



THE HEALTH LAWYER

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A CRYSTAL BALL: MANAGED CARE LITIGATION IN LIGHT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Joseph Friedman, Esq.
Elizabeth Collura, Esq.
Clark Hill, PLC
Pittsburgh, PA

Neda M. Ryan, Esq.
Clark Hill, PLC
Birmingham, AL

Jeremy D. Bowen, Esq.
Clark Hill, PLC
Phoenix, AZ¹

Over-Arching Litigation Issues

PPACA expands the administration of healthcare in numerous ways, including granting more responsibility to states to administer its requirements. As such, while it is arguable whether a private right of action exists under PPACA and while many provisions may be enforceable by plaintiffs utilizing the federal Employee Retirement Security Act of 1974 ("ERISA"),³ state law claims will begin to play a larger, more prominent role in the managed care litigation space. Specifically, with the administration of state Health Insurance Marketplaces (the "Exchanges"), health plans are now more susceptible to liability under the state and federal fraud and abuse laws because of the influx in federal funding to pay or subsidize costs in connection with the Exchanges.

Jurisdiction

PPACA expands the potential for litigation involving health plans both in federal and state court. Before PPACA, most individuals' health insurance was supplied by employers and, thus subject to ERISA, which, in part, sets forth minimum standards for

Introduction

With the enactment of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("PPACA")² in March 2010, controversy ensued while both citizens and states quickly filed court challenges across the country. Although the nation finds itself over four years and tens of thousands of pages of regulations beyond that date in 2010, many industries have just begun to scratch the surface of litigation arising out of the law's enactment. One such industry – the managed care industry – has been, and most likely will continue to be, gearing itself up for increased litigation.



By Sidney Welch, Guest Chair

The Relevance of Today's Conflict Management

As I reflect at the conclusion of another election season, perhaps the only thing most people seem to agree on is that there's a lot of disagreement in Washington, and that the consequence has been gridlock and inaction. The healthcare industry and our clients are not immune from this syndrome. I cannot imagine a time more ripe for effective conflict management. Luckily, we are well prepared, as our Section formed the Task Force on alternative dispute resolution ("ADR") and Conflict Management in Health Care ("Task Force") two years ago.

Some of us have witnessed ADR's constructive techniques firsthand. Others are not yet believers. However, I'd like to take a moment to ask you to think beyond what this term might have meant several years ago – apology systems in medical malpractice litigation; mediation and arbitration for the litigator – to give you a glimpse into what effective conflict resolution has to offer the healthcare industry and our Section today and for the future.

Pressure points litter today's healthcare landscape in the following forms, just to name a few:

- Conflict between hospitals and physicians related to costs versus clinical services and outcomes regarding operating a particular service line;
- Tensions among nursing staff, physician(s), and administrators over staffing and resources;
- Deal negotiation and the practical realities encountered in operationalizing today's deal;
- Disruptive conduct from frustrated physicians;
- Disputes between payors and providers regarding participation contracts, reimbursement structures, or various practices, such as tiering, rating, etc.;
- Medical staff tensions, including but not limited to employed versus non-employed medical staff members, physicians versus administrators, and economic or anti-competitive peer review;
- Practice acquisition negotiations and subsequent, related employment disputes, typically involving staffing, compensation renegotiation, fair market value ("FMV") and weighted Relative Value Unit ("wRVU") conflicts;

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The Health Lawyer (ISSN: 0736-3443) is published by the American Bar Association Health Law Section, 321 N. Clark Street, Chicago, IL 60654-7598. Address corrections should be sent to the American Bar Association, c/o Member Records.

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Chair Michael E. Clark <i>Duane Morris, LLP</i> Houston, TX 713/402-3905 meclark@duanemorris.com	Vice Chair C. Joyce Hall <i>Watkins & Eager</i> Jackson, MS 601/965-1982 jhall@watkinseager.com	Financial Officer Alexandria Hien McCombs <i>Concentra</i> Addison, TX 972/364-8241 alexandria_mccombs@concentra.com
Chair-Elect William W. Horton <i>Jones Walker, LLP</i> Birmingham, AL 205/244-5221 whorton@joneswalker.com	Secretary Hilary H. Young <i>Joy & Young, LLP</i> Austin, TX 512/330-0228 hyoung@joyyounglaw.com	Financial Officer-Elect Eugene M. Holmes <i>The Walt Disney Company</i> Burbank, CA 818/560-2611 eugene.m.holmes@disney.com
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Section Delegates to the House of Delegates

Gregory L. Pemberton <i>Ice Miller</i> Indianapolis, IN 317/236-2313 gregory.pemberton@icemiller.com	J. A. (Tony) Patterson, Jr. <i>Northwest Healthcare Corporation</i> Kalispell, MT 406/751-4175 tpatterson@krmc.org
---	---

Council

Michelle Apodaca <i>Waller Law Firm</i> Austin, TX 512/328-9300 michelle.apodaca@wallerlaw.com	Denise Glass <i>Fulbright & Jaworski LLP</i> Dallas, TX 214/855-8063 dglass@fulbright.com	Shannon H. Salimone <i>Holland & Knight LLP</i> Tallahassee, FL 850/425-5642 shannon.salimone@hklaw.com
Marcelo Corpuz <i>Walgreen Co.</i> Deerfield, IL 847/315-5228 marcelo.corpuz@walgreens.com	Hal Katz <i>Husch Blackwell LLP</i> Austin, TX 512/703-5715 Hal.Katz@huschblackwell.com	W. Thomas Smith <i>University of Florida College of Pharmacy</i> Gainesville, FL 352/273-5657 tsmith@cop.ufl.edu
Adrienne Dresevic <i>The Health Law Partners</i> Southfield, MI 248/996-8510 adresevic@thehlp.com	John H. McEniry IV <i>mediStat Specialized Pharmacy Services</i> Foley, AL 251/923-3011 jay@medistat.com	Sidney Welch <i>Kilpatrick Townsend & Stockton LLP</i> Atlanta, GA 404/815-6036 swelch@kilpatricktownsend.com

Young Lawyer Division Liaison

Greg L. Gambill
Davis Graham & Stubbs LLP
Denver, CO
303/892-7385
Greg.Gambill@dgslaw.com

Board of Governors Liaison

William Thomas Coplin, Jr.
William Thomas Coplin, Jr.
Demopolis, AL
334/289-3880
coplinlaw@bellsouth.net

Section Director

Wanda Workman
American Bar Association
321 N. Clark Street
Chicago, IL 60654-7598
T: 312/988-5548 F: 312/988-5814
wanda.workman@americanbar.org

The Health Lawyer Editor

Marla Durben Hirsch
Potomac, Maryland
301/299-6155
mdhirsch@comcast.net

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health benefit plans established by employers. Because ERISA is a federal law, with its preemptive effects, benefit claims against employers or group health plans subject to ERISA have usually arisen under federal law. Since PPACA imposed additional requirements on ERISA group health plans, it can be expected that ERISA litigation could increase as plan participants and providers seek to enforce the PPACA mandates. With the increase of individual health insurance policies being purchased at the Exchanges set up by PPACA, which policies are not subject to ERISA, the door has been opened for additional state and federal law claims, including claims by individuals and providers suing to enforce the PPACA rules applicable to these individual policies.

The implementation of the Exchanges established under PPACA and PPACA's individual mandate will cause more individuals to become purchasers of individual health insurance policies – a shift from the country's traditional employer-sponsored healthcare model. This shift in enrollment will lead to an uptick in lawsuits against insurance companies in state court alleging state law violations not subject to ERISA and federal jurisdiction. Such causes of action could include, *inter alia*, common law breach of contract and tort claims, claims of bad faith under state statutes, and potential state and federal False Claims Act (“FCA”) claims.⁴ Additionally, because PPACA sets forth certain minimum standards for insurance reform, leaving much of the details regarding implementation and regulation to the states, claims alleging causes of action under state or federal law — relating to the PPACA benefit and other mandates applicable to individual-health insurance policies — will likely increase.

No Explicit Private Right of Action

With the rocky and less-than-elegant start to the Exchanges last year, the legal and health insurance industries should expect disputes to arise between disappointed and disgruntled plan participants and their health plans. PPACA is silent as to whether it provides for a private right of action, namely, the right of a private party to seek judicial relief from injuries caused by another's violation of a legal requirement. Although the private right of action does not explicitly exist, it has not prevented plaintiffs from attempting to raise PPACA as a cause of action⁵ and/or from plaintiffs raising arguments of Congressional intent as a basis for a private cause of action to exist. Additionally, PPACA claims may be raised through other statutes that do contain a private right of action (e.g., ERISA or state insurance or other law) by applying PPACA's relevant provision as the legal standard against which the claim is measured.

Historically, a lack of specific language in a statute to confer a private right of action has not always prevented plaintiffs from arguing — and courts from holding — that Congress *intended* to include a private right of action in a statute.⁶ The U.S. Supreme Court has stated that whether a statute creates a cause of action, either expressly or by implication, is a matter of statutory construction and a matter of whether Congress intended to create the private remedy asserted.⁷ Moreover, the Court states that even if the legislative history is “entirely silent...it does not automatically undermine” the position that Congress intended a private right of action to exist.⁸

This Court has held that the failure of Congress expressly to

consider a private remedy is not inevitably inconsistent with such intent on its part to make such a remedy available. Such an intent may appear implicitly in the language or structure of the statute, or in the circumstances of its enactment.⁹

In 1975, the U.S. Supreme Court established a four-part test to determine whether Congress intended a private right of action to exist: (1) whether the statute was enacted for the special benefit of the individual filing suit (*i.e.*, does the statute create a federal right in favor of the plaintiff?); (2) whether the law's legislative history suggests that Congress intended to create a private right of action or to deny one; (3) whether providing a private right of action is consistent with the law's design; and (4) whether the right of action is one that traditionally would be based in state, rather than federal, law.¹⁰

The issue of whether PPACA impliedly establishes a private right of action is not one that has been ignored by members of Congress. Namely, before and after PPACA was enacted, Representative Henry Waxman [D-CA]¹¹ and Senator Diane Feinstein [D-CA]¹² both stated that PPACA was never intended to create a private right of action. Although the statements made by Representative Waxman and Senator Feinstein appear to be commentary, the Supreme Court has considered “such legislative history as indicative of congressional intent regarding the creation of private rights of action.”¹³

Congress called on the U.S. Government Accountability Office (“GAO”) to review and “consider whether the development, recognition, or implementation of any guideline or other standards under the 14 [PPACA] quality enhancement

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provisions identified in Section 3512 of the law would result in a ‘new cause of action or claim.’”¹⁴ In March 2012, the GAO published a report entitled *Causes of Action under the Patient Protection and Affordable Care Act*, wherein it determined that, under the four-part-test set forth by the Supreme Court, the quality enhancement provisions of Section 3512 of PPACA would not lead to an implied private right of action.¹⁵ While the GAO’s review was limited to a focus on Section 3512, its rationale can be used to evaluate whether other sections of PPACA could yield a different result; specifically, whether applying the GAO’s rationale could result in an implied private right of action under other provisions of PPACA.

Thus, it remains to be seen whether individuals purchasing health insurance at the Exchanges or whether participants in employer-sponsored ERISA group health plans will have a private cause of action to sue under PPACA.

The False Claims Act and the Anti-Kickback Statute

The FCA prohibits the knowing presentation of claims to the government that a person knows, or should have reason to know, are false or fraudulent.¹⁶ The Federal Anti-Kickback Statute (“AKS”) is a criminal statute that prohibits the exchange, or offer of exchange, of anything of value for the generation of healthcare business payable by state or federal healthcare programs.¹⁷ Under PPACA, the FCA was expanded to eliminate the requirement that a person have actual knowledge of the FCA and specific intent to violate it.¹⁸ Moreover, the knowledge requirement was expanded to include reckless disregard and deliberate ignorance.¹⁹ In other words, one neither has to know that the FCA exists nor has to have a specific intent to violate the FCA to be found liable

under it. PPACA also provides that claims submitted pursuant to a relationship that violates the AKS would also constitute false claims under the FCA.²⁰

In addition to these expansions of the FCA, PPACA modified the “public disclosure” provisions of the FCA making it easier for a plaintiff (*i.e.*, a *qui tam* relator or the U.S. Department of Justice (“DOJ”)) to have standing to bring a claim. Before PPACA, unless a *qui tam* relator could prove that s/he was the original source of the allegations, a court lacked subject matter jurisdiction to hear the case. Therefore, the case required dismissal when a relator’s action was founded upon allegations that had been publicly disclosed in: a previous criminal civil or administrative proceeding; at a Congressional or administrative or GAO report hearing, audit, or investigation; or in the news media. Now the FCA has an expanded scope of what constitutes an original source and narrows what constitutes publicly disclosed information, thereby diminishing the burden on the plaintiff to bring a claim and for a court to hear that claim.²¹

The revised public disclosure provisions provide that a court must dismiss an action if substantially the same allegations, or transactions alleged in the action or claim, were publicly disclosed unless the DOJ opposes the dismissal.²² In narrowing its definition of what constitutes publicly disclosed information, and thus broadening potential liability, publicly disclosed information now only includes those actions based on disclosures from federal sources or the news media. A *qui tam* action now may only be barred if substantially the same allegations or transactions were publicly disclosed in: (1) a federal criminal, civil, or administrative hearing in which the government or its agent was a party; (2) a Congressional, GAO, or other federal report, hearing, audit, or

investigation; or (3) from the news media.²³

Section 1313 of PPACA pertains to the financial integrity of Exchanges and is the vehicle through which FCA allegations will be made against issuers of qualified health plans²⁴ (“QHPs”) and healthcare providers. It requires an Exchange to keep an accurate accounting of all activities, receipts, and expenditures and submit an annual report to the U.S. Department of Health and Human Services (“HHS”) Secretary (the “Secretary”) regarding its accounting.²⁵ In receiving and analyzing such reports, the Secretary has the authority to investigate and audit Exchanges to determine if there is a pattern of abuse or serious misconduct.²⁶ Importantly, in this context, the FCA applies to payments made by, through, or in connection with an Exchange “if those payments include any Federal funds.”²⁷ Additionally, a “material condition” of an issuer’s entitlement to receive payments (including premium tax credits and cost-sharing reductions through the Exchange) involves the requirements concerning eligibility for a health insurance issuer to participate in the Exchange.²⁸

In the Exchanges, health insurer issuers of QHPs and the providers will receive subsidies for lower-income beneficiaries and thus will receive payments made by, through, or in connection with the Exchange. This subsidiary money is subject to FCA liability. Penalties under Section 1313 will be three (3) to six (6) times the amount of the penalties under the FCA.²⁹

The Interplay Between ERISA and PPACA in Employer-Sponsored Group Health Plans

Although PPACA does not explicitly establish a private right of action, it has been held that portions of PPACA are incorporated into ERISA and are enforceable by ERISA

plan participants in accordance with the terms of Section 502(a) of ERISA.³⁰ Section 502(a) permits private plaintiffs – either participants or beneficiaries – to bring actions against plans to recover benefits, enforce their rights, or clarify their rights under ERISA-regulated plans.³¹ Therefore, some PPACA claims may be raised by “piggybacking” on ERISA’s private right of action.

In 2013, the U.S. District Court for the Southern District of New York applied the “piggybacking” standard to a case wherein plan members alleged improper denial of benefits under a number of statutes, including ERISA and PPACA. Section 502(a) of ERISA provides a comprehensive enforcement scheme, which is the exclusive remedy for ERISA violations.³² “Section 502(a)(1)(B) affords relief when benefit claims are denied in violation of ERISA plan terms. Section 502(a)(3) ‘catch-all’ claims provide relief for ERISA violations not remedied elsewhere in § 502(a).”³³ The court continued to state:

The ACA requirements incorporated into ERISA ‘apply’ to group health plans, and health insurance insurers providing health insurance coverage in connection with group health plans....Only ‘group health plans’ or entities ‘providing health insurance coverage in connection with group health plans’ are liable for violations of the ACA.... Because ACA appeal rights are implicit terms of ERISA plans, plan participants may ‘enforce their rights under the terms of the plan’ by suing an appropriate party or parties. As with all § 502(a)(1)(B) claims, however, the only appropriate defendants are Plans, Plan trustees, or § 1002(16)(A) Plan Administrators.³⁴

Therefore, although it is unlikely that individuals may bring claims solely and directly under PPACA, at least one court has held that PPACA claims may be brought under ERISA.

Notwithstanding the foregoing, under ERISA entities other than plans – such as plan trustees and formally designated plan administrators – have obligations to ERISA plan participants as fiduciaries.³⁵ A fiduciary is a person that holds discretionary authority over the management of the plan. As such, a plan participant may bring claims against fiduciaries who breach their fiduciary duties under ERISA’s “catch-all” enforcement mechanism, Section 502(a)(3), provided, however, that adequate remedies are not available elsewhere in the statute.³⁶

Although specific PPACA provisions that may implicate ERISA are discussed throughout this article, because plaintiffs may generally raise claims couched in ERISA, plans should expect ERISA to be the primary enforcement vehicle for private actions by participants in group health plans subject to ERISA. Such claims may be brought as class actions with plaintiffs seeking unpaid benefits and equitable relief. Importantly, and in addition to ERISA and PPACA claims, breach of fiduciary duty claims also open the door for the potential to recover attorneys’ fees and costs.

Litigation Regarding Coverage and Payment of Benefits

Essential Health Benefits

As of January 1, 2014, PPACA prohibits non-grandfathered group health plans³⁷ and health insurance policies in the large group market from imposing annual or lifetime dollar limits on essential health benefits (“EHBs”). These EHBs must include items or services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory

services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.³⁸ Although litigation targeting and/or involving health plans has not yet begun, there has been a significant uptick in challenges to PPACA itself, often on constitutional grounds, which at times discuss the EHB requirements and the contours of EHBs.³⁹ However, please note that they are not required to cover EHBs⁴⁰ and may impose dollar limits on benefits which are not EHBs.

On the other hand, a QHP (an insurance policy that is certified to be sold by the Exchange) and insurance policies sold in the individual and small group markets are required to provide EHBs in order to follow established limits on cost-sharing (e.g. deductibles, copayments, and out-of-pocket maximum amounts) and to meet other requirements.⁴¹

PPACA requires that the EHBs be equal in scope to the benefits offered by a “typical employer plan.”⁴² As such, EHBs are defined according to a state-specific benchmark plan selected from among the following plans operating in that state: (a) the three largest small group plans, (b) the three largest state employee health plans, (c) the largest federal employee health plan options, or (d) the largest health maintenance organization (“HMO”) offered in the state’s commercial market.⁴³ All policies required to provide EHBs must offer benefits that substantially equal the benefits of the benchmark plan.⁴⁴ If a state’s benchmark plan does not cover one or more of the required ten (10) benefit categories, a state must identify supplemental benchmark plans for those benefits.⁴⁵ HHS will evaluate each state’s approach to defining its EHBs in 2016.⁴⁶

Between now and 2016, states will define EHBs differently – varying degrees of benefits, some requiring more expansive benefits than others based on current state-mandated benefits, among

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other factors. Some of these differences will include coverage for hospice care, in vitro fertilization, and treatments for morbid obesity. The differences among states will likely be leveraged by potential litigants to argue what some states should include as EHBs in state-regulated health plans and what dollar limitations are acceptable, for example, in non-grandfathered group health plan coverage. Furthermore, since traditionally medical necessity has been a standard used by insurers and plans to preclude benefits for services which do not meet this standard, the introduction of EHBs could lead to new definitions and requirements for medical necessity. As before, and until guidance is released, insurers will likely continue developing their own definitions of coverage for items such as habilitative services, which have not been traditionally covered by insurers. Patient advocates have already begun to lobby HHS to develop a federal definition of medical necessity that will clarify which services should be considered as EHBs.⁴⁷ Furthermore, plans and insurers should expect internal appeals and external reviews (discussed in greater detail below) to be focused on issues of medical necessity and EHBs.

Mental Health Parity

The concept of mental health parity arose in 1996 that “generally refers to the concept that health insurance coverage for mental health services should be offered on par with covered medical and surgical benefits.”⁴⁸ In 1996, Congress passed the Mental Health Parity Act (“MHPA”)⁴⁹ requiring plans and insurance policies⁵⁰ offering mental health benefits to eliminate lifetime limits on mental health benefits if the plan or policy did not have an aggregate lifetime limit on substantially all medical and surgical benefits.⁵¹ For plans or policies that did include an aggregate lifetime limit on medical and surgical benefits, the

same limit must be applied to mental health benefits.⁵² In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act⁵³ (“MHPAEA”) was enacted, which preserves the MHPA protections and added significant new ones.⁵⁴ The MHPAEA generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations (*i.e.*, deductibles, copayments, coinsurance, and out-of-pocket expenses) on those benefits than medical/surgical benefits.⁵⁵ Neither the MHPA nor the MHPAEA required coverage of mental health benefits; rather, *if* the benefits were provided, it required that such benefits be provided in parity with medical and surgical benefits. Prior to PPACA’s enactment, mental health parity had been the subject of substantial state litigation; recently, state attorneys general have also enforced mental health parity laws.⁵⁶

PPACA expands the reach of the applicability of the federal mental health parity requirements in a number of its provisions. For example, Section 1311(j) of PPACA extends parity beyond health insurance issuers and group health plans and includes QHPs; Section 2001(c) requires coverage of mental health services for Medicaid benchmark and benchmark-equivalent plans; and Section 1201 requires a health insurance issuer that offers health insurance coverage in the individual or small group market ensure that the coverage includes EHBs (which includes, in its ten (10) categories, mental health services).

