such as the exception saving state insurance laws. As a result, the letter shouldn't be viewed as sanctioning other actions an employer might want to take with respect to a fully-insured benefit plan.

Notes and Practical Issues

If an employer wants to implement an automatic enrollment policy, there are a few additional considerations that should be taken into account. For example, ERISA imposes certain fiduciary obligations on an employer in its role as plan administrator. Among other things, this requires comprehensive communications pieces about any plan terms and conditions as well as a clear explanation of the employee's right to decline coverage and the exact procedures and timeframes for doing so.

We realize that the inquiry dealt specifically with disability coverage and that many employers provide ancillary coverage such as basic life, AD&D, and disability at no cost to employees. It's also worth noting that disability was a tricky example to use, as many self-insured short term disability programs may not actually be eligible for ERISA preemption.[1] The DOL letter did not address whether the required contributions for benefits subject to automatic enrollment could be taken pre-tax or post-tax, which is really an IRS matter, but either should be permissible.[2] This contribution approach should be included in the communication material described earlier.

The DOL's response does support the use of an automatic enrollment approach with respect to medical/Rx coverage, although an employer may not wish to do so for various reasons including the higher required employee contributions for these benefits compared to ancillary coverage like life and disability coverage. Also, the Affordable Care Act's employer shared responsibility requirement can be met merely by offering coverage without regard to whether an employee actually enrolls. In any event, the employee must be given the opportunity to waive coverage.

ABOUT THE AUTHOR

Dawn Kramer is the Team Leader for Compliance Consulting for the Employee Health & Benefits practice in Marsh & McLennan Agency's Upper Midwest Region.

[1] Many employer-provided self-insured short term disability programs will fall within ERISA's payroll practice exception, and ERISA's preemption rules will not apply to them.
[2] An employer may prefer disability contributions to be taken post-tax so that the disability benefits will be tax free when paid to participants.

Government Considering Modifications to HIPAA Privacy and Security Rules

HHS Requests Feedback

The Health Insurance Portability and Accountability Act (HIPAA) includes the HIPAA Privacy and Security Rules (the "Rules") addressing the privacy and security of Protected Health Information (PHI). In a nutshell, Protected Health Information (PHI) is:

- Information about a past, present, or future health condition, treatment for a health condition, or payment for the treatment of a health condition;
- Identifiable to a specific individual;
- Created and/or received by a Covered Entity or Business Associate acting on behalf of a Covered Entity (as those terms are defined under the Rules); and
- Maintained or transmitted in any form.

We earlier addressed the Rules and their impact on employer-provided health plans and third parties providing services to those plans as a two-part series in our October and November 2018 newsletters.

The U.S. Department of Health and Human Services (HHS) released a Request for Information (RFI) through its Office for Civil Rights (OCR) in December 2018, for the purposes of soliciting feedback to help the OCR identify provisions in the Rules that unnecessarily affect the delivery of value-based health care or the coordination of patient care without meaningfully contributing to the protection of an individual's PHI. The ultimate goal is to enable the use of more innovative care and payment models that have developed since the Rules were initially implemented intended to improve cost, effectiveness, and health outcomes.

This RFI signals the first meaningful change to the Rules in several years is now on the horizon. The four key areas for which the OCR has provided observations and requested feedback are discussed below. Interested parties have until February 12, 2019 to provide comments.

1. **Promote the sharing of Information to health care providers –** The current Rules provide individuals the right to access their own PHI, which must generally be made available by a Covered Entity within 30 days of a request. The Rules contain no explicit requirement for a Covered Entity to disclose records requested by a health care provider. The OCR believes this is causing issues with care coordination and case management initiatives. The OCR also notes instances of health care providers refusing to share PHI with each other in the [often mistaken] belief it may be a violation of HIPAA's Rules.

   In addition, other parties are often involved in necessary activities not involving direct patient treatment that require PHI to function, such as population health management vendors, claims management, and utilization review. The OCR believes these activities are being

hampered by the Rules' existing minimum necessary disclosure standards which do not apply when PHI is disclosed for treatment.

2. **Sharing PHI with family members –** The OCR is concerned that providers are reluctant to share PHI with family members and caregivers in emergency situations out of an abundance of caution even though a patient in an emergency situation may not be able to effectively communicate with the provider, and the Rules generally permit PHI to be shared with an immediate family member or designated caregiver. This has come to light most dramatically in situations involving opioid overdoses and patients suffering from mental health issues.

3. **Revising the required accounting of disclosures from an Electronic Health Record –** As currently written, the Rules require *disclosures* of PHI for treatment, payment, and health care operations to be included in a requested accounting of disclosures for PHI maintained in an Electronic Health Record. The OCR notes that is has proven challenging to Electronic Health Record vendors to identify the difference between PHI that has been "accessed" (i.e. obtained by a user) versus PHI that has been "disclosed" (i.e. proactively shared with a user). The OCR requests information about whether all such uses and disclosures from an Electronic Health Record should be included in a requested accounting of disclosures.

4. **Relief for providers with notices of privacy practices –** The OCR requests feedback on whether the requirement for health care providers to make a good faith effort to obtain written confirmation that a patient received a notice of privacy practices should be modified or eliminated.

ABOUT THE AUTHOR
Sue Mathiesen is the Director for Research and Education in the Employee Health & Benefits Practice for Marsh and McLennan Agency's Upper Midwest Region.