Surprisingly, while PPACA extends parity to new categories of insurers, its extension to EHBs appears to be at odds with the current parity laws. Namely, the MHPA and MHPAEA only permit limits on

mental health and substance use disorder benefits so long as the parity requirements have been met. However, PPACA prohibits plans from imposing dollar limits on EHBs, which include certain mental health and substance use disorder services. In the preamble to their regulations issued on November 13, 2013, the Department of Labor (“DOL”), the Department of Treasury (“Treasury”) and HHS stated:

Thus, notwithstanding the provisions of MHPAEA that permit aggregate lifetime and annual dollar limits with respect to mental health or substance use disorder benefits as long as those limits are in accordance with the parity requirements for such limits, such dollar limits are prohibited with respect to mental health or substance use disorder benefits that are covered as EHB.⁵⁷

The federal agencies continued – in a footnote – to state:

For self-insured group health plans, large group market health plans, and grandfathered health plans, to determine which benefits are EHB for purposes of complying with [Public Health Service] Act section 2711, the Departments have stated that they will consider the plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.⁵⁸

As such, industry stakeholders can expect litigation to continue on the issue of mental health parity, but such litigation will also include issues arising due to the lack of clarity and uniformity in the definition of EHBs. Importantly, although litigation cannot arise specifically under the parity acts or PPACA provisions affecting mental health, mental health parity has been held by courts to be enforceable by ERISA and thus may be enforced by remedies provided under ERISA.⁵⁹

Non-Discrimination

Against Individuals

PPACA introduces considerable new non-discrimination requirements. For example, when defining EHBs, PPACA prohibits the Secretary from making coverage decisions, determining reimbursement rates, establishing incentive programs, or designing benefits in ways that discriminate against individuals because of their age, disability, or life expectancy.⁶⁰ Moreover, the Secretary must ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of individuals' age or life expectancy or of individuals' present or predicted disability, degree of medical dependency, or quality of life.⁶¹ In addition to the EHB requirements, in PPACA's general provisions at Section 1557 an individual may not be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving federal financial assistance on the basis of race, color, national origin, sex, age, or disability.⁶²

HHS' Office for Civil Rights ("OCR") oversees and enforces Section 1557. Although significant guidance and regulations have not been issued,⁶³ this has not kept individuals and organizations from filing complaints of insurer and employer practices under the new requirement. Individuals believing to have been

victims of discrimination on one of the bases protected by this section may file a complaint with OCR, and OCR will conduct an investigation.⁶⁴ It is expected that these complaints will be used as a mechanism to ensure and/or enforce PPACA's non-discrimination provisions.⁶⁵

Unfortunately for any organization subject to Section 1557, neither PPACA nor OCR in regulations has set forth a gold standard which would indicate compliance with Section 1557. In fact, in its research entitled *Nondiscrimination Under the Affordable Care Act*, the Georgetown University Health Policy Institute's Center on Health Insurance Reform found the following:

- Stakeholders struggled to articulate an ideal standard for identifying discriminatory benefit design and raised concerns about the potential for discrimination in the design of drug formularies and the adoption of narrow provider networks, among other plan features;
- States and insurers have not changed their approach to nondiscrimination but are using new tools, such as attestations, outlier analysis, and internal tracking databases to monitor for compliance;
- States raised questions about how nondiscrimination requirements relate to the EHBs benchmark plan and identified challenges in enforcement because of a lack of clinical expertise and inability to fully see benefits in the filing process;
- Stakeholders stressed the need for ongoing monitoring of discriminatory benefit design; and
- Some stakeholders supported meaningful federal guidance with clear examples of discrimination.⁶⁶

In concluding its research, Georgetown stated that the industry would benefit from clearer guidance on discrimination and reconciling the

vulnerabilities inherent in the EHB benchmark plan.⁶⁷

Therefore, while health plans and providers can likely expect increased litigation and/or enforcement on the basis of discrimination against individuals, much of it may be difficult to avoid as industry stakeholders do not have a clear understanding of OCR's expectations or intentions due to its lack of rulemaking and commentary on the issue. Until rules and/or commentary are released, OCR's intention will be made apparent through its enforcement activity.

Against Providers

In addition to prohibiting discrimination against individuals, PPACA prohibits discrimination against providers. Litigation against health plans from providers believing to have been victims of discrimination can arise from a number of various provisions enacted under PPACA, ranging from general prohibitions on discriminating against providers, the implementation of the Exchanges and payment for out-of-network emergency services, and requirements that QHPs have providers accessible to beneficiaries.

PPACA prohibits various types of insurance plans, including issuers for QHPs, from discriminating "with respect to participation under the plan or coverage" against a health care provider acting within the scope of his/her license or certification.⁶⁸ In other words, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical techniques specified under the plan with respect to frequency, method, treatment or setting for an item or service, a plan or issuer may not discriminate based on a provider's license or certification, if the provider is acting within the scope of his/her license or certification under applicable state law. Moreover, it does not prevent group health plans, health insurance issuers, or the Secretary from establishing varying reimbursement

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rates based on quality or performance measures.⁶⁹

According to the DOL, provider reimbursement may also be based on “market standards.”⁷⁰ Furthermore, the DOL states, “[u]ntil further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of [the Public Health Service (“PHS”)] Act section 2706(a) using a good faith, reasonable interpretation of the law.”⁷¹

Notwithstanding the DOL’s guidance, the DOL and Congress are currently at odds regarding whether this provision requires plans or issuers to accept all types of providers into a network and whether reimbursement rates may be based on “market considerations.” According to the DOL — in the response to a frequently asked question (“FAQ”) — this requirement does not mandate insurers to contract with any willing provider and does not require plans or issuers to accept all types of providers into a network.⁷² However, the Senate Committee on Appropriations Report (the “Committee”) criticizes the DOL for this position, stating, “[s]ection 2706 was intended to prohibit exactly these types of discrimination” and that “[t]he goal of this provision is to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State.”⁷³ The Committee also states that the statute is much narrower in its discussion of reimbursement rates and does not include “market considerations.” The Committee directs HHS to work with the DOL and the Treasury (HHS, the DOL, and the Treasury are collectively referred to herein as the “Departments”) to correct the FAQ to reflect the law and Congress’ intent.⁷⁴ Therefore, on March 12, 2014, the Departments issued a Request for Information Regarding Provider Non-Discrimination, citing the apparent disparity

between the Departments’ position and the Committee’s. The Departments requested comments on all aspects of interpretation of the new provision, including “comments on access, costs, other federal and state laws, and feasibility.”⁷⁵ The Departments were accepting comments until June 10, 2014.⁷⁶

Industry stakeholders can likely expect litigation to arise if, and when, classes of providers are excluded if, and until, additional guidance is issued by the DOL retracting or revising its position. Litigation may also arise due to the DOL’s guidance itself depending on how it may affect different stakeholders. Moreover, litigation will likely arise regarding the provider payment rates if there are no limitations on the definition of “quality or performance measures” or “market considerations” when developing fee schedules for certain providers and services. An additional risk to increased litigation by providers alleging discrimination involves health insurers having different fee schedules for services performed by different providers (*e.g.*, a service furnished by a physician versus a psychologist) for the same current procedural terminology (“CPT”) code. Alternatively, there may be an increased risk of litigation by providers if an insurer pays certain specialists a higher rate for a CPT code based on an apparent or supposed market need to have those physicians in network and/or if those physicians demand higher rates.

In addition, because of PPACA payors are likely minimizing their networks to ensure even greater discounts from participating providers and hospitals. Another reason for narrow networks is the unwillingness of certain hospitals or other providers to participate in any QHPs. Thus, for many insureds, the number of out-of-network hospitals is on the rise and the issue of out-of-network payment for emergency services is likely to

increase dramatically. Section 10101 of PPACA requires a group health plan or a health insurance issuer offering group or individual health insurance that provides or covers any benefits with respect to services in an emergency department of a hospital to cover emergency services whether or not the healthcare provider that is furnishing the services is a participating provider.⁷⁷ Moreover, the services must be provided without more restrictive requirements or limitations if the provider does not participate with the plan than if the provider does participate with the plan, and if the services are provided out-of-network, the copayment amount or the coinsurance rate must be the same that would apply if the services were provided in-network.⁷⁸

Interestingly, this statute does not prohibit out-of-network providers from balance billing patients for the difference between the providers’ charges and the amount collected from the plan or issuer and from the patient in the form of a copayment or coinsurance amount.⁷⁹ As such, the Departments have promulgated regulations requiring a reasonable amount be paid before a patient becomes responsible for a balance billed and such reasonable amount must be determined by an objective standard.⁸⁰ The Departments determined that a plan or issuer satisfies the copayment and coinsurance limitations if it provides benefits for out-of-network emergency services in an amount equal to the greater of the following: (1) the amount negotiated with in-network providers for the emergency service furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable charges) but substituting the in-network cost-sharing provisions for the out-of-network cost-sharing

provisions; or (3) the amount that would be paid under Medicare for the emergency service.⁸¹

The issue of payment to participating and non-participating providers and balance billing is likely to become an issue for which health plans should prepare. Questions regarding whether the amount paid to an out-of-network provider was, in fact, reasonable and the corresponding balance billing of the patients could result in litigation from providers and patients alike.

In March 2012, HHS released final regulations regarding the establishment of exchanges and QHPs. HHS requires a QHP to 1) ensure that the provider networks for each of its QHPs includes all essential community providers; 2) maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services; 3) assure that all services will be accessible without unreasonable delay; and 4) be consistent with the network adequacy provisions of Section 2702 of the PHS Act.⁸² Essential community providers are those providers that serve predominantly low-income, medically underserved individuals.⁸³ Health plans can expect litigation from providers with claims of discrimination if a plan refuses to contract with them, alleging that the regulations require the plan to ensure adequate access to care. Likewise, health plans can expect litigation from enrollees if the plan fails to provide reasonable access or does not maintain a network that is accessible without unreasonable delay.⁸⁴

Litigation Regarding Plan Administration and Oversight

Internal Appeals

PPACA provides enrollees both an internal and an external claims appeals process on health plans or policies that were created or purchased after March 23, 2010 (however, the new appeal rights do not apply to

grandfathered plans).⁸⁵ In adding a new Section 2719 to the PHS Act, group health plans and health insurance issuers offering group or individual health insurance coverage must implement an effective internal appeals process for appeals of coverage determinations and claims.⁸⁶ Such appeals process must, at a minimum, have an internal claims appeal process; provide notice to enrollees, in a culturally and linguistically appropriate manner, of the available internal and external appeals process; and allow the enrollee to review his/her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process.⁸⁷

In June 2011, the Departments promulgated final regulations adding additional requirements for group health plans and group health insurance issuers as well as for individual health insurance issuers.⁸⁸ Both group health plans and group health insurance issuers, as well as individual health insurance issuers, must meet the following requirements:

- “Adverse benefit determinations” are to have the same definition as set forth in ERISA regulations (29 C.F.R. § 2560.503-1), and rescissions of coverage (regardless of whether the rescission has an adverse effect on any particular benefit at that time) constitutes an adverse benefit determination.
- Notifications of benefit determinations involving urgent care must be expedited.
- A plan and issuer must allow a claimant to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.
- All claims and appeals must be adjudicated in a manner designed to ensure the independence and impartiality of those involved in making the decision.
- Notice must be furnished to individuals, in a culturally and linguistically

appropriate manner, that includes information sufficient to identify the claim involved, a statement describing the availability of the diagnosis code and treatment code and their corresponding meanings associated with any adverse benefit determination or final internal adverse benefit determination, the reason or reasons for the adverse benefit determination or final internal adverse benefit determination including the denial code and its corresponding meaning as well as a description of the plan’s or issuer’s standard that was used in denying the claim, a description of available internal appeals and external review processes, and the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PHS Act to assist with the internal claims and appeals and external review processes.

- In the case of plans or issuers failing to adhere to the aforementioned requirements (unless such failures are *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant) with respect to the claim, the claimant is deemed to have exhausted the internal claims and appeals process and may then initiate an external review. Importantly, and *in addition to* the internal appeals and external review, the claimant may pursue any available remedies under ERISA or state law on the basis that the plan or issuer failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.⁸⁹

Health insurance issuers offering individual health insurance coverage must abide by two additional requirements: (1) they must provide for only one level of internal appeal before issuing a final determination; and (2) they must maintain for six (6) years records of all claims and notices associated with the internal claims and appeals process and must make such records available for examination

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upon the claimant's or a state or federal oversight agency's request.⁹⁰

These additional requirements expose insurers to a great deal of potential litigation. Specifically, claimants will likely raise issues pertaining to notice and whether notice was properly tendered. Additionally, ensuring all of the requirements involving a full and fair review and the avoidance of conflicts of interest will be significant areas in which claimants will litigate, as the burden of proof is on the plan to prove that its failure to meet such obligations did not cause prejudice or harm to the claimant. The plan must also prove that the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. Namely, the exception is unavailable if the violation is a pattern of the plan or issuer.⁹¹ Finally, as indicated explicitly in the regulations, claimants also have the right to pursue remedies under Section 502(a) of ERISA and any other applicable state laws.

External Reviews

If, after an internal appeal, a plan still decides to deny payment, PPACA gives individuals the right to have an independent review organization decide whether to uphold or overturn the plan's decision.⁹² Group health plans and health insurance issuers offering group or individual health insurance coverage must comply with external review processes established by the plan's applicable state external review process, or if a state has not established an external review process, it must implement an effective external review process that meets minimum standards established by the Secretary.⁹³

The regulations set forth sixteen (16) minimum standards for state external review processes.⁹⁴ These

minimum standards are based on the Uniform Health Carrier External Review Model Act,⁹⁵ written by the National Association of Insurance Commissioners ("NAIC").⁹⁶ States meeting all of the sixteen minimum standards are considered to be "NAIC-Parallel."⁹⁷ States operating an external review process under standards *similar* to the sixteen minimum standards are considered to be "NAIC-Similar."⁹⁸ Contemporaneous with the release of the Final Rule regarding internal appeals and external reviews in June 2011, the Departments issued technical guidance that established the standards for NAIC-Similar consumer protections that were set to apply until January 1, 2014.⁹⁹ If a state's external review process did not meet these minimum consumer protection standards and were not considered to be NAIC-Parallel, group health plans and health insurance issuers in the group and individual market in that state were required to implement an effective external review process that either utilizes the HHS-administered federal external review process, or to contract with accredited independent review organizations to review external appeals on their behalf.¹⁰⁰

In both the technical guidance issued in 2011 and the technical guidance issued in March 2013, the Departments also established a transition period for state external review process implementation to determine whether states meet the standards for an NAIC-Parallel process.¹⁰¹ While in the initial technical guidance the Departments extended the deadline for states to comply with the NAIC-Similar processes until January 1, 2014, the subsequent technical guidance further extended the deadline to January 1, 2016. During the extended transition period, states that are determined to be NAIC-Similar may continue to be considered compliant until January 1, 2016.¹⁰²

Potential litigation may arise under the external review during the transition period where litigants may argue that they fell through the cracks due to the numerous, and confusing, administrative requirements. Moreover, plans can expect litigation to arise due to the numerous procedural requirements associated with the state, federal, and private external review processes. Finally, plans should expect litigation to arise under state law under breach of contract or bad faith theories, claiming plans failed to adhere to the internal appeal and external review requirements.

Risk Adjustment

Beginning in 2014, individuals and small businesses were able to purchase private health insurance through the Exchanges. The purpose of the Exchanges is to force insurance companies to compete for business, thus, theoretically, reducing the cost of health insurance. PPACA contains three (3) provisions that are intended to promote competition among insurers on the basis of quality and value and to promote insurance market stability: risk adjustment, reinsurance, and risk corridors. The impetus behind these three provisions was to limit insurers' use of adverse selection and risk selection in their efforts to expand healthcare coverage to Americans. The risk adjustment provision of PPACA was established to redistribute funds from lower-risk enrollees to plans with higher-risk enrollees.¹⁰³ In other words, non-grandfathered health plans and health insurance issuers will be assessed a charge by the state if the actuarial risk of the enrollees of those plans for a year is *less* than the average actuarial risk of all enrollees in all plans or coverage in that state for that year.¹⁰⁴ Likewise, health plans and health insurance issuers will be provided a payment by the state if the actuarial risk of the enrollees is *greater* than the state average for that year.¹⁰⁵

Put differently and according to some, plans with less healthy members (*i.e.*, riskier members) are rewarded whereas plans with healthier members are penalized. States that operate an exchange have the option to either establish their own state-run risk adjustment program or allow the federal government to take charge of the program.¹⁰⁶ Any risk adjustment methodology used by a state, or by HHS on behalf of a state, must be a federally certified risk adjustment methodology.¹⁰⁷ Regardless of the methodology used to adjust risk, they will all follow the same general formula: using enrollee demographics and medical diagnoses, each geographic area and market segment will be compared based on the average risk of their enrollees to determine whether plans will be charged or issued payments.

As industry stakeholders have seen under the existing Medicare Advantage risk adjustment system, plans can expect the risk adjustment calculation to be complex and become the subject of dispute with state and/or federal agencies. Currently, under the Medicare Advantage system, payors are accused of manipulating risk adjustment scores through imprecise documentation and reporting of members' health status, as well as vague data filtering processes. Similar tactics are expected to arise under the Exchange's risk adjustment program, as well.

Reinsurance

Section 1341 of PPACA requires that each state establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during 2014 through 2016. Under this provision, all health insurance issuers, and third party administrators on behalf of self-insured group health plans, must make contributions (beginning January 1, 2014) to support reinsurance payments.¹⁰⁸ In 2014, the aggregate contributions for all states will be equal to ten billion dollars.¹⁰⁹ Such payment will be paid to

non-grandfathered plans of individual market issuers that cover high-cost individuals.¹¹⁰ As the basis for identifying individuals as high-risk individuals and, thus, reinsurance payments, the law requires HHS to develop a list of fifty (50) to one hundred (100) medical conditions based on identifying diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions, or to identify alternative methods for payment in consultation with the American Academy of Actuaries.¹¹¹ After HHS collects funds from insurers, it will make payments to plans with high cost enrollees.¹¹² Unlike the risk adjustment provisions, reinsurance is meant to stabilize premiums by reducing the incentive for insurers to charge higher premiums due to the uncertainty about the health status of enrollees.

In light of this effort to balance premiums over the next three years, plans may anticipate litigation from accusations that a plan manipulated its plan risk calculation and, therefore, disproportionately benefitted from the reinsurance payments.

Medical Loss Ratio Requirement

Section 1001(1) of PPACA establishes a new Section 2718 of the PHS Act, which requires insurance companies in the individual and small group markets to spend at least eighty percent (80%), and insurance companies in the large group market spend at least eighty-five percent (85%) of the total premium dollars they collect on medical care and quality improvement activities.¹¹³ Annually, health insurance issuers offering group or individual health insurance coverage must report to the Secretary the percentage of total premium revenue that the coverage expends on: (1) reimbursement for clinical services provided to enrollees under such coverage; (2) activities that improve healthcare quality; and (3) all other non-claims costs, including an

explanation of the nature of such costs, and excluding state taxes and licensing or regulatory fees (including reinsurance contributions).¹¹⁴ This process and standard is known as the medical loss ratio ("MLR"). Insurance companies failing to meet the MLR standard must provide rebates to enrollees in the amount by which the premium revenue expended by the issuer does not meet or exceed the respective eighty percent or eighty-five percent.¹¹⁵

Generally, reimbursement for clinical services includes direct claims paid to or received by providers, including those pursuant to capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies.¹¹⁶ Additionally, the report includes claim reserves associated with claims incurred the MLR reporting year, the change in contract reserves, reserves for contingent benefits, the medical claim portion of lawsuits, and any incurred experience rating refunds.¹¹⁷

The next requirement of the report to the Secretary includes activities conducted by the issuer to improve quality and must meet a number of requirements.¹¹⁸ The activity must be primarily designed to improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations; prevent hospital readmissions through a comprehensive program for hospital discharge; improve patient safety, reduce medical errors, and lower infection and mortality rates; implement, promote, and increase wellness and health activities; and enhance the use of healthcare data to improve quality, transparency, and outcomes as well as support meaningful use of health information technology.¹¹⁹

Activities *not* included in quality improving activities are those that are designed primarily to control or contain costs; the pro rata share of expenses

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that are for lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans; those which otherwise meet the definition for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue; those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services; establishing or maintaining a claims adjudication system; that portion of activities of healthcare professional hotlines that does not meet the definition of activities that improve health quality; all retrospective and current utilization review; fraud prevention activities; the cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason; provider credentialing; marketing expenses; costs associated with calculating and administering individual enrollee or employee incentives; that portion of prospective utilization that does not meet the definition of activities that improve health quality; and any function that is not expressly included and not otherwise approved by the Secretary.¹²⁰

If it is determined that an issuer must rebate premium payments, it may do so in the form of a premium credit (for current enrollees), lump-sum check, or, if an enrollee paid the premium using a credit card or debit card, by a lump-sum reimbursement to the account used to pay the premium.¹²¹ In the individual market, an issuer must provide rebates due to the individual or, for policies covering more than one person, a lump-sum payment may be made to the subscriber on behalf of all enrollees covered by the policy.¹²² In the large group and small group markets, rebates are provided to the policyholder, often an employer.¹²³ In such cases, the employer must pass on

the rebate to current subscribers either by reducing the subscribers' premium payment the subsequent year or by making a cash refund to the subscribers.¹²⁴ If the employer chooses the latter, the employer has the option of providing a cash refund by evenly dividing the rebate amount among the subscribers, dividing it based on each subscriber's actual contributions to the premium, or apportioning the payment in a manner that reasonably reflects each subscriber's contribution to the premium.¹²⁵

On December 2, 2011, the DOL issued a technical release wherein it acknowledged that the MLR regulations "do not give specific instructions to policyholders who are group health plans covered by [ERISA] or the sponsors of such plans regarding their responsibilities under ERISA concerning rebates. However, when rebates are issued to such policyholders, issues concerning the status of such funds under ERISA and how such funds must be handled necessarily arise."¹²⁶ The DOL takes the position that, to the extent that distributions, such as the premium rebates made under the MLR constitute plan assets, they become subject to the requirements of ERISA.¹²⁷ "For group health plans, a distribution such as the rebate will be a plan asset if a plan has a beneficial interest in the distribution under ordinary notions of property rights."¹²⁸ For employers who are policyholders and the policy or contracts or other governing documents of the plan "can fairly be read" to provide that some or all of a distribution belongs to the employer, then the employer may retain the distributions.¹²⁹

Plans can expect litigation to arise in a number of forms with respect to the MLR. Litigation can arise from providers alleging that plans are inappropriately reporting costs and/or inappropriately allocating certain costs as "activities improving healthcare."¹³⁰ Plans can also expect litigation from

enrollees with respect to rebates. ERISA, again, would become the basis of such litigation. Plans can expect litigation from employees regarding whether the MLR rebates constitute plan assets and, if so, whether the distributions were proper. Finally, plans may expect litigation surrounding MLR requirements and other kinds of litigation, such as anti-trust litigation.¹³¹

Conclusion

The managed care industry should expect increased litigation as a result of PPACA, and such litigation will arise from plan participants, providers, *qui tam* relators, state governments, and the federal government. While the predictions in this article include a non-exhaustive list of potential areas of vulnerability for health plans, what is clear is that the managed care industry, and attorneys representing managed care organizations, must keep apprised of areas of vulnerability and, although a great deal of guidance from state and federal regulators is still unavailable, ensure that they have internal policies, procedures, and safeguards in place to ensure minimum exposure for alleged violations of PPACA's provisions.



Joseph Friedman is a Member of Clark Hill PLC and the leader of Clark Hill's Managed Care Litigation Practice Group. He has exten-

sive trial and litigation experience in state and federal trial and appellate courts. He has more than 35 years' experience counseling and litigating on behalf of clients in the health insurance industry. He has tried antitrust, ERISA, intellectual property, trade secret, healthcare, insurance industry, bankruptcy, employment, and commercial litigation cases. Mr. Friedman has also represented clients in RICO, class action and public finance-related

matters. He may be reached at jfriedman@clarkhill.com.



Jeremy D. Bowen is an Associate with Clark Hill's Healthcare Practice Group. He practices in all areas of healthcare law —

healthcare transactional and litigation matters; compliance with HIPAA, fraud and abuse, and other healthcare regulations; and healthcare business agreements. He also assists with healthcare business start-ups, including experience with health information exchanges. Mr. Bowen may be reached at jbowen@clarkhill.com.



Elizabeth Collura is a Senior Attorney in Clark Hill PLC's Managed Care Litigation and Commercial and Corporate Litigation

Practice Groups. She represents healthcare insurers, third party administrators, and managed care organizations in litigation of contract and business disputes. Ms. Collura represents clients in the state and federal courts, as well as in alternative dispute resolution forums. She also represents clients in tort, civil rights, and product liability matters. She may be reached at ecollura@clarkhill.com.



Neda M. Ryan is an Associate with Clark Hill's Healthcare Practice Group. She practices in all areas of healthcare law, assisting clients with

transactional and corporate matters; healthcare litigation matters; compliance, fraud and abuse, and reimbursement matters; and in third party payor audit appeals. Ms. Ryan may be reached at nryan@clarkhill.com.

Endnotes

¹ The authors would like to give special thanks and recognition to Jena Grady for her further assistance with this article.

² Pub. L. No. 111-148.

³ Pub. L. No. 93-406.

⁴ Because many of the individual health insurance policies via the Exchanges could involve payments or subsidies backed by federal funds, the large enrollments entail an increase in federal funds that could be potentially collected through false claims by insurance companies from healthcare providers involved in the Exchanges.

⁵ In 2013, the law firm of Lillard & Lillard, P.C. filed a cause of action against Blue Cross and Blue Shield Association, R&R Professional Recovery, NCO Financial Systems, First Financial Credit Control, Quantum Practice Management, and Alacrity Collections Corporation under the Racketeer Influenced & Corrupt Organizations Act, the Federal Fair Debt Collection Practices Act, and PPACA. *Lillard & Lillard, P.C. v. Blue Cross and Blue Shield Ass'n.*, 971 F. Supp. 2d 116 (D.D.C. 2013). Plaintiff's case was dismissed for lack of standing to bring the claims. *Id.* at 120.

⁶ *Transamerica Mortgage Advisors, Inc. ("TAMA") v. Lewis*, 444 U.S. 11 (1979).

⁷ *Id.* at 18.

⁸ *Id.*

⁹ *Id.*, citing *Cannon v. University of Chicago*, 441 U.S. 667, 694 (1979).

¹⁰ *Cort v. Ash*, 422 U.S. 66, 78 (1975).

¹¹ 156 Cong. Rec. H1857 (daily ed. Mar. 21, 2010).

¹² 156 Cong. Rec. S2079 (daily ed. Mar. 25, 2010).

¹³ U.S. Gov't Accountability Office, GAO B-322525, Causes of Action under the Patient Protection and Affordable Care Act, Pp. 5 (Mar. 2012), FN 31.

¹⁴ U.S. Gov't Accountability Office, GAO B-322525, Causes of Action under the Patient Protection and Affordable Care Act, Pp. 5 (Mar. 2012).

¹⁵ U.S. Gov't Accountability Office, GAO B-322525, Causes of Action under the Patient Protection and Affordable Care Act, Pp. 5 (Mar. 2012).

¹⁶ 31 U.S.C. §§ 3729-33.

¹⁷ 42 U.S.C. § 1320a-7b.

¹⁸ PPACA § 6402(f)(1).

¹⁹ PPACA § 6402(f)(2).

²⁰ PPACA § 6402(f)(2).

²¹ PPACA § 1303(j)(2); 31 USC § 3730(e).

²² 31 U.S.C. § 3730(e).

²³ PPACA § 1303(j)(2); 31 USC § 3730(e).

²⁴ A "qualified health plan" is a health plan certified — according to certain criteria issued by an Exchange — that provides PPACA's "essential health benefits" at a specific level of coverage. For example, PPACA provides for a bronze, silver, gold, or platinum level of coverage (i.e. benefits that are actuarially equivalent to 60, 70, 80, or 90 percent of the full actuarial benefits provided under the plan).

²⁵ PPACA § 1313(a)(1).

²⁶ PPACA § 1313(a)(2)-(4).

²⁷ PPACA § 1313(a)(6)(A).

²⁸ PPACA § 1313(a)(6)(A).

²⁹ PPACA § 1313(a)(6)(B). Liability under the FCA includes treble damages and civil penalties ranging from \$5,500 to \$11,000 per claim (29 U.S.C. § 3729(a)(1)(G)).

³⁰ *N.Y. State Psychiatric Ass'n v. Unitedhealth Group*, 2013 U.S. Dist. LEXIS 158438, 20, 38 (S.D.N.Y. Oct. 31, 2013).

³¹ 29 U.S.C. § 1132(a).

³² *N.Y. State Psychiatric Ass'n v. Unitedhealth Group*, 2013 U.S. Dist. LEXIS 158438, 19 (S.D.N.Y. Oct. 31, 2013) (internal citations omitted).

³³ *Id.*

³⁴ *Id.* at 38-39 (internal citations omitted).

³⁵ *Id.* at 20.

³⁶ *Id.* at 24-25.

³⁷ To understand what might qualify as a non-grandfathered group health plan, it is easier to identify the elements required for a grandfathered group health plan and see if a group health plan does not qualify as a grandfathered health insurance plan. Grandfathered health insurance plans are defined as follows on www.healthcare.gov: "If you are covered by a plan that existed March 23, 2010, your plan may be "grandfathered." "Grandfathered plans are those that were in existence on March 23, 2010 and haven't been changed in ways that substantially cut benefits or increase costs for consumers. Insurers must notify consumers with these policies that they have a grandfathered plan. There are 2 types of grandfathered plans: job-based plans and individual plans (the kind you buy yourself, not through an employer). Job-based grandfathered plans can enroll people after March 23, 2010 and still maintain their grandfathered status. They can do this as long as the plans haven't been changed in ways that substantially cut benefits or increase costs for consumers, notify consumers with these policies that they have a grandfathered plan, and have continuously covered at least one person since March 23, 2010. Individual grandfathered plans can't newly enroll people after March 23, 2010 and have that new enrollment be considered a grandfathered policy. But insurance companies can continue to offer the grandfathered plans to people who were enrolled before that date. An insurance company can also decide to stop offering a grandfathered plan. If it does, it must provide notice 90 days before the plan ends and offer enrollees other available coverage options."

³⁸ PPACA § 1302(b).

³⁹ In *Florida v. United States HHS*, the court determined that the two key terms of PPACA are EHB and minimum essential coverage. *Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1250 (11th Cir. 2011) *aff'd* in part, *rev'd* in part sub nom. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (U.S. 2012). The court provided that the EHB package must be provided by individual and small group markets by 2014, but the EHB package is not required for plans offered by large group employers to their employees. *Id.* Rather, the court pointed out that large group market plans

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- are only subject to a few coverage-reform requirements. *Id.* at 1252 (citing Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 Va. L. Rev. 125, 147 (2011)).
- 40 Treas. Reg. § 54.9815-2711T(b)(2); DOL Reg. § 2590.715-2711(b)(2); HHS Reg. § 147.126(b)(2).
- 41 PPACA § 1301.
- 42 PPACA § 1302.
- 43 45 C.F.R. § 156.100.
- 44 45 C.F.R. § 156.115.
- 45 45 C.F.R. § 156.110.
- 46 Centers for Medicare & Medicaid Services, "Frequently Asked Questions on Essential Health Benefits Bulletin, available at <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.
- 47 The National Patient Advocate Foundation set an agenda in 2012 to put greater pressure on CMS to define medical necessity. See www.npaf.org/files/NPAF%202012%20Policy%20Priorities.pdf.
- 48 Amanda Sarata, Cong. Research Serv., R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010* (2010).
- 49 P.L. 104-204.
- 50 The law applies to both fully insured state-regulated health plans and self-insured plans that are exempt from state laws under the Employee Retirement Income Security Act ("ERISA"), which are regulated by the Department of Labor ("DOL"). See www.nami.org/Content/ContentGroups/ENews/1996/The_Mental_Health_Parity_Act_of_1996.htm. The law has a small business exemption which excludes businesses with 50 employees or less. The law allows an increased cost exemption; employers that can demonstrate a one percent or more rise in costs due to parity implementation will be allowed to exempt themselves from the law.
- 51 29 U.S.C. § 1185a(a).
- 52 *Id.*
- 53 P.L. 110-343.
- 54 CMS, The Center for Consumer Information & Insurance Oversight, *The Mental Health Parity and Addiction Equity Act*, available at: www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaefactsheet.html.
- 55 29 U.S.C. § 1185a(3).
- 56 See e.g. Press Release, A.G. Schneiderman Announces Settlement With Health Insurer That Wrongly Denied Mental Health Benefits To Thousands Of New Yorkers (Mar. 20, 2014), available at www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-insurer-wrongly-denied-mental-health-where-New-York's-attorney-general-settled-with-MVP-Health-Care-requiring-it-to-reform-its-behavioral-health-claims-review-process-cover-residential-treatment-and-charge-the-lower
- primary care copayment for outpatient visits to most mental health and substance abuse treatment providers. According to the attorney general's investigation, MVP Health care issued 40% more denials of behavioral health coverage cases than in medical cases.
- 57 78 Fed. Reg. 68240, 68244 (Nov. 13, 2013) (emphasis added).
- 58 78 Fed. Reg. 68240, 68244, FN 15 (Nov. 13, 2013).
- 59 *N. Y. State Psychiatric Ass'n v. Unitedhealth Group*, 2013 U.S. Dist. LEXIS 158438 20 (S.D.N.Y. Oct. 31, 2013).
- 60 PPACA § 1302(b)(4); 42 U.S.C. § 18022(b)(4)(B).
- 61 PPACA § 1302(b)(4); 42 U.S.C. § 18022(b)(4)(D).
- 62 PPACA § 1557. Earlier this year, the HHS Office for Civil Rights ("OCR") released commentary on its website stating that discrimination on the basis of sex would include gender identity, sex-stereotyping, and pregnancy. However, that commentary has since been removed from its website. Although proposed regulations have not yet been issued for Section 1557, in its Request for Information issued on August 1, 2013, OCR does request experiences commenters have had with sex discrimination and includes in a parenthetical that it includes discrimination on the basis of gender identity, sex stereotyping, or pregnancy (78 Fed. Reg. 46558, 46559 (Aug. 1, 2013)). Although official commentary or guidance is not available regarding the breadth of sex discrimination, it appears that OCR is considering it to include gender identity, sex-stereotyping, and pregnancy.
- 63 In OCR's *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities* (78 Fed. Reg. 46558 (Aug. 1, 2013)), OCR solicited comments from industry stakeholders on experiences with, and examples of, discrimination in health programs and activities, the types of programs and activities that should be considered health programs or activities under Section 1557, the impacts of discrimination, issues pertaining to those with limited English proficiency, issues pertaining to sex discrimination in health programs, issues relative to the benefits and barriers encountered by those with disabilities in accessing electronic and information technology in health programs and activities, and issues pertaining to enforcement. The deadline for submitting comments was September 30, 2013.
- 64 HHS Office for Civil Rights, *Section 1557 of the Patient Protection and Affordable Care Act*: www.hhs.gov/ocr/civilrights/understanding/section1557.
- 65 In June 2013, the National Women's Law Center ("NWLC") filed sex discrimination complaints against five institutions (Battelle Memorial Institute, Beacon Health System, Auburn University, Gonzaga University, and the Pennsylvania State System of Higher Education) that exclude pregnancy coverage from the health insurance benefits provided to their employees' dependent children. *NWLC Files Complaints Against Five Institutions for Sex Discrimination in Health Care Coverage*, available at: www.nwlc.org/print/press-release/nwlc-files-complaints-against-five-institutions-sex-discrimination-health-care-coverage-splash. In December 2013, OCR announced that it had also received two complaints, one involving a male who suffered from domestic violence and was allegedly subject to rude comments from hospital staff at the Touro Infirmary and another involving the differing treatment by St. Bernard Medical Center of male versus female spouses when assigning patients' guarantors. *Corrective Actions Taken in Sex Discrimination Cases Enforcement of "Section 1557" of the ACA*, available at: www.hhs.gov/ocr/office/1557_bulletin.pdf.
- 66 Katie Keith et al., *Cntr. on Health Ins. Reform Georgetown Univ. Health Policy Institute, Nondiscrimination under the Affordable Care Act 10* (July 2013), p. 4, available at www.chir.georgetown.edu/pdfs/NondiscriminationUndertheACA_GeorgetownCHIR.pdf.
- 67 *Id.* at p.5.
- 68 PPACA § 1201(2)(A), adding a new Section 2706 to the Public Health Service ("PHS") Act.
- 69 PPACA § 1201(2)(A).
- 70 DOL FAQs About Affordable Care Act Implementation (Part XV), p. 3, available at www.dol.gov/ebsa/pdf/faq-PPACA15.pdf.
- 71 DOL FAQs About Affordable Care Act Implementation (Part XV), p. 3, available at www.dol.gov/ebsa/pdf/faq-PPACA15.pdf.
- 72 DOL FAQs About Affordable Care Act Implementation (Part XV), p. 3, available at www.dol.gov/ebsa/pdf/faq-PPACA15.pdf.
- 73 www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf.
- 74 www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf.
- 75 79 Fed. Reg. 14051, 14052 (Mar. 12, 2014).
- 76 79 Fed. Reg. 14051 (Mar. 12, 2014).
- 77 PPACA § 10101; 29 C.F.R. § 2590.715-2719A(b)(2).
- 78 PPACA § 10101; 29 C.F.R. § 2590.715-2719A(b)(2)-(3).
- 79 75 Fed. Reg. 37188, 37194 (June 28, 2010); 29 C.F.R. § 2590.715-2719A(b)(3).
- 80 75 Fed. Reg. 37188, 37194 (June 28, 2010).
- 81 75 Fed. Reg. 37188, 37194 (June 28, 2010); 29 C.F.R. § 2590.715-2719A(b)(3).
- 82 45 C.F.R. § 156.230(a).
- 83 45 C.F.R. § 156.235(c).
- 84 CMS is still determining what the "reasonable access" review standard would be. For the 2015 benefit year, issuers will be required to submit a provider list that includes all in-network providers and facilities for all plans for which a QHP certification application is submitted. CMS will review this information and

- will identify networks that fail to provide access without unreasonable delay. To determine whether an issuer meets the reasonable access standard, CMS will focus on hospital systems, mental health providers, oncology providers, and primary care providers – those areas which have historically raised network adequacy concerns. Cntrs. for Medicare & Medicaid Servs., Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 4, 2014), available at www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf.
- 85 PPACA § 10101(g).
- 86 *Id.*
- 87 *Id.*
- 88 76 Fed. Reg. 37208 (June 24, 2011); 45 C.F.R. § 147.136(b)(2) & (b)(3).
- 89 45 C.F.R. §§ 147.136(b)(2)(ii) and (b)(3)(ii).
- 90 45 C.F.R. § 147.136(b)(3)(ii).
- 91 45 C.F.R. §§ 147.136(b)(2)(ii)(F)(2) and (b)(3)(ii)(F)(2).
- 92 PPACA § 10101(g).
- 93 *Id.*
- 94 PPACA § 10101(g); 45 C.F.R. § 147.136(c)(2).
- 95 The Uniform Carrier External Review Model Act, available at www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.
- 96 PPACA § 10101(g); 45 C.F.R. § 147.136(c)(1)(i); NAIC, “The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.” Available at www.naic.org/index_about.htm.
- 97 The following states and jurisdictions are NAIC-Parallel: Arkansas, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana (beginning January 1, 2015), Maine, Maryland, Mississippi, Missouri, Nebraska (for all claims submitted on or after January 1, 2014), Nevada, New Hampshire, New Jersey, New York, North Carolina (beginning January 1, 2016), North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, and Puerto Rico. www.cms.gov/CCIIO/Resources/Files/external_appeals.html.
- 98 45 C.F.R. § 147.136(1)(ii). The following states and jurisdictions are NAIC-Similar: Arizona, Delaware, District of Columbia, Indiana, Kansas, Massachusetts, Michigan, Minnesota, New Mexico, Texas, and Wyoming. www.cms.gov/CCIIO/Resources/Files/external_appeals.html.
- 99 DOL, *Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes*, Technical Release 2011-02, Pp. 5, available at: www.dol.gov/ebsa/pdf/tr11-02.pdf.
- 100 45 C.F.R. § 147.136(1)(iii). The following jurisdictions follow an HHS administered process or an independent review organization process: Alabama, Alaska, Florida, Georgia, Montana, Pennsylvania, West Virginia, Wisconsin, American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands. www.cms.gov/CCIIO/Resources/Files/external_appeals.html; The DOL’s guidance on external review processes discusses how the Departments intend for all states to establish NAIC-parallel processes and that they will evaluate state processes to see if they comply or give them a reasonable opportunity to respond. See www.dol.gov/ebsa/newsroom/tr11-02.html.
- 101 DOL, *Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes*, Technical Release 2011-02, available at: www.dol.gov/ebsa/pdf/tr11-02.pdf; U.S. DOL, *Extension of the Transition Period for the Temporary NAIC-Similar State External Review Process Under the Affordable Care Act*, Technical Release 2013-01, available at: www.dol.gov/ebsa/newsroom/tr13-01.html.
- 102 DOL, *Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes*, Technical Release 2011-02, available at: www.dol.gov/ebsa/pdf/tr11-02.pdf; U.S. Department of Labor, *Extension of the Transition Period for the Temporary NAIC-Similar State External review Process Under the Affordable Care Act*, Technical Release 2013-01, available at: www.dol.gov/ebsa/newsroom/tr13-01.html.
- 103 PPACA § 1343.
- 104 PPACA § 1343(a)(1).
- 105 PPACA § 1343(a)(2).
- 106 45 C.F.R. § 153.310(a).
- 107 45 C.F.R. § 153.320(a). On March 11, 2014, HHS issued its Notice of Benefit and Payment Parameters for 2015 (79 Fed. Reg. 13744 (Mar. 11, 2014)).
- 108 PPACA § 1341(b)(1)(A).
- 109 PPACA § 1341(b)(3)(B)(iii); 45 C.F.R. § 153.220(c)(1).
- 110 PPACA § 1341(b)(1)(B).
- 111 PPACA § 1341(b)(2)(A).
- 112 PPACA § 1341(b)(1)(B).
- 113 PPACA § 1001(1); PHS Act § 2718(b); 45 CFR § 158.110(a); 45 C.F.R. § 158.210. States may enact laws that provide issuers in the state must meet a higher MLR (45 C.F.R. § 158.211(a)).
- 114 PPACA § 1001(1); PHS Act § 2718(a); 45 C.F.R. § 158.161(a).
- 115 PPACA § 1001(1); PHSA Act § 2718(a); 45 C.F.R. § 158.240.
- 116 45 C.F.R. § 158.140(a).
- 117 45 C.F.R. § 158.140(a).
- 118 45 C.F.R. § 158.150.
- 119 45 C.F.R. § 158.150(b)(2).
- 120 45 C.F.R. § 158.150(c).
- 121 45 C.F.R. § 158.241.
- 122 45 C.F.R. § 158.242(a).
- 123 45 C.F.R. § 158.242(b).
- 124 45 C.F.R. § 158.242(b)(1) & (2).
- 125 45 C.F.R. § 158.242(b)(1)(iv).
- 126 DOL, *Guidance on Rebates for Group Health Plans Paid Pursuant to the Medical Loss Ratio Requirement of the Public Health Service Act*, Technical Release 2011-04, Pp. 1, available at: www.dol.gov/ebsa/pdf/tr11-04.pdf.
- 127 *Id.* at p.2.
- 128 *Id.*
- 129 *Id.*
- 130 In January 2013, MRI Scan Center, LLC and MRI Scan Center, Inc. filed suit in the U.S. District Court for the Southern District of Florida alleging that CIGNA was inappropriately allocating costs as “activities improving healthcare” when such costs were actually administrative costs, thus making an inaccurate MLR report to state and federal regulators. In May 2013, the court dismissed the case. *MRI Scan Center, LLC v. National Imaging Associates, Inc. et al.*, U.S. District Court, S.D. Florida 13-cv-60051.
- 131 In December 2013, the U.S. District Court for the Eastern District of New York issued an opinion approving a proposed settlement of a class action by merchants alleging antitrust claims against credit card networks and banks. In an argument against the proposed settlement, Wellpoint, Inc. and the Blue Cross Blue Shield Entities stated that the settlement could affect them differently from other merchants as the settlement may require them to pay rebates under the MLR. However, the court held that “[t]he notion that interchange fees may cause health insurers to cross the wrong side of that 80% threshold is entirely speculative.” *In re Payment Card Interchange Fee & Merch. Disc. Antitrust Litig.*, 2013 U.S. Dist. LEXIS 179340 (E.D. N.Y. Dec. 13, 2013).

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Marla Durben Hirsch
Potomac, Maryland
301/299-6155
mdhirsch@comcast.net

Howard D. Bye-Torre
Stoel Rives LLP
Seattle, WA
Employee Benefits & Executive Compensation
206/386-7631
hdbye-torre@stoel.com

Marcelo N. Corpuz III
Walgreen Co.
Deerfield, IL
Editorial Board Chair
847/964-8228
marcelo.corpuz@walgreens.com

Janet Dolgin
Hofstra University Deane School of Law
Hempstead, NY
Public Health & Policy
516/463-5873
lawjld@hofstra.edu

Adrienne Dresevic
The Health Law Partners
Southfield, MI
Liaison to the Publications Committee
248/996-8510
adresevic@thehlp.com

Marlene S. Garvis
Jardine Logan & O'Brien, PLLP
Lake Elmo, MN
Health Care Facility Operations
651/290-6569
mgarvis@jloilaw.com

David L. Haron
Foley & Mansfield
Ferndale, MI
Healthcare Fraud & Compliance
248/721-8184
dharon@foleymansfield.com

Bruce F. Howell
Schwabe, Williamson & Wyatt, PC
Portland, OR
Life Sciences
503/222-9981
bhowell@schwabe.com

Lauren K. Mack
Law Office of Lauren Mack
Lombard, IL
Tax & Accounting
312/813-7802
lauren@laurenmack501c3law.com

Ari Markenson
Duane Morris LLP
New York, NY
Business and Transactions
212/692-1012
amarkenson@duanemorris.com

Rakel M. Meir
Biogen Idec Inc.
Cambridge, MA
Managed Care and Insurance
617/914-5897
Rakel.Meir@biogenidec.com

Kirk J. Nahra
Wiley Rein LLP
Washington, DC
eHealth, Privacy & Security
202/719-7335
knahra@wileyrein.com

Monica P. Navarro
Vezina Law
Birmingham, MI
Physician Issues
248/558-2702
mnavarro@vezinalaw.com
Leonard M. Rosenberg
Garfunkel Wild, PC
Great Neck, NY
Healthcare Litigation & Risk Management
516/393-2260
lrosenberg@garfunkelwild.com

Felicia Y. Sze
Hooper, Lundy & Bookman, P.C.
San Francisco, CA
Payment & Reimbursement
415/875-8503
fsze@health-law.com

Edward Vishnevetsky
Munsch Hardt Kopf & Harr PC
Dallas, TX
Young Lawyers Division
214/855-7546
evishnevetsky@munsch.com

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Chair's Corner

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- Creation and operation of accountable care organizations and patient-centered medical homes;
- HIPAA privacy and security concerns and breaches, perceived or real;
- The utilization of social media in healthcare; and
- Government investigations, enforcement, and *qui tam* actions.

Sound like the day-to-day norm in your healthcare practice? The Health Law Section established the Task Force specifically to collect and share best practices and expertise in conflict resolution for disputes like these and to avoid their oftentimes damaging consequences. Let's see how these might play out.

Scenario 1 – Employment and Contract Issues

Pediatric gastroenterologist, Dr. Kidd Belly, sold his practice to, and became an employee of, a large multi-hospital system.¹ He hoped to spend more time taking care of his patients and less time on administrative work. The hospital, in turn, needed a pediatric gastroenterologist due to a nationwide shortage of pediatric subspecialists. In spite of the mutually beneficial relationship, myriad problems developed. As a hospital employee Dr. Belly was required to use hospital-provided office and nursing staff. However, every few days he saw a different set of staff, causing confusion as Dr. Belly constantly had to search for equipment in his repeatedly-rearranged exam rooms. Additionally, the staff ended each workday promptly on time, no matter what tasks remained, leaving important matters undone, such as entering information into patients' charts. The hospital, however, considered the problem to be a familiar adjustment that typically arises during a physician-practice acquisition and concluded that the kinks would probably smooth themselves out. Eventually the hospital assigned a single set of nursing and office staff to work regularly at Dr. Belly's office, noting that the hospital would have done so earlier had it known how troubled Dr. Belly was about the situation.

Counsel could have used conflict management to effectively resolve these disputes and others by writing a conflict management structure, such as a hospital-physician liaison, into the employment contract from the outset. This liaison, either a trained hospital employee or an outside consultant, could help the physician navigate the hospital system, identify the appropriate department or person to talk to when a problem arises, and serve as a negotiation coach, advising the physician on how to explain problems and negotiate

mutually acceptable resolutions. Many of Dr. Belly's frustrations were the result of not knowing whom to approach to resolve a dispute. If the hospital had a conflict management structure with a hospital-physician liaison, such disputes could be resolved earlier and without engendering needless frustrations.

Scenario 2 – Medical Staff and Employment Issues

As problems boiled over, Dr. Belly lost all patience, screaming at office and hospital staff on several occasions. Nursing complaints prompted the Medical Staff to dub him a "disruptive doctor," after which the Hospital threatened to terminate his employment.

Other hospital-physician disputes arise in situations where medical staff bylaws overlap or conflict with a physician's employment or professional services agreement. For instance, even if an employment agreement references bylaws provisions that establish prehearing rights for the physician, those prehearing rights may not apply to the physician employment agreement because the parties intended to execute an "at-will" employment agreement.² Other disputes stemming from contract-versus-bylaws clashes include territorial issues, peer review, due process, exclusive contracts, and medical malpractice coverage.³

When these conflicts arise, both sides have incentive to resolve the issues harmoniously at the earliest possible stage. Hospitals and physicians can avoid protracted litigation, and physicians can avoid adverse reports to the state medical board or National Practitioner Data Bank. Building conflict resolution into the employment agreement from the outset, whether as in-house mediation or other ADR, can maximize the parties' chance to preserve their relationship.

Scenario 3 – Compliance and False Claims Act Liability

Another issue arose from Dr. Belly's transition to the hospital's billing software. This software requires that all information be complete in the patient's chart and that the chart be "locked" before a claim is submitted to the payor. Due to incompatibilities between the hospital's system and Dr. Belly's own prior electronic medical record software, patients' medical records contained inaccuracies. Additional errors, created by the constantly rotating staff, were not always immediately spotted. Dr. Belly therefore delayed completing and "locking" his records. Hospital administrators were hesitant to contact Dr. Belly about the problem

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SIGNIFICANT PROPOSED CHANGES TO THE ANTI-KICKBACK STATUTE AND THE CIVIL MONETARY PENALTIES LAW

Adrienne Dresevic, Esq.
Clinton Mikel, Esq.
Leslie Rojas, Esq.
The Health Law Partners, P.C.
Southfield, MI

Introduction

On October 3, 2014, the Office of Inspector General (“OIG”) published a proposed rule¹ (“Proposed Rule”) to amend the safe harbors under the Anti-Kickback Statute (“AKS”), codify the changes to the Civil Monetary Penalties’ (“CMP”) definition of “remuneration” from the Patient Protection and Affordable Care Act (“PPACA”), and add a gainsharing provision under the CMP. If adopted, several provisions of the Proposed Rule would have a major impact on the AKS and CMP regulations. Numerous portions of the Proposed Rule do not include proposed or definitive regulatory text. Rather, the OIG invited comments on regulatory text while discussing concepts and considerations related to fraud and abuse. Comments on the Proposed Rule had to be submitted by December 2, 2014.

Changes to the Safe Harbor Provisions of the AKS

The AKS² is a criminal statute that prohibits individuals and entities from knowingly and willfully (even if there is no specific knowledge of, or intent to violate, the AKS) offering, paying, soliciting or receiving remuneration to induce the referral of federal healthcare program business. The OIG has adopted a number of “safe harbors” that protect against prosecution under the AKS. Under the Proposed Rule, the OIG intends to: (i) make a technical correction to the existing “referral services” safe

harbor;³ (ii) add new provisions to the “waiver of beneficiary coinsurance and deductible amounts” safe harbor⁴ for cost-sharing waivers by pharmacies under Medicare Part D and for certain emergency ambulance services; (iii) codify a safe harbor for Medicare Advantage payments to Federally Qualified Health Centers (“FQHCs”); (iv) codify a safe harbor for discounts in the price of certain drugs under the Medicare Coverage Gap Discount Program; and (v) add a safe harbor for free or discounted local transportation.

Referral Services

At the outset of the Proposed Rule, the OIG proposes a technical correction to one of the four factors required to meet the “referral services” safe harbor at 42 C.F.R. § 1001.952(f). The current language of 42 C.F.R. § 1001.952(f)(2) reads:

Any payment the participant makes to the referral service is assessed equally against and collected equally from all participants, and is only based on the cost of operating the referral service, and not on the volume or value of any referrals to or business otherwise generated by **either party for the referral service** for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. (Emphasis added.)

Under the Proposed Rule, the bolded language above will be replaced by the language found in the 1999 final rule,⁵ which clarified that any payment made to a referral service may not be based on “the volume or value of referrals to, or business otherwise generated by, *either party for the other party*.”⁶ The OIG claims that this language was inadvertently changed during revisions in 2002, and the OIG intends to revert to the 1999 language to correct such error.

Cost-Sharing Waivers

The OIG emphasizes its longstanding concern that blanket waivers of cost-sharing amounts have a high potential for abuse and may violate the AKS and CMP. However, the OIG proposes two new provisions for cost-sharing waivers that, according to the OIG, pose a low risk of harm.

Part D Cost-Sharing Waivers by Pharmacies

The OIG seeks to add a new subparagraph (3) under the “waiver of beneficiary coinsurance and deductible amounts” safe harbor found at 42 C.F.R. § 1001.952(k). The provision originates from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”) and would protect waivers or reductions by pharmacies of any cost-sharing imposed under Medicare Part D. To be entitled to protection, three criteria must be met: (i) the waiver or reduction must not be advertised; (ii) the pharmacy must not routinely waive the cost-sharing; and (iii) before waiving the cost-sharing, the pharmacy either must determine in good faith that the beneficiary has a financial need or fail to collect the cost-sharing amount only after making a reasonable effort to collect. However, conditions (ii) and (iii) are not required if the waiver or reduction is made on behalf of a subsidy-eligible individual.⁷

Cost-Sharing Waivers for Emergency Ambulance Services

The OIG proposes to add an additional subparagraph to the “waiver of beneficiary coinsurance and deductible amounts” safe harbor at 42 C.F.R. § 1001.952(k)(4) for certain emergency ambulance services. By way of brief background, through the years the OIG has issued many favorable advisory opinions approving of the reduction or

waiver of cost-sharing amounts for emergency ambulance services to an ambulance supplier that is owned and operated by a state or political subdivision of a state.⁸ Nevertheless, the OIG notes that it continues to receive requests for advisory opinions on this topic each year.⁹ Therefore, the OIG proposes to add the new subparagraph to clarify the OIG's position on, and provide safe harbor protection for, these types of cost-sharing waivers.

First, to receive protection under the new provision, the ambulance provider or supplier would need to be the Medicare Part B provider or supplier of the emergency ambulance services and must be owned by a state, a political subdivision of a state, or a federally recognized Indian tribe. The OIG advises that the protection **would not** extend to situations where the governmental unit owns but does not operate the ambulance provider or supplier (e.g., where the governmental unit contracts with outside ambulance providers or suppliers). Second, protection would be limited to services that are not paid for directly or indirectly by a government entity (i.e., the government entity furnishes the services free of charge without expectation of payment), subject to certain exceptions.¹⁰ Third, the ambulance provider or supplier would need to offer the reduction or waiver on a uniform basis, without regard to patient-specific factors. Fourth, the reduction or waiver would need to be borne by the ambulance provider or supplier and not claimed as bad debt for payment purposes or otherwise shifted to Medicare or other payors.

Under the proposal, the OIG intends to define "ambulance provider or supplier" as "a provider or supplier of ambulance transport services that furnishes emergency ambulance services," but not one that furnishes only nonemergency transport services.¹¹ Additionally, the OIG intends to define "emergency ambulance services" in accordance with the definition found

in the "ambulance replenishing" safe harbor.¹² Lastly, the OIG is soliciting comments regarding whether to protect reductions or waivers of cost-sharing amounts owed under other federal healthcare programs, such as Medicaid.

FQHCs and Medicare Advantage Organizations

The OIG proposes to codify an additional statutory safe harbor at 42 C.F.R. § 1001.952(z), which originates from the MMA and would protect any remuneration between an FQHC¹³ and a Medicare Advantage organization¹⁴ pursuant to a written agreement under 42 U.S.C. § 1395w-23(a)(4). Further, the Proposed Rule would codify the MMA requirement that the written agreement provide that the Medicare Advantage organization "will pay the contracting FQHC no less than the level and amount of payment that the plan would make for the same services if the services were furnished by another type of entity."¹⁵

Medicare Coverage Gap Discount Program

Under the Medicare Coverage Gap Discount Program, established by PPACA, prescription drug manufacturers provide certain beneficiaries access to point-of-sale discounts on drugs.¹⁶ The Proposed Rule would add protection for these discounts provided by manufacturers who participate in and are in full compliance with all requirements of the Medicare Coverage Gap Discount Program. Specifically, the new safe harbor would protect a discount in the price of an "applicable drug" furnished to an "applicable beneficiary," as those terms are defined in 42 U.S.C. § 1395w-114A. The Proposed Rule would add the new safe harbor at 42 C.F.R. § 1001.952(aa).

Local Transportation

The OIG proposes to add a new safe harbor at 42 C.F.R. § 1001.952(bb) to protect free or discounted local transportation services provided to federal healthcare program beneficiaries. The OIG notes that the CMP law's

legislative history reveals that Congress did not intend to preclude the provision of complimentary local transportation of nominal value.¹⁷ Currently, the OIG interprets "nominal value" to mean "no more than \$10 per item or service or \$50 in the aggregate over the course of a year."¹⁸ However, the OIG is concerned that this definition is overly restrictive. The proposal would protect not only certain free local transportation but also certain discounted local transportation services as long as specific requirements are met. The OIG notes that any safe harbor offering protection under the AKS would exempt the same practice from the definition of "remuneration" under the CMP law. In fact, transportation services have recently been the subject of numerous favorable advisory opinions issued by the OIG.¹⁹

First, the safe harbor would protect transportation services provided to the patient (and, if necessary, someone to assist the patient) only to obtain medically necessary items or services within the local area (25 miles) of the healthcare provider or supplier. However, protection **would not** extend to laboratories or to individuals and entities that primarily supply healthcare items that are heavily dependent on practitioner prescription and referrals, such as DME suppliers, and the OIG is soliciting comments on whom else to exclude from protection. For example, the OIG is concerned that the protection of free or discounted transportation by home healthcare providers to physician offices may result in unnecessary physician visits or serve as an inducement to physicians to refer to the home healthcare provider.²⁰

Additionally, protection would be available for the transportation of established patients only. This restriction is intended to reduce the risk that a provider or supplier could use the safe harbor to inappropriately induce referrals of new patients from other providers. Similarly, the provider or supplier would not be protected if: (i) the transportation is limited to patients

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Significant Proposed Changes to the Anti-Kickback Statute

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who were referred by a particular referral source; or (ii) the transportation is contingent on a patient seeing a particular provider or supplier who may be a referral source. Further, a provider or supplier would be able to restrict the offer of free or discounted transportation to patients whose conditions require frequent or critical appointments. However, the provider or supplier **would not** be allowed to restrict the offer to patients receiving expensive treatments that are lucrative for the provider or supplier offering the transportation.

Other scenarios that the OIG said would not be protected under the proposed safe harbor include: (a) transportation by air, luxury transportation (e.g., limousine), or ambulance-level transportation; (b) transportation involving payment to the transporter on a per-beneficiary basis (as opposed to an hourly or mileage basis); (c) transportation services that are publicly advertised to patients or potential referral sources; and (d) transportation that includes the marketing of healthcare items and services during the transportation (not including signage on the vehicle designating the source of the transportation).²¹ These exclusions are not surprising because they are consistent with the OIG's longstanding guidance on these issues as addressed in numerous advisory opinions and OIG notices of intent to develop regulations.²²

More so than any other provision in the Proposed Rule, the OIG spends significant time discussing numerous fact scenarios related to patient transportation. This is likely due to the number of factors that must be considered in order to adequately protect against fraud and abuse when free or discounted transportation is offered to patients.²³ The OIG is soliciting comments on the proposed safe harbor, including whether it should require providers and suppliers to document beneficiary eligibility criteria,

such as documenting a "need" for free or discounted transportation, and whether the protection should apply to transportation for non-medical care (e.g., counseling or social services).

Changes to the Definition of Remuneration Under the Beneficiary Inducement CMP Provisions

The CMP law,²⁴ among other things, prohibits the offer or transfer of remuneration to Medicare or Medicaid beneficiaries that the offeror knows or should know is likely to influence the beneficiary to order or receive items or services from a particular provider or supplier paid for by federal or state healthcare programs. For this reason, the CMP law is often referred to as the "beneficiary inducement" or "patient inducement" law.

First, the Proposed Rule amends the CMP definition of "remuneration" related to the beneficiary inducement CMP by adding a self-implementing exception that was enacted in the Balanced Budget Act of 1997, but was never codified in the regulations due to a purported oversight. This amendment would add subparagraph (5) to the CMP definition of "remuneration" found in 42 C.F.R. § 1003.101,²⁵ which states that a "reduction in the copayment amount for covered OPD services under section 1833(t)(8)(B) of the [Social Security] Act" would be excluded from the CMP definition of "remuneration."²⁶

Second, the Proposed Rule would codify four new exceptions to the CMP law's definition of "remuneration," which emanate from PPACA, by adding subparagraphs (6)-(9) to the definition of "remuneration" found in 42 C.F.R. § 1003.101.²⁷ The OIG explains that the new exceptions are "intended to protect certain arrangements that offer beneficiaries

incentives to engage in their wellness or treatment regimens or that improve or increase beneficiary access to care," while at the same time reducing the potential for abuse if beneficiaries receive inducement to obtain unnecessary, expensive, or poor quality services.²⁸

Promoting Access to Care

The first of the new proposed exceptions would protect remuneration that promotes access to care and poses a low risk of harm to patients and federal healthcare programs. The OIG defines "promotes access to care" as remuneration that "improves a particular beneficiary's ability to obtain medically necessary health care items and services."²⁹ The OIG seeks comments on whether to interpret this exception more broadly to include, for example: (i) beneficiaries from a designated population instead of a "particular beneficiary"; (ii) care that is non-clinical but related to medical care, such as social services; or (iii) encouraging patients to access care or making access to care more convenient for patients.

Additionally, the OIG defines "low risk of harm" to mean that the remuneration: (i) is unlikely to interfere with, or skew, clinical decision-making; (ii) is unlikely to increase costs to federal healthcare programs or beneficiaries through overutilization or inappropriate utilization; and (iii) does not raise patient safety or quality-of-care concerns.³⁰ In fact, these concerns are the driving force behind the AKS.³¹

Further, the OIG emphasizes that it views the offering of valuable gifts in connection with marketing activities and rewards for compliance with treatment regimens as activities with a high potential for abuse. However, the OIG recognizes that there may be beneficial incentives for compliance with treatment regimens that should be included in the exception; it is

seeking comments on this issue and what safeguards it must put into place to lower the risk of abuse. Lastly, the OIG does not propose regulatory text for this exception and is soliciting proposals for the language to be included at 42 C.F.R. § 1003.101³² under subparagraph (6) of the CMP definition of “remuneration.”

Retailer Rewards Programs

In the Proposed Rule, the OIG explains that retailer rewards programs, through which retailers “attempt to incentivize and reward customer loyalty by providing benefits to shoppers,” have “proliferated in recent years at grocery stores, drug stores, ‘big-box,’ and other retailers.”³³ Many of these retailers have pharmacies selling items or services reimbursable by federal healthcare programs. The OIG acknowledges that many retailer reward programs have specifically excluded federal healthcare program beneficiaries from participation in these programs, perhaps out of fear that offering this type of remuneration will violate the informal “inexpensive gifts” limitation currently set at \$10 individually and \$50 annually per patient.³⁴ The OIG believes that creating an exception for these programs will increase the chance that retailers will include federal healthcare program beneficiaries in their rewards programs. Therefore, the OIG intends to codify the provision of PPACA that excludes retailer rewards programs from the CMP definition of “remuneration” at subparagraph (7) of 42 C.F.R. § 1003.101.³⁵

Financial Need-Based Exception

The OIG proposes to codify the new exception to the CMP definition of “remuneration” that allows for the offer or transfer of free or less than fair-market value items or services to a beneficiary in financial need. The new exception would be found in subparagraph (8) of the CMP definition of “remuneration” at 42 C.F.R. 1003.101.³⁶ The OIG notes that “items or services” do not include “cash or instruments convertible to cash.”³⁷

Under the Proposed Rule, the items or services would be provided only after a good-faith determination that the individual is in financial need. Moreover, protection would only apply to items or services that are not advertised, are not tied to other services reimbursed by federal or state healthcare programs, and are “reasonably connected” to the individual’s medical care.

As guidance, the OIG provides examples of certain items and services that it may consider to be “reasonably connected” to medical care, including: (i) safety gear for hemophiliac children; (ii) pagers to alert patients with chronic medical conditions to take their drugs; (iii) free blood pressure checks to hypertensive patients; (iv) free nutritional supplements to malnourished patients with end-stage renal disease; and (v) air conditioners to asthmatic patients. However, the OIG notes that, in order for these items or services to qualify for the exception, the item or service must be medically indicated. In order to better advise the public on this exception, the OIG seeks comments on the concepts of “medically indicated” and “reasonably connected.”

Waivers of Cost-Sharing for the First Fill of a Generic Drug

The OIG proposes to exempt from the CMP definition of “remuneration” waivers of any copayment for the “first fill” of a generic drug if the waiver is by an authorized PDP sponsor³⁸ or Medicare Advantage organization. The purpose of this exception is to encourage the use of lower cost generic drugs, and it would be found at subparagraph (9) of the CMP definition of “remuneration” under 42 C.F.R. § 1003.101.³⁹ While this proposed regulation will not be effective until a future date, the Centers for Medicare & Medicaid Services (“CMS”) already permits similar waivers. For that reason, the OIG advises that it will not “exercise [its] enforcement authority against plans complying with CMS requirements for these waivers in the interim.”⁴⁰

The CMP’s Gainsharing Provisions

The CMP’s gainsharing provisions⁴¹ prohibit “hospitals and critical access hospitals from knowingly paying a physician to induce the physician to reduce or limit services provided to Medicare or Medicaid beneficiaries who are under the physician’s direct care.”⁴² However, the OIG observes that there is a shift in healthcare to accountable and high-quality care at lower costs. Therefore, along with codifying the CMP’s previous gainsharing guidance in a regulation, the OIG seeks comments on an appropriate definition for the term “reduce or limit services” in order to allow programs to improve patient care or reduce costs without reducing patient care or diminishing its quality.

After reciting the numerous favorable gainsharing guidance that has been issued,⁴³ the OIG enumerates its thoughts and solicits comments on potential rules. In particular, the OIG poses the following questions:

- Should the prohibition on payments to reduce or limit services include payments to limit items?
- Should a hospital’s decision to standardize certain items constitute reducing or limiting care? What if the hospital simply encouraged the use of standardized items, but other items remained available?
- Should a hospital’s decision to rely on protocols based on objective quality metrics for certain procedures constitute reducing or limiting care?
- Should it require a hospital that wants to standardize items or processes as part of a gainsharing program to establish certain thresholds based on historical experience or clinical protocols, beyond which participating physicians could not share in cost savings?
- Should the regulation include a requirement that the hospital or

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Significant Proposed Changes to the Anti-Kickback Statute

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physician participating in a gain-sharing program notify potentially affected patients about the program in order to ensure that the payments were for legitimate purposes and not for the purpose of reducing or limiting care?

The Proposed Rule does not offer any text for the definition of “reduce or limit services,” which will allow the OIG time to receive and digest comments on the above-mentioned issues before ultimately issuing regulatory text.

Conclusion

Attorneys representing providers and suppliers should stay tuned for the final rule, which will have a large impact on the AKS safe harbors and CMP regulations. In a number of instances, the OIG refrained from proposing regulatory text on the topics laid out in the Proposed Rule, and is instead soliciting comments on regulatory text for the same. The OIG has shown flexibility in certain areas under the Proposed Rule, while also being hesitant to adopt new rules that may have a broad impact without heavy analysis and lengthy requirements intended to protect the Medicare program. In light of the many comments the OIG is likely to receive, and the nebulous nature of much of the Proposed Rule, there may be an extended wait before the OIG publishes the final rule.



Adrienne Dresevic, Esq., is a Founding Shareholder of The Health Law Partners, P.C., a nationally recognized healthcare law firm with offices

in Michigan, New York, and Ohio. Practicing in all areas of healthcare law, she devotes a substantial portion of her practice to providing clients with counsel and analysis regarding compliance, Stark

law, Anti-Kickback Statute, and fraud and abuse related issues. Ms. Dresevic is the Chair of the Publications Committee of the American Bar Association Health Law Section. She is licensed to practice law in Michigan and New York, and can be contacted at adresevic@thehlp.com.



Clinton Mikel, Esq., is a Partner with The Health Law Partners, P.C., a nationally recognized law firm focusing on health-care legal issues. Mr.

Mikel practices out of his firm's Michigan office, but is also licensed in California and New York (soon). He is the Chair of the American Bar Association Health Law Section's eHealth, Privacy & Security Interest Group.

Mr. Mikel practices in almost all areas of healthcare law, but devotes a substantial portion of his practice to compliance with federal and state healthcare regulations and transactional matters. He focuses his practice on state and federal telehealth/telemedicine issues, HIPAA and state privacy laws, federal and state information breaches, including strategic investigations and disclosures, self-referral laws, including Stark, anti-kickback laws, and information technology issues. He is a prolific speaker, writer and commentator in the healthcare industry. He can be contacted at cmikel@thehlp.com.



Leslie Rojas, Esq., is an Associate with The Health Law Partners, P.C. She practices in all areas of healthcare law, with a focus on

compliance with federal and state healthcare regulations, health information privacy and technology issues, fraud and abuse issues, and transactional and corporate aspects of healthcare. Ms. Rojas is licensed to practice law in Michigan and Illinois, and can be contacted at lrojas@thehlp.com.

Endnotes

- 1 79 Fed. Reg. 59717 (Oct. 3, 2014).
- 2 42 U.S.C. § 1320a-7b(b).
- 3 42 C.F.R. § 1001.952(f).
- 4 42 C.F.R. § 1001.952(k).
- 5 64 Fed. Reg. 63518, 63526 (Nov. 19, 1999).
- 6 79 Fed. Reg. 59717, 59720.
- 7 42 U.S.C. 1395w-114(a)(3)(A) defines a “subsidy eligible individual” as “a part D eligible individual who (i) is enrolled in a prescription drug plan or [Medicare Advantage prescription drug] plan; (ii) has income below 150 percent of the poverty line applicable to a family of the size involved; and (iii) meets the resources requirement described in subparagraph (D) or (E) [of 42 U.S.C. 1395w-114(a)(3)].”
- 8 79 Fed. Reg. 59717, 59720. *See, for example*, OIG Advisory Opinion No. 03-09 (issued April 17, 2003; posted April 25, 2003).
- 9 79 Fed. Reg. 59717, 59720.
- 10 *See* 42 C.F.R. 411.8(b). *See also* CMS Medicare Benefit Policy Manual, Pub. No. 100-02, ch. 16, § 50.3.1, which states that a “facility which reduces or waives its charges for patients unable to pay, or charges patients only to the extent of their Medicare and other health insurance coverage, is not viewed as furnishing free services and may therefore receive program payment.”
- 11 79 Fed. Reg. 59717, 59721.
- 12 The “ambulance replenishing” safe harbor defines “ambulance provider” as “a provider or supplier of ambulance transport services that provides emergency ambulance services. The term does not include a provider of ambulance transport services that provides only non-emergency transport services.” 42 C.F.R. § 1001.952(v)(4)(iv).
- 13 The requirements to qualify as an FQHC are listed in 42 U.S.C. 1395x(aa)(4).
- 14 A Medicare Advantage Organization is generally defined as a “public or private entity organized and licensed by a state as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.” Medicare Advantage is the managed care plan offered by the United States government to eligible individuals. *See* CMS Medicare Managed Care Manual, Pub. No. 100-16, ch. 1, § 20.
- 15 79 Fed. Reg. 59717, 59721.
- 16 *See*, 42 U.S.C. 1395w-114A.
- 17 79 Fed. Reg. 59717, 59721 (*citing*, H.R. Conf. Rep. No. 104-736 at 255 (1996)).
- 18 79 Fed. Reg. 59717, 59721.
- 19 *See, for example*, OIG Advisory Opinions No. 09-01 (issued March 6, 2009; posted March 13, 2009); No. 11-01 (issued January 3, 2011; posted January 10, 2011); No. 11-02 (issued March 17, 2011; posted March 24, 2011); and

No. 11-16 (issued November 8, 2011; posted November 13, 2011).

²⁰ 79 Fed. Reg. 59717, 59722.

²¹ *Id.* at 59723-59724.

²² See n. 19. See also, 67 Fed. Reg. 72892 (Dec. 9, 2002).

²³ This article merely provides a summary of the main issues raised in the Proposed Rule; therefore, attorneys representing providers and suppliers offering or considering offering patient transportation should review the specific factual scenarios addressed in the Proposed Rule.

²⁴ 42 U.S.C. § 1320a-7a(a)(5).

²⁵ Note that the OIG proposes to re-designate the current 42 C.F.R. § 1003.101 to 42 C.F.R.

§ 1003.110.

²⁶ 79 Fed. Reg. 59717, 59732. OPD services are outpatient department services as defined in 42 U.S.C. 1395l(t)(1)(B).

²⁷ See n. 24.

²⁸ 79 Fed. Reg. 59717, 59725.

²⁹ *Id.*

³⁰ *Id.*

³¹ See Office of Public Affairs, U.S. Department of Health & Human Services, Office of Inspector General, Fact Sheet November 1999, Federal Anti-Kickback Law and Regulatory Safe Harbors.

³² See n. 24.

³³ 79 Fed. Reg. 59717, 59726.

³⁴ *Id.*

³⁵ See n. 24.

³⁶ See n. 24.

³⁷ 79 Fed. Reg. 59717, 59727.

³⁸ A prescription drug plan ("PDP") sponsor is a nongovernmental entity certified under, and meeting the requirements and standards of, Medicare Part D (i.e., part D of Title XVIII of the Social Security Act). See 42 U.S.C. 1395w-151(a)(13).

³⁹ See n. 24.

⁴⁰ 79 Fed. Reg. 59717, 59728.

⁴¹ 42 U.S.C. § 1320a-7a(b).

⁴² 79 Fed. Reg. 59717, 59729.

⁴³ *Id.* at 59729-59730.

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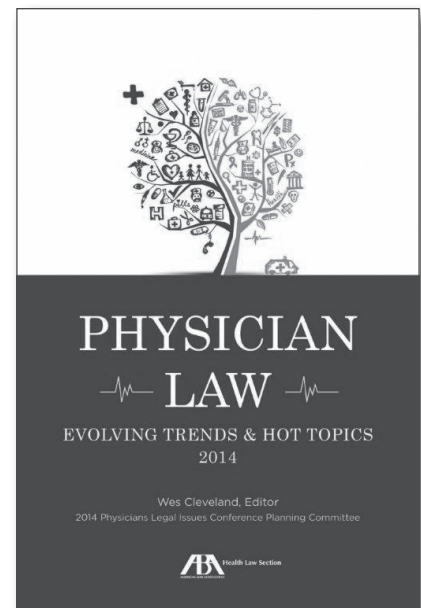
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The Health Law Section Responds to Concerns Over Ebola

The Section's Public Health & Policy Interest Group held a complimentary webinar titled **"Ebola 2014: A Public Health and Legal Perspective,"** to provide timely, reliable information on the Ebola virus. Speakers included **Montrece Ransom** from the Centers for Disease Control and Prevention ("CDC") and **Melissa Markey**, a legal expert on pandemics, from Hall Render, Troy, MI. The webinar was moderated by **Deirdre Golden**, Wayne State University Law School, Grosse Pointe, MI and chair of the Public Health & Policy Interest Group. A recording of the program is available on the Section's website, www.americanbar.org/health.

The Section also held a **Tweet Chat** ([@abahealthlaw](https://twitter.com/abahealthlaw)) creating the opportunity to collectively discuss and assess legal issues associated with the detection and treatment of Ebola. The chat was moderated by Section Chair **Michael E. Clark**, Duane Morris, Houston, TX ([@MichaelEClark](https://twitter.com/MichaelEClark)). Participants included **Melissa Markey** and **Kirk Nahra**, Wiley Rein, Washington, DC ([@KirkJNahrawork](https://twitter.com/KirkJNahrawork)), an expert on privacy issues. Comments were categorized with the hashtag **#HLSChat**. The full tweet chat is available on the Section's website, www.americanbar.org/health.

Cancer Rights Legal Advocacy Workshop at 2015 Midyear Meeting

The ABA's Breast Cancer Task Force will host a complimentary **Cancer Rights Legal Advocacy Workshop** at the ABA Midyear Meeting being held in Houston on February 6, 2015. The Task Force trains attorneys from across the country to advocate for breast cancer and other cancer patients. This seminar will focus on equal access to cancer care, patient navigation, and legal rights. Participants will learn about

practices, procedures, and statutory enactments that they can use to help resolve legal problems that their clients face as cancer patients. The Section has applied for 3.5 hours of CLE for this workshop. For more information about how to participate in the workshop, please contact Susan Pachikara, Program Specialist, at susan.pachikara@americanbar.org.

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Breast Cancer Task Force Presents Webinar on Legal Advocacy and Social Resources for Cancer Patients Facing Bankruptcy and Financial Issues

December 17, 2014 from 12:00 PM – 1:30 PM CST

This webinar will discuss the financial issues cancer patients face and legal advocacy in the area of bankruptcy and financial rights. In addition, the webinar will provide an overview of the

various social resources available for cancer patients. To register, please visit ambar.org/breastcancer. For more information, or to join the Breast Cancer Task Force at no cost, please contact Susan Pachikara, Program Specialist, at susan.pachikara@americanbar.org.

Chair's Corner

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because they did not want to exacerbate the increasingly contentious employment relationship, and instead submitted claims for his services even as they realized this potential compliance issue. A former hospital billing employee filed a complaint of healthcare fraud with the federal government. A young federal prosecutor, looking to make a name for himself, has made high-dollar demands to resolve the matter.

Civil penalties for submitting false claims can range from \$5,500 to \$11,000 per claim plus treble damages. Given the prosecutor's entrenched position, ADR can be a very attractive alternative. In fact, False Claims Act cases (brought by federal or state agencies alleging fraud in connection with payments under government healthcare programs) are resolved increasingly through mediation. Hospitals can avoid potentially catastrophic financial liability and the costs, expense, and time of further investigation, discovery, and trial, not to mention the negative publicity surrounding any trial. They can also preserve confidentiality if the mediation occurs before the complaint is unsealed. Reciprocally, the government can recover financial payments without the time, risk, and costs associated with a healthcare fraud case. Thus, both parties can benefit from this alternative dispute mechanism.

Conclusion

I would encourage Section members – litigators and non-litigators alike – to take a moment to check out what the Task Force is up to and appreciate the relevance to most healthcare practices and clients today. In the words of our healthcare clients – an ounce of prevention is often worth a pound of cure. A copy of the agenda and minutes from the Task Force's November Open Membership Call

can be accessed, along with its Action Plan for the year at www.americanbar.org/groups/health_law/interest_groups/conflict_management.html. In addition to quarterly membership calls, highlights include:

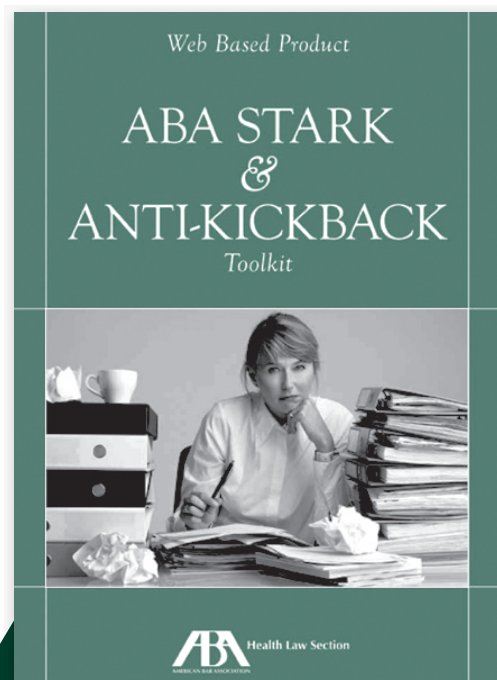
- Free Membership Benefit Calls, including:
 - **Today's Healthcare-Driving Conflict Out of Integrated Structures and Operations**, January 15, 2015, 1:00 pm EST
 - **Doing the Deal!**, February 12, 1:00 pm EST
 - **Did you really Just Say That? Conflict in Social Media**, April 17 1:00 pm ET
 - **Payor/Provider Disputes**, June 19th, 1:00 pm ET
- **EMI Breakfast Eggs Benedict & Conflict**, Friday, March 6, 2015, 8:00 – 9:00 am EST
- EMI sessions:
 - **"The Legal Ethics of Seeking Cooperative Resolutions versus Fighting Till the Bitter End,"** Thursday, March 5, 2015, 1:15 – 2:15 pm EST
 - **"Mediating Health Care Disputes: The Complicating Factors of Aggressive Regulatory and Enforcement Environments,"** Friday, March 6, 2015, 11:30 am – 12:30 pm EST

We welcome your participation and engagement.

Endnotes

- ¹ This story is drawn from E. H. Morreim, In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers, *The Health Lawyer* Volume 26, Number 3 (February 2014), pp. 10-14.
- ² *Bryant v. Glen Oaks Medical Center*, 650 N.E.2d 622, 629 (Ill. App. Ct. 1995).
- ³ Charles M. Key, Risk of Employed Physician Liability May Be Obscured by Corporate Liability Coverage, *The Health Lawyer* Volume 26, Number 6 (August 2014), pp. 36-40.

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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT'S EMPLOYER SHARED RESPONSIBILITY RULES – THE BIG PICTURE

Joni Landy, Esq.
Pittsburgh, PA

Starting in 2010, the Patient Protection and Affordable Care Act (“PPACA”) ushered in health coverage reforms that were popular with many individuals, such as coverage of adult children to age 26, no more preexisting condition exclusions, coverage for extensive preventative care provided without cost to the employee and no more lifetime and annual dollar limits on essential health benefits. Starting in 2014, some of the more controversial PPACA reforms go into effect, including the individual mandate in 2014 and the employer shared responsibility rules (also called the “pay-or-play” rules) starting in 2015. This article is intended to provide a big picture understanding of the employer shared responsibility rules as reflected in implementing final employer shared responsibility regulations (“Employer Shared Responsibility Regulations”) issued in February 2014.

The Big Entrance – Background on the Employer Shared Responsibility Regulations

PPACA's employer shared responsibility rules or “pay-or-play rules” involve complicated and detailed tax rules found in Internal Revenue Code Section 4980H and the Employer Shared Responsibility Regulations.¹ Section 4980H imposes *non-deductible excise taxes* (called “assessable payments”) on “applicable large employers” triggered by at least one full-time employee receiving subsidized health insurance coverage³ from an Affordable Insurance Exchange.⁴ The penalties apply in the following circumstances:

1. The employer fails to offer⁵ for any month health coverage that constitutes “minimal essential

coverage”⁶ to “substantially all”⁷ “full time”⁸ employees; and “dependents”⁹ (commonly referred to as the “4980H(a)” or “no offer” penalty) and at least one full time employee receives subsidized health coverage from an Affordable Insurance Exchange; or

2. The employer does offer minimal essential coverage to substantially all full-time employees and dependents, but at least one full-time employee receives subsidized health coverage from an Affordable Insurance Exchange because the employer coverage did not provide “minimum value,”¹⁰ was “unaffordable”¹¹ or both (the “4980H(b)” penalty).¹²

Therefore, the employer shared responsibility rules do not require large employers to offer coverage to full-time employees. Rather, they impose a penalty if any full-time employee receives subsidized health coverage at an Affordable Insurance Exchange and the employer either does not offer minimal essential coverage to the requisite percentage of full-time employees or does make the offer but the coverage either does not meet the minimum value or affordability requirements, or both.

In general, the amount of the 4980H(a) “no offer” penalty for a month, subject to annual inflationary increases, is 1/12th of \$2,000 (\$166.67) multiplied by the number of the employer's full-time employees for the month minus 30.¹³ For applicable large employer controlled group members, the 30-employee reduction is pro-rated across the members of the controlled group based on the number of full-time employees employed by each applicable large employer member during the calendar year. The amount of the 4980H(b) penalty for a month, subject to annual inflationary

increases, is the *lesser of*: (1) 1/12th of \$3,000 (or \$250), multiplied by the number of full-time employees who receive subsidized health coverage through an Affordable Insurance Exchange for the month; or (2) the penalty that would apply if no coverage was offered at all.¹⁴

To enable enforcement of the employer shared responsibility rules, large employers are required to file an annual information report with the IRS containing certain information about full-time employees and coverage for the previous calendar year. The reporting is required under Code section 6056; final regulations were issued on March 10, 2014.¹⁵

The Big Picture of “Applicable Large Employers”

The pay-or-play penalties apply only to “applicable large employers.” In general, an employer is considered an applicable large employer if it employed an average of at least 50 full-time employees in the previous calendar year. The Employer Shared Responsibility Regulations contain detailed rules for calculating large employer status.¹⁶

In making the determination, the employer must take into consideration not only the number of full-time employees but also the number of full-time equivalent employees (“FTEs”). To arrive at the number of FTEs for a month, the employer calculates the number of total hours worked by non-full-time employees (but not more than 120 hours of service for any employee) and divides that by 120.¹⁷ For example, if an employee has 30 full-time employees for a month and 100 part-time employees who worked a total of 4,800 hours during the

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The Patient Protection and Affordable Care Act's Employer Shared Responsibility

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month, for purposes of the large employer determination, the employer is considered to have 70 full-time employees for the month (the 30 full-timers and 40 FTEs).

Importantly, the large employer determination also requires aggregation of employees of all employers that are part of a "controlled group" or "affiliated service group."¹⁸ If the controlled group in the aggregate has 50 or more full time and FTEs, each member of the controlled group is treated as a large employer.

A special exception to large employer status applies in the event the employer's workforce exceeds 50 full-time employees for 120 days or less during the prior calendar year, and the employees in excess of 50 employed during that period were "seasonal workers."¹⁹

All employers that constitute "large employers" are subject to the employer shared responsibility rules, including for-profit, non-profit, and government entity employers (including federal, state, local, and Indian tribal government employers).

Effective Date

Under PPACA, the Employer Shared Responsibility Regulations were scheduled to take effect in 2014, with the first associated 6056 reporting due in 2015 for the 2014 calendar year. However, due to delays with the reporting mechanics, enforcement of the Regulations was delayed until January 1, 2015.²⁰ With the final Employer Shared Responsibility Regulations came further transitional relief from penalties – until 2016 – for certain "limited size" large employers.²¹ Under this transition provision, employers with at least 50 but fewer than 100 full-time employees in 2014 that meet certain other conditions will not be subject to penalties for any calendar month during 2015. For

employers with non-calendar-year health plans, this "limited size" large employer relief applies to any calendar month during the 2015 plan year, including months during the 2015 plan year that fall in 2016.²²

The Big Challenge – Determining Who is Full-Time

The focus of the employer shared responsibility rules is on "full-time" employees. Even though employers take into account hours worked by part-time employees for purposes of determining whether they are considered applicable large employers, penalties are only assessed for full-time employees.²³ Employers will need to know who their "full-timers" are for each month of the year for reporting purposes and because penalties are assessable month-by-month.

In general, the term "full-time employee" means, with respect to any calendar month, an employee who is employed on average at least 30 hours of service²⁴ per week (or 130 per calendar month as the monthly equivalent).²⁵ The employer is allowed to choose which method (30/week or 130/month) it will use.

The Employer Shared Responsibility Regulations provide two methods for determining an employee's status as full-time: (1) the monthly measurement period method; and (2) the look-back measurement period method.²⁶ Employers must use either the monthly measurement period or the look-back measurement period for all employees in a particular category; permissible categories are limited to those specified in the Employer Shared Responsibility Regulations.²⁷ Special rules apply when an employee moves from a position measured by the monthly method to a position measured by the look-back method and vice versa.²⁸

Monthly Method

Under the monthly measurement method, full-time employees are identified based on their hours of service for each calendar month. Other than for new full-time employees or newly eligible full-time employees (discussed later in this description of the monthly method), the large employer must offer minimum essential coverage as of the first day of the calendar month for employees who are or will be full-time or risk the 4980H(a) penalty.²⁹ Because of this, the monthly method will be of limited use to an employer who plans to offer health coverage to its employees but who has a workforce with employees whose hours fluctuate. In other words, it will be too late to offer minimum essential coverage for the month if the employee's full-time status cannot be determined until the end of the month. Bottom line: Use of the monthly method appears to be a feasible method only for employers who have decided just to pay the penalties, who plan to offer coverage to all employees regardless of the number of hours worked, or with workforces whose hours do not vary (i.e., their employees will clearly always be full-time or part-time employee working less than 30 hours/week or 130 hours a month).

With respect to new employees reasonably expected to work full-time or newly eligible full-time employees employed in a monthly measurement category, there is a limited penalty non-assessment period. Under this limited non-assessment period, the employer will not be subject to a 4980H(a) penalty for the first three *full* calendar months in which the employee is first "otherwise eligible"³⁰ for an offer of minimum essential coverage so long as coverage is offered and provided by no later than the first day following the three month period if the employee is still employed on that day.³¹ In addition, no 4980H(b)

penalty will be imposed for the same period if the coverage provides “minimum value.”³² But a 4980H(b) penalty can be imposed thereafter if the coverage is also not affordable. This rule applies only once per period of employment and appears to apply to both new employees and newly eligible employees (such as those part-time employees measured monthly who change status to full-time).

There is another special limited non-assessment period that does not apply penalties for the calendar month in which the employee’s start date occurs if the start date is on a date other than the first day of the calendar month. This prevents application of penalties in the first “partial” month for any new full-time employee starting in the middle of a month.³³

Look-Back Method

This method uses look-back measurement periods to determine which employees must be treated as full-time for subsequent time periods, called stability periods. Under this method, the employer must establish a continuing measurement and stability period that applies to all “ongoing” employees (called the “standard” measurement and standard stability period).³⁴ An ongoing employee is an employee who has been employed for the entire standard measurement period established by the employer. Everyone else is treated as “new.”

The employer may utilize an “initial” measurement and initial stability period for new “variable hour,” “seasonal,” and “part-time” employees.³⁵ However, initial measurement and stability periods may not be used for new non-seasonal employees who are reasonably expected to work full-time when hired.

Employees Hired Into a Look-Back Measured Category Who are Reasonably Expected to Work Full-Time

If an employee is reasonably expected at his or her start date to

work a full-time schedule (and the employee is not a seasonal employee), the employee must be treated as full-time when hired rather than using the look-back method to average the employee’s hours over an initial measurement period. The Employer Shared Responsibility Regulations include factors that should be taken to account when determining “reasonableness,” such as whether the new employee is replacing an employee who was full-time, whether employees in similar positions are full-time, and whether the job was advertised as requiring 30 or more hours per week. Educational organization employers cannot take into account the potential for, or likelihood of, an employment break period in determining their expectations of future hours of service.³⁶

For new non-seasonal employees who are reasonably expected on the start date to be a full-time employee, no 4980H(a) penalty will be assessable for any calendar month of the three-month period beginning with the first day of the first full calendar month of the employee’s employment, if for the calendar month, the employee is “otherwise eligible”³⁷ for an offer of health coverage and is offered coverage by no later than the fourth full calendar month of employment (assuming that the employee is still employed on that day).³⁸ In addition, if the coverage offered provides minimum value, no 4980H(b) penalty will apply for the above three-month period.³⁹ However, a 4980H(b) penalty can be imposed for calendar months after that period if the coverage provided is also not “affordable.” There is a special rule where no penalty (either under 4980H(a) or (b)) will apply in the first partial calendar month in which the employee’s start date occurs if the start date is on a date other than the first day of the calendar month.⁴⁰

Initial Measurement and Stability Period for New Variable Hour, Part-Time and Seasonal Employees

For new variable hour employees and also for new seasonal and part-time

employees, employers may use an “initial” measurement and initial stability period along with an optional administrative period. But employers may only use an initial measurement and stability period for an employee if the employer uses the look-back measurement method for the same category of ongoing employees. The initial measurement period must be no less than three and no more than 12 consecutive months.⁴¹ The start date for an employee’s initial measurement period can be the employee’s date of hire, any date up to and including the first day of the of the first calendar month following date of hire, or the first day of the first payroll period following date of hire.⁴² The employer may use an administrative period between the initial measurement and initial stability period that may not exceed 90 days. However, the initial measurement period and administrative period together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the employee’s start date.⁴³

Employee Not Measuring Full-Time during Initial Measurement Period

If the employee did not work full-time during his or her initial measurement period, then the employer can treat the employee as not full-time during the initial stability period. In this case, the stability period must not be more than one month longer than the initial measurement period and not exceed the remainder of the first entire standard measurement period in which the employee has been employed.⁴⁴

Employee was Full-Time during Initial Measurement Period

Employees averaging at least 30 hours of service per week (130 per month) during the initial measurement period are treated as full-time during the “initial stability period.” The stability period must begin immediately after the end of the measurement period and any associated administrative period and must be at

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least six consecutive calendar months and no shorter in duration than the initial measurement period.⁴⁵ The initial stability period must also be the same length as the standard stability period for the ongoing employees in their particular category.⁴⁶

Employers have a limited non-assessment period with respect to any employee measuring full-time during his/her initial measurement period. Under this limited non-assessment period, the employer will not be subject to a "no offer" penalty under 4980H(a) for any calendar month during the initial measurement period and any associated administrative period if coverage is offered by no later than the first day of the employee's initial stability period.⁴⁷ In addition, if the offer of coverage for which the employee is otherwise eligible during the initial measurement period, and which the employee actually is offered by the first day of the stability period provides minimum value, the employer also will not be subject to an assessable payment under 4980H(b) during the initial measurement period and any associated administrative period.⁴⁸ But a 4980H(b) penalty can be imposed for calendar months after that period if the coverage provided is also not "affordable."⁴⁹

Special Rule When Employment Status Changes During Initial Measurement Period

A special rule and limited non-assessment period applies if an employee experiences a change in employment status before the end of the initial measuring period such that if the employee had begun employment in the new position or status the employee would have been reasonably expected to be full-time (or would not be a seasonal employee and have been expected to work full-time). Assuming certain conditions are met, the employer will not be subject to a penalty under 4980H(a)

before the fourth full calendar month following the change in employment status (or if earlier and the employee averaged 30 hours or more during the initial measurement period, the first day of the first month following the end of the initial measurement period and the associated administrative period, if any).⁵⁰

Transitioning from New Employee to Ongoing under the Look-Back Method

Once a new employee in a look-back category is employed for a standard measurement period, the employee must also be tested for full-time status as an ongoing employee, beginning with that standard measurement period.⁵¹

The Employer Shared Responsibility Regulations also address what happens when an employee who tests as full-time during his/her initial measurement period but not full-time during an overlapping or immediately following standard measurement period, and also what happens when an employee tests part-time during his/her initial measurement period but full-time during an overlapping or immediately following standard measurement period.⁵²

Standard Measurement and Stability Period for Ongoing Employees

Employers using the look-back method must establish a standard measurement period of between three and 12 calendar months for measuring all ongoing employees (not just variable hour, part-time and seasonal employees).⁵³ The Employer Shared Responsibility Regulations allow an employer to adjust the starting and ending dates of the measurement period in order to avoid splitting employees' regular payroll periods.⁵⁴ An employer may utilize an administrative period of up to 90 days following the measurement period.⁵⁵ The stability period for

employees who measure full-time during the standard measurement period, and during which they must be treated as full-time,⁵⁶ must be at least six consecutive calendar months but no shorter in duration than the standard measurement period, and must begin immediately after the standard measurement period and any administrative period.⁵⁷ In order not to risk 4980H(a) penalties, minimum essential coverage will need to be offered to these full-time employees and dependents as of the first day of the stability period.⁵⁸ The stability period for employees not measuring full-time during the standard measuring period may be no longer than the standard measuring period.⁵⁹ Practically speaking, many employers using the look-back measurement period will use a 12-month standard measurement period, followed (after an administrative period) by a 12-month stability period consisting of the 12-month plan year. For example, employers could have a standard measurement period each year from November 1 to the following October 31 (such as November 1, 2015 to October 31, 2016), an administration period from November 1 to December 31 (November 1 to December 31 of 2016), and a stability period from January 1 to December 31 (2017 calendar plan year).

Changes in Measurement Periods or Methods Applicable to an Employee

The Employer Shared Responsibility Regulations contain special rules that apply to situations where an individual transfers from a position measured by the look-back method to a position measured by the monthly method and vice versa. In general, these rules are intended to protect an employee's status as a full-time employee during the transition period.⁶⁰ IRS Notice 2014-49 provides proposed approaches to situations where an employee measured by the

look-back method transfers to another position also measured by the look-back but having a different measurement period, and situations where an employer modifies the measurement method applicable to a position.⁶¹

The Big Time – Hours of Service

“Hours of service” is a key concept in determining the full-time status of employees. Hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment by the employer, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.⁶²

For employees paid on an hourly basis, an employer is required to calculate actual hours of service from records of hours worked and hours for which payment is made or due.⁶³ Equivalency methods may not be used for employees who are compensated on an hourly basis because employers are required to maintain records of hours worked for those compensated hourly and because the equivalency methods could understate or overstate the number of hours actually worked.⁶⁴

For employees paid on a non-hourly basis (such as salaried employees), an employer may calculate the actual hours of service using the same method as for hourly employees, or use a “days-worked” equivalency crediting the employee with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service, or a “weeks-worked” equivalency where the employee is credited with 40 hours of service for each week for which the employee would be required to be credited with at least one hour of service.⁶⁵ However, use of equivalencies is prohibited when their use would

result in a substantial understatement of an employee’s hours of service in a manner that would cause that employee not to be treated as a full-time employee.⁶⁶

Employers are not required to use the same method of calculating a non-hourly employee’s hours of service for all non-hourly employees, and instead can use different methods for different categories of non-hourly employees, so long as the categories are reasonable and consistently applied. The final regulations specifically allow an employer to change the method of calculating non-hourly employees’ hours of service for each calendar year.⁶⁷

Exclusions from Hours of Service

Hours of service do not include hours worked as a “bona fide volunteer,”⁶⁸ hours of service performed by students in positions subsidized through the federal work study program or a substantially similar program of a state or political subdivision thereof,⁶⁹ or hours of service for any work performed by an individual who is a member of a religious order who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.⁷⁰ In addition, the Employer Shared Responsibility Regulations exclude from the definition of hours of service any hours for which the compensation constitutes income from sources outside the United States.⁷¹

Special Categories of Employees and Hours

The preamble to the Employer Shared Responsibility Regulations provides some guidance with respect to certain categories of employees and hours that present service crediting challenges, such as crediting hours of service for adjunct faculty,⁷² layover hours for airline industry employees,⁷³ on-call hours,⁷⁴ and commissioned salespeople.⁷⁵

Adjunct Faculty

Until further guidance is issued, employers of adjunct faculty compensated on the basis of courses or credit hours assigned are required to use a reasonable method for crediting hours of service with respect to those employees that is consistent with the law. One (but not the only) method that is reasonable for this purpose is to credit the adjunct faculty member with 2.25 hours of service for every credit hour he/she teaches (or, to put it another way, an additional 1.25 hours for every credit hour taught) and an hour of service per week for each additional hour outside the classroom the faculty member spends performing duties he/she is required to perform (such as required office hours or meetings).

Layover Hours

The preamble to the Employer Shared Responsibility Regulations includes examples where it would be unreasonable to not provide any hours of credit, such as if an airline employee receives compensation for a layover or is required to have an overnight layover away from home.

On-Call Hours

The IRS continues to consider additional rules for determining hours of service that need to be credited for on-call hours. Until further guidance is issued, employers are instructed to use a reasonable method. The preamble to the Employer Shared Responsibility Regulations clarifies that it is not reasonable to fail to credit an employee with an hour of service for any on-call hour for which payment is due by the employer, for which the employee is required to remain on-call on the employer’s premises, or for which the employee’s activities while remaining on call are subject to substantial restrictions that prevent the employee from using the time effectively for the employee’s own purposes.

Commissioned Salespeople

Similarly, the preamble notes that it would not be a reasonable method

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of crediting hours to fail to take into account travel time for a traveling salesperson compensated on a commission basis.

The Big Break – Breaks in Service

The Rehire Rule

To prevent employers from evading the rules through a pattern of terminating and rehiring employees, the Employer Shared Responsibility Regulations contain a rehire rule.⁷⁶ The rehire rule applies regardless of whether the employee was measured using the monthly or look-back method. Under this rule, an employee must be treated as a “continuing employee,” rather than a new hire, unless the employee had a period of at least 13 weeks (26 weeks for educational institutions) during which no hours of service are credited. At the employer’s option, it may use a rule of parity. Using a rule of parity, the employee may be treated as a new hire, rather than a continuing employee, after the employee returns to work from a break if the break was at least four weeks long and was longer than the period of work immediately preceding the break.⁷⁷

Special Rules Applicable to Returning Look-Back Measured Employees Treated as Continuing Employees

Accounting for Periods of Special Unpaid Leave and Employment Break Periods for Returning Look-Back Measured Employees Treated as Continuing

Special averaging rules apply for purposes of applying the look-back measuring method to a returning employee who is treated as a continuing employee.⁷⁸ These rules involve how to account for periods of “special unpaid leave”⁷⁹ and “employment break periods”⁸⁰ for purposes of determining an employee’s average hours of

service during the look-back measurement period. “Special unpaid leave” means unpaid leave subject to the Family and Medical Leave Act of 1993 (“FMLA”),⁸¹ unpaid military leave subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”),⁸² and unpaid leave on account of jury duty. An “employment break period” applies only to educational institutions and means a period of at least four consecutive weeks (disregarding special unpaid leave), measured in weeks, during which an employee of an educational organization is not credited with hours of service for the employer.

Special unpaid leave and employment break periods can be handled in one of two ways in determining average hours of service during the measurement period: (1) the employer may exclude the period of time when no hours are credited as a result of the period of special unpaid leave (and in the case of an educational organization, the employment break period), or (2) the employer may credit the period of special unpaid leave (and for educational organizations, the employment break period) at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measuring period that are not part of the special unpaid leave (or employment break period). Employers are not required to exclude or to credit greater than 501 hours of service in connection with employment break periods in a calendar year. No similar limit applies in the case of special unpaid leave.⁸³

Other Rules Applicable to Returning Continuing Employees

The Employer Shared Responsibility Regulations also have rules addressing how a returning “continuing” employee measured by the look-back is treated with respect to the application of any stability period. For example, if the

continuing employee returns during a stability period in which the employee is treated as full-time, the employee is treated as full-time upon return and through the end of that stability period.⁸⁴

Bottom Line on the Big Picture

PPACA’s employer shared responsibility requirements are technically complicated, game changing Internal Revenue Code rules and regulations that have been in constant flux, including delays in implementation. First construed by sub-regulatory guidance, then proposed regulations, the final regulations now flesh out many administratively complex details. While the devil is in those details, the bottom line on the big picture is that applicable large employers who fail to offer affordable, minimum value, minimum essential health coverage to a sufficient percentage of full-time employees risk tax penalties under the employer shared responsibility rules. The rules apply to those large employers determined on a controlled group basis so it is critical even for employers with fewer than 50 employees to determine whether they may be subject as an applicable large employer as a result of being part of a tax controlled or affiliated service group. And since large employers are exposed to penalties with respect to full-time employees and dependents, they must be prepared to understand, track, substantiate and report on which of those employees are full-time. This applies whether the large employer ultimately decides to pay or play.

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Joni Landy has practiced employee benefits law with a focus on health and welfare benefits for over 20 years. She is Vice Chair of the

ABA Health Law Section Employee Benefits Interest Group and a member of the ABA Joint Commission on Employee Benefits. Ms. Landy is admitted to practice in Pennsylvania. She can be reached at jonilandy@me.com.

Endnotes

- ¹ The final regulations can be found at Shared Responsibility for Employers Regarding Health Coverage, Federal Register / Vol. 79, No. 29, 79 Fed. Reg. 8543 (February 12, 2014), (hereinafter "Employer Shared Responsibility Regulations") and encompass 54.4980H-0- 54.4980H-6 www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf.
- ² The meaning of "applicable large" employer is described *infra* under "The Big Picture of Applicable Large Employers."
- ³ "Subsidy" or "subsidized" as used here means receipt of a federal premium tax credit or cost sharing assistance. Employees will be certified to the employer as having enrolled in subsidized coverage under a process established by the Secretary of Health and Human Services referred to as a Section 1411 Certification. In general, an employee may be eligible for a subsidy if all of the following apply: (1) The employee has household income of no more than 400% of the federal poverty level for the year; (2) the employee is not offered employer minimum essential coverage that is both affordable (based on household income) and meets minimum value standards (however, employees who actually enroll in employer minimum essential coverage are not eligible even if the coverage is not affordable or does not meet the minimum value standards); (3) is a citizen or legal resident of the United

States; and (4) is not eligible for certain other government-provided coverages such as Medicaid, the Children's Health Insurance Program ("CHIP"), Medicare Part A, and TRICARE. So, for example, individuals on Medicaid will not trigger employer shared responsibility penalties.

- ⁴ Also known as Marketplaces or health insurance exchanges. These are state-run, or federally-run if a state does not establish its own exchange. On November 7, 2014, The United States Supreme Court granted certiorari in *King v. Burwell* on the issue of whether subsidies may be provided by a federally-run exchange or may only be provided in a state-run exchange.
- ⁵ The Employer Shared Responsibility Regulations address the term "offer" and also address when an offer of coverage under a plan sponsored by another entity will be considered an offer of coverage by the employer. See 54.4980H-4(b) and 54.4980H-5(b).
- ⁶ In general, "minimum essential coverage" includes employer-provided health coverage other than coverage for certain "excepted benefits" (such as, but not limited to, stand-alone dental and vision insurance). See Internal Revenue Code section 5000A(f)(1); 26 CFR § 1.5000A-2.
- ⁷ Internal Revenue Code Section 4980 H requires an offer to full-time employees. The Employer Shared Responsibility Regulations incorporate a "substantially all" standard. Under the Employer Shared Responsibility Regulations, a large employer will be considered to have offered coverage to its full-time employees for a month if coverage is offered to all but 5% of the full-time employees for the month (or all but 5 employees, if greater) — the 95% standard. However, there is a transition rule for 2015. Under this transitional rule, a large employer will satisfy the requirement to offer coverage to its full-time employees for a month if it offers coverage to at least 70% of full-time employees. For employers with non-calendar year plans, the 70% applies to all calendar months of 2015 plus any calendar months of 2016 that fall within the employer's 2015 plan year and is available only if the employer did not modify the plan year of its plan after February 9, 2014 to begin at a later date. See 54.4980H-4 and preamble to Employer Shared Responsibility Regulations at pages 8575-8576 with respect to the transition relief.
- ⁸ In general "full-time employee" means, with respect to any month, an employee who is employed, on average at least 30 hours of service per week (or 130 per calendar month as the monthly equivalent). Methods for determining who is full-time are discussed *infra* at "The Big Challenge – Determining Who is Full-Time."
- ⁹ An employer is only required to offer coverage to a dependent child in order to avoid the penalties. There is no adverse consequence under the final regulations for failure to provide coverage to spouses. For purposes of the pay-or-play rules "dependent child" means a child born to or adopted by (or placed for adoption with) the full-time employee. Such child is considered a dependent under the pay-or-play regulations for the entire calendar month during which he or she attains age 26.

A child who is not a U.S. citizen or national is not considered a dependent, unless the child is a resident of a country contiguous to the United States or falls within an exception for adopted children described in Code section 152(b)(3)(B). There are special transitional rules for employers who have not previously offered dependent coverage. See generally, 54.4980H-1(7); preamble to Employer Shared Responsibility Regulations at 8567. Note that the pay-or-play mandate requiring coverage to be offered to dependent children of full-time employees differs from the "Age 26" mandate requiring coverage of dependents to the child's 26th birthday. The categories of children that are considered dependents for purposes of the Age 26 mandate differs from the categories of persons who must offered coverage as dependents of full-time employees under the Employer Shared Responsibility Regulations.

- ¹⁰ Coverage provides "minimum value" if the plan's share of the total allowed costs of benefits under the plan is at least 60%. See Code section 36B(c)(2)(C)(ii). IRS methodologies for determining minimum value include minimum value calculators, certain safe harbor designs and actuarial certifications of plans. See IRS Notice 2012-31 (April 26, 2012). www.irs.gov/pub/irs-drop/n-12-31.pdf. However, in Notice 2014-69 (November 4, 2014), the IRS announced intent to revise minimum value regulations to deny minimum value status to plans that do not also provide substantial coverage for inpatient hospitalization and physician services. The revisions were slated to be included in proposed regulations to be published in the November 26, 2014 *Federal Register*.
- ¹¹ Coverage is considered "affordable" if the "cost" is not more than 9.5% (adjusted for years after 2014, for 2015 9.56%) of the employee's household income for employee-only coverage under the lowest cost minimum value plan offered to the employee by the employer. Since employers will not know employees' household income, they may rely on one of three affordability "safe harbor" methods for determining whether coverage is affordable to the employee: (1) the W-2 safe harbor, (2) the rate of pay safe harbor; and (3) the federal poverty line safe harbor. In order to use any of the affordability safe harbors, affordability to the employee is tested using the employee's cost of coverage for the lowest cost plan offered to the employee, regardless of in which plan the employee is enrolled. See 54.4980H-5(e) for details on the safe harbors. If an employee receives a subsidy because the employer coverage was unaffordable, the employee will not trigger a penalty so long as the employer offered the employee minimum essential coverage which was affordable under one of the affordability safe harbors.
- ¹² See note 3 for eligibility conditions for a subsidy. For an employee who is offered coverage by an employer to be eligible to receive a premium tax credit, the employer coverage must either fail to provide minimum value or fail to be affordable to the employee, or both. See preamble to the Employer Shared Responsibility Regulations at p. 8563. The 4980H(b) penalty could also be triggered by full-time employees who fall in the (30% or 5%) coverage gap who receive subsidized exchange coverage even though the employer otherwise covered

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- "substantially all" employees (under the applicable 70% or 95%) standard. See preamble to Employer Shared Responsibility Regulations at 8563.
- 13 For any calendar month in 2015, and any calendar month in 2016 that falls within an employer's non-calendar 2015 plan year, the number of disregarded employees is 80, rather than 30, for large employers with 100 or more full and full-time equivalent employees on business days during 2014. See preamble, Employer Shared Responsibility Regulations at page 8575-8576.
- 14 See 54.4980H-4 and 5 and 54.4980H-1(41) and (42). The penalty calculations also have carve outs for certain employees in limited non-assessment periods, and the 4980H(b) calculation also has a carve out in the case of subsidies (resulting from coverage being unaffordable) if the coverage otherwise provided minimum value and the employer used the affordability safe harbors.
- 15 See "Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans," 79 Fed. Reg. 13231 (March 10, 2014). www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05050.pdf. Another type of new information reporting is imposed by Code Section 6055. The 6055 report is required to be filed by insurers, self-insuring employers and others providing minimal essential coverage. See "Information Reporting of Minimum Essential Coverage," 79 Fed. Reg. 13220 (March 10, 2014). www.gpo.gov/fdsys/pkg/FR-2014-03-10/pdf/2014-05051.pdf. Both reports are first due in early 2016 for 2015 data. The reporting rules have their own penalties for non-compliance.
- 16 See 54.4980H-2 generally with respect to large employers. There is a transitional rule for the first year only allowing employers to use any consecutive six-month period in 2014 (rather than the full 12 months) to determine their status as a large employer for 2015. See preamble, Employer Shared Responsibility Regulations at page 8573. Also, for employers not in existence the preceding year, the determination of whether the employer is a large employer is based on the average number of employees the employer reasonably expects to employ in the current year. 54.4980H-2(b)(3).
- 17 See 54.4980H-2(c). Note the difference in the amount of hours taken into consideration for purposes of the "full-time equivalent" determination (120 hours/month) and the number of hours considered the monthly equivalent of at least 30 hours per week for purposes of determining who is full-time (in general, 130 hours/month unless a special weekly rule applies). See 54.4980H-21. See also, *infra* under the "Monthly Method" and note 29.
- 18 See 54.4980H-1(16).
- 19 "Seasonal Worker" means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including (but not limited to) certain agricultural workers covered by 29 C.F.R. 500.20(s)(1) and retail workers employed exclusively during holiday seasons. Employers may apply a reasonable, good faith interpretation of the term "Seasonal Worker" and a reasonable good faith interpretation of 29 C.F.R. 500.20(s)(1) (including as applied by analogy to workers and employment positions not otherwise covered under 29 C.F.R. 500.20(s)(1)).
- 20 Notice 2013-45, issued on July 9, 2013. www.irs.gov/pub/irs-drop/n-13-45.pdf.
- 21 See Employer Shared Responsibility Regulations preamble at page 8574 and IRS Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act at Q&A34. www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act#Transition. Although pay-or-play penalties may be delayed until 2016, Code Section 6050 and 6055 reporting is still required for 2015.
- 22 *Id.* Other 2015 transitional relief is available in certain circumstances for employers maintaining non-calendar year plans as of Dec. 27, 2012 for periods prior to the start of the 2015 non-calendar plan year. This relief is available with respect to employees eligible under the terms of the plan as in effect on February 9, 2014, and also with respect to other employees not so eligible if a certain percentage of employees were previously covered or offered coverage. Relief is only available if the employer did not change the plan year after December 27, 2012 to start at a later date, offers the employee minimum value, affordable coverage by the first day of the plan year beginning in 2015, and the employee was not eligible for coverage under a calendar year plan of the employer as of Feb. 9, 2014. The employer risks 4980H(a) penalties retroactive to January 1, 2015 unless the employer offers substantially all full-time employees and dependents minimum essential coverage as of the first day of the 2015 non-calendar plan year. The employer also risks 4980H(b) penalties for the full calendar year for any employee who is not offered minimum value, affordable coverage as of the first day of the 2015 non-calendar plan year. See Employer Shared Responsibility Regulations preamble at section XV.D.1(a)-(e), pp. 8570-72, with respect to non-calendar year plan 2015 transition relief.
- 23 "Full-time" equivalents are only taken into account for purposes of the large employer determination.
- 24 "Hours of Service" are explained *infra* under "The Big Time – Hours of Service."
- 25 54.4980H-(21). Although in general 130 hours is the monthly equivalent, the Employer Shared Responsibility Regulations allow use of an optional "weekly rule" when using the monthly method where an employee's full-time status for some calendar months is based on hours of service over four-week periods and for other calendar months based on hours of service over five-week periods. Under this special weekly rule, the period measured for a month must contain either the week including the first day of the month or the week including the last day of the month, but not both. For months calculated using four week periods, an employee with at least 120 hours of service is a full-time employee, and for calendar months calculated using five week periods, an employee with at least 150 hours of service is a full-time employee. See 54.4980H-(21) and 54.4980H-3(c)(3).
- 26 The look-back method may NOT be used for purposes of determining whether an employer is an applicable large employer.
- 27 Only the following categories are permitted: collectively bargained employees and non-collectively bargained employees; each group of collectively bargained employees covered by a separate collective bargaining agreement; salaried employees and hourly employees; and employees whose primary places of employment are in different states. See preamble to Employer Shared Responsibility Regulations at 8562, 54.4980H-3(e), and 54.4980H-3(d)(1)(v).
- 28 See 54.4980H-3(f)(1)(i) and (ii).
- 29 For purposes of the monthly method, the Employer Shared Responsibility Regulations allow use of an optional "weekly rule" where an employee's full-time status for some calendar months is based on hours of service over four-week periods and for other calendar months based on hours of service over five-week periods. Under this rule, the period measured for a month must contain either the week including the first day of the month or the week including the last day of the month, but not both. For months calculated using four week periods, an employee with at least 120 hours of service is a full-time employee, and for calendar months calculated using five week periods, an employee with at least 150 hours of service is a full-time employee. However, regardless of whether the employer uses the special weekly rule, an employer will only be treated as having offered coverage for a calendar month if coverage is offered to a full-time employee for the entire calendar month (otherwise the employer risks the 4980H(a) penalty).
- 30 See Employer Shared Responsibility Regulations at 54.4980H-3(c)(2) for the meaning of "otherwise eligible."
- 31 See 54.4980H-3(c)(2). However, employers must also be mindful of other PPACA rules (and penalties) applicable to the timing of coverage – i.e., rules that prohibit coverage waiting periods in excess of 90 days (the "90 Day Rule"). Final regulations have been issued under the 90-Day Rule. See Ninety-Day Waiting Period Limitation, 79 Fed. Reg. 10296 (February 24, 2014) www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf and 79 Fed. Reg. 35942 (June 25, 2014). Employers will need to ensure compliance with both the Employer Shared Responsibility Regulations and those under the 90 Day Rule. Thus, coverage will need to begin earlier than required by the Employer Shared Responsibility Regulations to the extent necessary to satisfy the 90-Day Rule. The 90-Day regulations permit an orientation period of up to a month that might help bridge any gap.
- 32 See *supra* note 10 for description of Minimum Value.
- 33 See 54.4980H-(4)(c) and 54.4980H-(5)(c).
- 34 See 54.4980H-3(d) for details on the rules governing the look-back method, including

regulatory parameters on measurement, stability, and administrative periods.

- ³⁵ A “variable hour employee” means an employee if, based on the facts and circumstances at the employee’s start date, the employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the employee’s hours are variable or otherwise uncertain. See 54.4980H-1(46). A “seasonal employee” is an employee who is hired into a position for which the customary annual employment is six months or less that coincides with a particular season of the year. See 54.4980H-1(38); preamble to Employer Shared Responsibility Regulations at 8557-8558. A “part-time employee” is a new employee who the employer reasonably expects to be employed on average less than 30 hours of service per week during the initial measurement period based on the facts and circumstances on the employee’s start date. See 54.4980H-1(32).
- ³⁶ See 54.4980H-3(d)(2).
- ³⁷ See 54.4980H-3(d)(2)(iii) for an explanation of “otherwise eligible” for this purpose.
- ³⁸ See 54.4980H-3(d)(2)(iii). But again, the 90-Day Rule comes into play here and coverage may need to start earlier to the extent required under the 90-Day Regulations.
- ³⁹ 54.4980H-3(d)(2)(iii).
- ⁴⁰ 54.4980H-4(c) and §54.4980H-5(c).
- ⁴¹ See 54.4980H-3(d)(3)(i).
- ⁴² See 54.4980H-3(d)(3)(i) and (ii).
- ⁴³ See 54.4980H-3(d)(3)(vi)(A) and (B). The 90-day limit on the administrative period includes any period of time before the start of the initial measurement period. The administrative period includes all periods between the start date and the date the employee is offered coverage under the group health plan other than the initial measurement period.
- ⁴⁴ A special rule applies when an employee changes status to full-time before the end of his/her initial measurement period. See *infra* under “Special Rule for Employees Who Change Employment Status during Initial Measurement Period.”
- ⁴⁵ 54.4980H-3(d)(3)(iii).
- ⁴⁶ 54.4980H-3(d)(3)(i); see 54.4980H-3(d)(1)(v) for categories.
- ⁴⁷ 54.4980H-3(d)(3)(iii).
- ⁴⁸ *Id.*
- ⁴⁹ *Id.*
- ⁵⁰ See 54.4980H-3(d)(3)(vii).
- ⁵¹ 54.4980H-3(d)(4).
- ⁵² 54.4980H-3(d)(4)(ii) and (iii), 54.4980H-1(46).
- ⁵³ See 54.4980H-3(d)(1).
- ⁵⁴ See 54.4980H-3(d)(1)(ii).
- ⁵⁵ The administrative period must overlap the stability period. See 54.4980H-3(d)(1)(vi).
- ⁵⁶ An exception applies under certain limited circumstances, where a full-time employee who has continuously been offered minimum value coverage following the employee’s initial three months of calendar service has a change in status to part time. See 54.4980H-3(f)(2).
- ⁵⁷ See 54.4980H-3(d)(1)(iii).
- ⁵⁸ And, in order not to risk 4980H(b) penalties, the coverage will also need to provide minimum value and be affordable with respect to the employee-only level of coverage.
- ⁵⁹ See 54.4980H-3(d)(1)(iv).
- ⁶⁰ See 54.4980H-3(f)(1) and (2).
- ⁶¹ See Notice 2014-49- Section 4980H – Shared Responsibility for Employers Regarding Health Coverage – Approach to Changes in Measurement Periods or Methods Applicable to an Employee. Employers can rely on the proposed approaches in Notice 2014-49 until further guidance is issued, but in any case through the end of the 2016 calendar year.
- ⁶² See 54.4980H-1(24).
- ⁶³ 54.4980H-3(b)(2).
- ⁶⁴ See preamble to the Employer Shared Responsibility Regulations at 8549.
- ⁶⁵ See 54.4980H-3(b)(3).
- ⁶⁶ The final rules also prohibit use of an equivalency method if the method results in an understatement of hours of service for a substantial number of employees (even if no given employee’s hours of service are understated substantially). The concern is understatement of hours of service for calculation of full-time equivalents for the large employer determination. For example, if an employer has 100 salaried employees, each of whom normally work two days per week for 10 hours each day, it would be impermissible for the employer to use a 8-hour a day equivalency (even though in either case the employees are still part-time) because the equivalency would result in 400 fewer hours being included in the full-time equivalent calculation for each week. In other words, the total number of hours worked for the 100 employees for a week
- using actual hours worked is 2000 hours and only 1600 hours using the 8-hour day equivalency, – a difference of 400 hours.
- ⁶⁷ See 54.4980H-3(b)(3)(ii).
- ⁶⁸ Hours contributed by bona fide volunteers for a government or tax-exempt entity, such as volunteer firefighters and emergency responders, will not cause them to be considered full-time employees even if the volunteer receives some payment for the volunteer work, so long as that is the only work the individual does for the entity and the pay is nominal or just intended to cover the volunteer’s expenses. Similarly, hours worked by a volunteer who does not receive compensation from the entity does not need to be credited with hours worked. See Employer Shared Responsibility Regulations at page 8550 and definition of bona fide volunteer at 54.4980H-1(7).
- ⁶⁹ However, the final regulations do not include a general exception for student employees. All hours of service for which a student employee of an educational organization (or of an outside employer) is paid or entitled to payment in a capacity other than through the federal work study program (or a state or local government’s equivalent) are required to be counted. See preamble to Employer Shared Responsibility Regulations pages 8550-8551.
- ⁷⁰ See preamble to Employer Shared Responsibility Regulations at page 8551.
- ⁷¹ 54.4980H-1(24)(ii)(C).
- ⁷² See preamble to Employer Shared Responsibility Regulations at 8551.
- ⁷³ *Id.* at 8552.
- ⁷⁴ *Id.*
- ⁷⁵ See preamble to Employer Shared Responsibility Regulations at 8551.
- ⁷⁶ 54.4980-3(d)(6)(i)(A) and 54.4980-3(d)(6)(ii)(A).
- ⁷⁷ 54.4980-3(d)(6)(iv).
- ⁷⁸ 54.4980-3(d)(6)(i)(B) and 54.4980-3(d)(6)(ii)(B).
- ⁷⁹ 54.4980-1(44)).
- ⁸⁰ 54.4980-1 (17).
- ⁸¹ Family and Medical Leave Act of 1993, Public Law 103–3, 29 U.S.C. 2601 *et seq.*
- ⁸² Uniformed Services Employment and Reemployment Rights Act of 1994, Public Law 103–353, 38U.S.C. 4301 *et seq.*
- ⁸³ See 54.4980-3(d)(6)(i) and (ii).
- ⁸⁴ 54.4980-3(d)(6)(iii).

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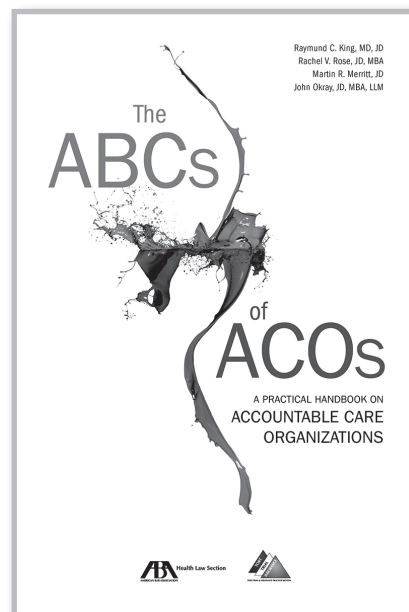
Product Code: 5630125

Editor: Raymund C. King, Rachel V. Rose, Martin R. Merritt, and John Okray

Publication Date: July 2014

Page Count: 166, paperback **Trim Size:** 6" x 9"

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PREPARING FOR THE ELIMINATION OF THE MINIMUM WAGE AND OVERTIME EXEMPTION FOR HOME HEALTHCARE AIDES

Angelo Spinola, Esq.
Shannon Creasy, Esq.
Littler Mendelson
Atlanta, GA

On October 1, 2013, the Department of Labor's ("DOL") Wage and Hour Division published a final rule in the *Federal Register* eliminating the Fair Labor Standard Act's ("FLSA") minimum wage and overtime exemption for home care workers employed by home care agencies and other third-party employers.¹

The New Regulations

In 1974, when extending FLSA coverage to "domestic service" workers, Congress also created an exemption from the minimum wage and overtime requirements for "any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves."² Congress granted the Secretary of Labor authority to define the terms in the exemption through regulation. The DOL exercised that authority in 1975 by issuing the regulations at 29 C.F.R. Part 552 to define the scope of this "companionship exemption." Section 552.109 of the 1975 regulations established that the exemption applies to employees "who are engaged in providing companionship services" and "who are employed by an employer or agency other than the family or household using their services." The current changes arise from the DOL's authority to modify its regulations rather than Congressional action.³

In the 39 years since Congress enacted the exemption, home care workers employed by home care agencies and other employers (rather than directly by the individual or household

receiving the services) have been exempt from the FLSA minimum wage and overtime requirements. That is all about to change. The DOL acknowledges that most home care workers already earn above the minimum wage, but, beginning January 1, 2015, employers must begin paying such employees overtime at one-and-a-half times their regular rate of pay for all hours worked over 40 in a workweek, as is required for other non-exempt employees in the workforce.⁴

The final rule amends the regulations to provide that the companionship exemption is not available to home care workers employed by a third-party company.⁵ In addition, and equally important, the final rule amends the regulations to narrow the definition of companionship services, thereby narrowing the exemption even for home care workers directly employed by the individual, household, or family receiving the services.

DOL Enforcement Efforts in the Home Health Industry

Notably, the DOL has already specifically targeted the home health industry in its outreach and enforcement efforts. Recently, when launching its "We Can Help" campaign, designed to educate workers about their rights and how to file a complaint with the DOL, the agency announced that it was placing "a special focus on reaching employees" in home healthcare and other traditionally lower-wage industries.⁶ Other target industries include construction, janitorial services, child care services, transportation, warehousing, meat and poultry processing, professional

and personnel service industries, hotel/motel services, and food services.⁷ In addition, the DOL has disseminated a number of fact sheets specifically addressed to employers of healthcare workers to provide particular guidance in anticipation of an increase in investigations and lawsuits.⁸ To date, enforcement actions by the DOL have targeted the alleged failure to pay in-home caregivers for travel time between worksites, incorrect calculations of the overtime rate, failure to pay minimum wages and overtime in connection with a flat daily rate, child labor violations, and misclassification of employees as independent contractors.⁹ The penalties generally available for violations have not changed and include back wages, liquidated damages, attorneys' fees, and civil monetary penalties for recurring violations.¹⁰

Additionally, the DOL recently issued new guidance relating to live-in healthcare aides.¹¹ Although the new guidance preserves the exemption in limited circumstances for live-in domestic service workers who reside in the employer's home permanently or for an extended period of time and are employed solely by an individual, family, or household, these workers must now be paid at least the federal minimum wage for all hours worked. Furthermore, live-in domestic service workers who are jointly or solely employed by a third-party employer, such as a home healthcare agency, now must be paid minimum wage and overtime pay for hours worked, and these third-party employers must also maintain an accurate record of hours worked by live-in domestic service workers.¹² Previously, "any reasonable agreement of the parties which takes into consideration all of the pertinent facts will be accepted."¹³ Such a reasonable

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agreement may exclude from paid time “normal private pursuits” such as “eating, sleeping, entertaining, and other periods of complete freedom from all duties when he may leave the premises for purposes of his own.”¹⁴ The DOL made clear in the Final Rule, however, that the reasonable agreement cannot replace a record of actual hours worked; if a provider spends more time performing work tasks than anticipated by the agreement, he or she is entitled to be compensated for the additional work time.¹⁵

Moreover, earlier this year, David Weil, the new Wage and Hour Administrator of the DOL, published a book entitled *The Fissured Workplace* in which he criticized business structures such as the franchisor-franchisee relationship for neglecting compliance with labor standards in low-wage industries.¹⁶ Since Administrator Weil’s appointment in May 2014, there has been growing concern among employers that he may steer the DOL toward more punitive enforcement, particularly against franchisors.

Although the new regulations will take effect as scheduled on January 1, 2015, the DOL announced a time-limited, non-enforcement period during which the agency will not bring enforcement actions with regard to the new final rule.¹⁷ In addition to announcing this suspension of enforcement efforts through June 30, 2015, the DOL also stated that during the subsequent six months, through the end of 2015, the agency will exercise “prosecutorial discretion” in enforcement “with particular consideration given...to good faith efforts...to bring [] home care programs into compliance....”¹⁸ While the DOL has explained that the delay is intended to give states and private employers additional time to make the necessary adjustments, employers should not have a false sense of security due to

this announcement. Employers who delay compliance could still face lawsuits from employees suing independently.¹⁹ And, in such cases, employees would likely be entitled to recover all of the same remedies, including back wages and liquidated damages.²⁰

The regulatory change comes after several years of increased auditing of employers relating to the FLSA under the direction of previous Labor Secretary Hilda Solis.²¹ Upon entering office in 2009, Secretary Solis vowed to increase enforcement efforts, telling union leadership, “[y]ou can rest assured, there’s a new sheriff in town.”²² In support of her enforcement goals, Secretary Solis added 250 investigators to the DOL Wage & Hour Division.²³ All indications are that these stepped-up enforcement efforts will continue under current Labor Secretary Thomas Perez.²⁴

A lawsuit has been filed challenging the new regulations, alleging they discriminate against third-party employers and will adversely affect access to home care services for millions of vulnerable citizens.²⁵ While a successful outcome may preserve the status quo for the home health industry, employers should not delay compliance in reliance on the legal challenge. It is highly unlikely that the litigation will resolve before the regulations take effect in January and there is no guarantee of a success. Therefore, home care employers should not adopt a “wait and see” approach to compliance. Rather, home care employers need to prepare now for the transition.

This is not the first time the DOL has changed course in this manner. In 2010, the DOL reversed its position regarding the applicability of the administrative exemption to mortgage loan officers. Prior to 2010, mortgage loan officers were widely considered exempt from the FLSA’s overtime requirements.²⁶ This

assessment was based primarily on a 2006 DOL Opinion Letter in which the agency concluded that mortgage loan officers were “exempt administrative employees.”²⁷ However, the DOL issued an Administrator’s Interpretation in 2010, withdrawing the 2006 Opinion Letter and announcing that mortgage loan officers were non-exempt because the primary duty of the position was sales.²⁸ This switch caused considerable confusion among employers. Despite a 2013 D.C. Circuit decision vacating the DOL’s 2010 interpretation on the ground that it was promulgated improperly (without the required notice and rulemaking), uncertainty persists because the court did not rule on the merits.²⁹ On June 14, 2014, the United States Supreme Court granted certiorari to hear the case on appeal.³⁰

Compliance: What Can Home Care Employers Do to Prepare for the Change?

Reclassifying impacted employees to non-exempt status is not an easy task. Reclassifications can take months to complete, requiring employers to review current compensation structures, implement new timekeeping systems, reprogram payroll systems, adopt new pay policies, and train the newly non-exempt employees and their managers on the new policies and procedures. The following are recommendations for reclassification of home care workers from exempt to non-exempt:

Reducing Costs Through Alternative Compensation Models

Home care employers should determine the expected increase in labor overtime costs if their current compensation structure continues after their home care employees become non-exempt, and consider options for controlling or passing on

those costs to their clients. Employers may need to plan to hire additional home care workers in order to reduce overtime and consider whether overtime costs could be controlled through alternative compensation methods. Employers also may need to begin preparing consumers for price increases.

Most non-exempt employees are paid by the hour. The FLSA requires that overtime pay for such employees be calculated as one-and-a-half times the employee's regular rate of pay.³¹ However, under the FLSA and most state laws, there are other compliant compensation options that permit an employer to pay overtime at a half-time rate, rather than time-and-a-half.³² In addition, in most states, an employee's overtime pay rate can be legally reduced if the regular rate is calculated by dividing a salary by the actual hours worked by the employee each week, rather than dividing by 40 hours.³³ These options, briefly summarized below, can provide substantial benefits in terms of controlling overtime costs; however, there are complexities involved in each, requiring careful implementation and ongoing administration to ensure that all legal requirements are met. Furthermore, some states restrict the use of these methods, and not all plans are compliant with the laws in every state.

Pay-Per-Visit

An employer may pay a non-exempt home care aide on a pay-per-visit basis where the employee receives a fee for each patient visit and all visit-related activities, inclusive of travel time.³⁴ The per-visit rate may vary depending on the type of visit. Under the FLSA overtime regulations, such a plan is known as paying on a "piece rate."³⁵ Under a piece rate plan, the per-visit earnings are considered straight time (1 x the hourly rate of pay) for all hours worked during the visit and, thus, only the additional half-time premium (0.5 x the hourly rate of pay) is due on the overtime hours.

While the pay-per-visit method reduces overtime costs, there are

complexities that can increase the risk of an overtime violation if not implemented correctly.³⁶ First, the per-visit rates must be sufficient to ensure that the employee is paid at least the applicable federal or state minimum wage. Second, employees paid on a piece-rate basis must still accurately record all hours worked to allow the employer to test for compliance. Third, a piece-rate method must carefully define the work activities that are included within the piece-rate pay. Some states restrict the types of activities that can be included in the piece rate.³⁷ Fourth, and most importantly, the overtime calculation itself is more complex for a piece-rate employer, increasing administrative costs and risk of errors. Under the piece-rate method, the overtime pay rate is calculated by dividing the sum of all straight-time earnings in the week – all per-visit earnings, other hourly earnings, any incentive pay, etc. – by the total number of hours worked in that workweek. The resulting hourly rate, known as the "regular rate," is then multiplied by 0.5 to determine the overtime pay rate. Because home care employees' earnings and work hours may change every week, the regular rate and overtime pay rate must be recalculated separately for each workweek.

Day Rate

The FLSA and most state laws also allow employers to pay home care aides on a day rate. A day rate is a flat sum for a day's work, regardless of the number of hours worked that day. Similar to per-visit pay, the day-rate earnings are considered straight time (as defined above) for all hours worked during the day and, thus, only the additional half-time premium is due on the overtime hours.³⁸ This may reduce overtime costs, but most of the complexities and risks discussed above for per-visit pay also apply for employees paid a day rate. The day rate adopted by the employer must be sufficient to ensure that the employee is paid at least the applicable federal

or state minimum wage for all hours worked. Day rate employees must still accurately record all hours worked to allow the employer to test for compliance with the minimum wage and to calculate overtime pay properly. Because home care employees' work hours may change every week, the regular rate and overtime pay rate must be recalculated separately for each workweek.

Fluctuating Workweek

An employer can also consider paying home care aides on a salary, and reduce overtime costs by using the fluctuating workweek method for calculating overtime pay. Under the fluctuating workweek method, a fixed salary is considered straight time (the 1.0) for all hours worked during the week – whether 30 hours or 50 hours. Thus, only the additional half-time premium (the 0.5) is due on the overtime hours.³⁹ This fluctuating work week method can provide substantial savings over conventional salaried pay plans, but can be used only if *all* of the following requirements are met:

1. The employee's hours actually fluctuate from week to week (although hours do not have to fluctuate both under and over 40, they can always fluctuate over 40);
2. The employee receives the same fixed weekly salary every week, without reduction if the employee does not work his or her full schedule and the weekly salary is never supplemented with bonuses, incentive pay, or any other earnings;
3. The salary is sufficiently high to assure that no workweek will be worked in which the employee's average hourly earnings from the salary fall below the minimum wage; and
4. The employee clearly understands that the salary covers straight-time pay whatever hours the job may demand in a particular workweek.⁴⁰

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While a fluctuating workweek pay plan can provide substantial benefits in terms of controlling overtime costs, it requires careful implementation and ongoing administration. In addition, the fluctuating workweek plan is generally permissible in most, but not all states.⁴¹

Fixed Salary for Fixed Hours

Another salary option available in some states that can reduce overtime costs is paying home care aides a fixed weekly salary for a fixed number of hours worked each week.⁴² Under this method, the employer and home care employee agree that a fixed salary will cover the straight-time pay for a pre-determined number of hours each week (e.g., 50 hours). Of course, the fixed salary must be sufficiently high to assure that no workweek will be worked in which the employee's average hourly earnings from the salary fall below the minimum wage. Further, the pre-determined number of hours must be reasonably related to the actual number of hours the employee is expected to work – the fixed hours cannot be set at 50 if employees usually work only 45 hours per week. In addition, the fixed hours and fixed salary must be exactly that – fixed – and cannot fluctuate from week to week. Employees must receive their full fixed salary even if they work less than the agreed number of weekly hours. If these requirements are met, overtime for hours worked up to the fixed hours are paid at the half-time rate because the salary is the straight-time rate for all hours up to the fixed hours. Hours worked above the fixed hours are paid at time-and-a-half.

Tracking and Defining Hours Worked

The DOL's new regulations will require home care employers to track the hours worked by home care aides – regardless of the compensation

structure – to ensure that the aides are paid at least the applicable federal or state minimum wage for all hours worked and overtime pay at one-and-a-half times each employee's regular rate of pay for all hours worked over 40 in a workweek.⁴³ Claims for "off-the-clock" work are one of the most common types of employment law claims asserted in class/collective actions by non-exempt employees, and are likely to increase after the DOL's new companionship regulations become effective.⁴⁴ In the home health industry, where employees typically work remotely in the homes of patients, it will be difficult for employers to monitor and track accurately the hours worked by home care employees. Home care employers will likely find four areas particularly challenging in accurately tracking hours worked by home care aides: (1) meal periods and rest breaks; (2) travel time; (3) pre- and post-shift activities; and (4) sleep time. Employers can reduce liability risk by adopting wage and hour policies specifically addressing these challenges and by implementing appropriate timekeeping systems.

Meal Periods and Rest Breaks

About 20 states require employers to provide employees with a meal period,⁴⁵ and seven states require employers to provide employees with rest breaks.⁴⁶ Although state laws vary, an employer typically must provide a 30-minute meal period to an employee working a shift of at least five or six hours. Failure to provide a meal period or rest break can result in penalties under state law (e.g., an hour of additional pay in California). The federal FLSA does not *require* employers to provide meal periods. However, if employers do provide a meal period, the FLSA governs when such meal periods may be unpaid. A meal period may be unpaid under the FLSA and most state laws if the period is 30 minutes or longer and the

employee is completely relieved of duty. A few state laws also provide that a meal period cannot be unpaid unless employees are free to leave the worksite. For non-exempt employees, class action lawsuits involving missed meal periods are perhaps the most common type of overtime claim.⁴⁷ Thus, home care employers need to be ready to comply with state and federal laws on meal breaks when home care aides become non-exempt effective January 1, 2015.

Home care employers should consider not requiring home care aides to take unpaid meal periods if their state of employment does not require them to be provided. For states that require meal periods be provided, employers should adopt a policy requiring home care aides to take meal periods and rest breaks in accordance with state law with clear parameters for doing so. If the meal period will be unpaid, the policy should state that the home care aides should not perform any work during the meal period, and provide a process for home care aides to report and be paid for meal periods that are interrupted with work. Neither the FLSA nor state laws require paid meal periods, but a policy is needed to ensure compliance with state laws, even if the employer chooses to pay employees during the meal period or the employee is paid on a per-visit or per-day basis.

In addition, to comply with state law, especially in California, home care employers must implement a process for recording that home care aides took (or waived, when state law allows) their meal periods and rest breaks.⁴⁸ The best practice for unpaid meal periods is to require employees to record the actual times when they left and returned from the meal period. Another option is to require employees to certify each pay period that they took all of their required

meal periods and rest breaks. Time-keeping systems that automatically deduct 30 minutes from the employee's time each day for an unpaid meal period are not recommended, as these systems are often an invitation for litigation by employees claiming they worked through the meal period and were not paid for that work.

Travel Time

Another challenge for home care employers will be tracking and paying home care aides for time spent traveling between work locations. Under the FLSA and state laws, normal commuting between work and home is generally not considered "work" for which an employee must be paid. Home-to-work commuting time is not compensable even if the employee works at different job sites (such as patients' homes) rather than a fixed location (e.g., an office or manufacturing plant).⁴⁹ Thus, the time that home care aides spend traveling from their personal residence to the home of their first patient in the morning, and the time driving from the home of the last patient back to their personal residence, need not be paid. However, all travel by a home care aide that occurs during the work day – for example, travel from one patient's home to the next – is compensable work time.⁵⁰ Home care aides must be paid for this travel time, and this travel time counts towards determining whether the aide worked over 40 hours in the workweek.

In addition, even a normal commute can potentially become compensable work time if a home care aide spends significant time performing work at home before or after the work day. For example, if a home care aide spent several hours at home every evening to complete paperwork required by the employer, the aide's home may be deemed another work site, thus transforming the typically non-compensable commute into a compensable worksite-to-worksite trip.

The DOL estimates that the additional cost to the industry of paying home care employees for travel time will be over \$107 million annually, and many experts believe that the agency's entire cost projection, including travel time, is grossly underestimated.⁵¹ Paying home care aides for their travel time will be a significant challenge for nearly every home care employer. Thus, home care employers should consider options for reducing travel time costs. For example, whenever possible, home care employers could assign home care aides to work at patient homes within a small geographic area to reduce the travel time between work locations. Alternatively, employers could pay employees at a lower hourly rate (the minimum wage, for example) for time spent traveling from patient to patient.

Employers also should consider adopting a travel time policy explaining when and how much home care aides will be paid for travel time. The policy should address reimbursement for travel expenses (e.g., will home care aides be reimbursed based on the IRS mileage rate?).⁵² Under California law, non-exempt employees cannot bear the burden of any expense incurred in the course of performing their work.⁵³ Under the FLSA, travel expenses incurred for work cannot effectively reduce an employee's wages below the minimum wage.⁵⁴ Without a clear policy and established processes, a home care employer could be vulnerable to claims for failure to reimburse home care aides for travel and other business expenses.

Pre- and Post-Shift Activities and Other Compensable Work

Some home care aides perform work activities outside of patient visits, and some of that work may be performed in the home care aide's home either before or after patient visits. In addition to travel time, home care employers must recognize all types of activities not involving direct patient care that are nonetheless compensable

work. For example, compensable work in the home care industry could include: (a) completing paperwork or charting that is required or necessary for the job; (b) making telephone calls, sending or reading emails or other communications with supervisors or patients; (c) attending meetings; and (4) attending training that is required by the employer or related to the job.

Home care employers must be prepared to ensure that these and other work-related activities are properly recorded and paid. As discussed below, home care employers also need to have a comprehensive set of policies and explore options for timekeeping systems that allow home care aides to record their work time wherever they may be when the work is performed.

Sleep Time

In the home care industry, patients often need 24/7 care. To meet this need, home care companies may assign two home care aides to each work a 12-hour shift, have home care aides work 24-hour shifts, or provide "live-in" companions (as that term is defined by the DOL).⁵⁵ Without some advanced planning, after home care aides become non-exempt on January 1, 2015, their employers may have to pay the aides for the time they spend sleeping. How much and under what circumstances depend on whether the home care aides work shifts of less than 24 hours, work shifts of 24 hours or more, or qualify as "live-in" domestic employees.

Because "work" does not require either mental or physical exertion, under the FLSA and state law an employee may be "working" even while sleeping.⁵⁶ If an employer requires a home care aide to remain at the patient's home for less than 24 hours, any time the aide spends sleeping or "engaging in other personal activities when not busy" is "work" for which the employee must be paid.⁵⁷

For employees working in a patient's home for a shift of 24 hours

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or more, the home care employer can exclude up to eight hours of sleep time from hours worked – but only if certain other requirements are met.⁵⁸

To take advantage of this exclusion, home care employers should enter into written agreements with such employees to exclude sleep time – a period not more than eight hours – from hours worked. To properly exclude this time from the hours worked, the employer must provide adequate sleeping facilities and the employee's time sleeping must usually be uninterrupted. Additionally, home care employers should consider adopting a sleep time policy that includes a procedure for home care aides to report when their sleeping period is interrupted, for how long it was interrupted, and whether they got at least five hours of uninterrupted sleep. Without a sleep time agreement and policy, home care employers not paying 24-hour employees for sleep time may find themselves facing potential liability.

Developing a Comprehensive Compliance Program

By proactively taking steps today to ensure that their systems are functioning properly and that exceptions are reported, home health employers will be more likely to remain compliant and be better positioned in the event of a DOL investigation or litigation. Appropriate practices, summarized below, include updating wage and hour policies and electronic timekeeping systems, implementing internal complaint and investigation procedures, providing ongoing training, conducting audits, and developing evidentiary support to defend against potential future challenges.

Update Timekeeping and Payroll Policies

Homecare employers should adopt and update payroll policies, like

those identified above, to help ensure compliance with wage-hour laws and fortify against potential litigation. The policies should also specifically state that employees may be subject to discipline for violation of the policies. Policies to consider include policies related to timekeeping procedures, travel, sleep time, remote work, and meal and rest breaks.

Employers should consider adopting a policy specifically defining what constitutes working time and prohibiting managers from requiring non-exempt employees to work off-the-clock. Such a policy should state that employees are required to report all hours worked, and may be disciplined for submitting falsified time records. The policy also could specifically identify the types of work activities for which employees must report time worked and be paid (e.g., charting, meetings, training, emails, etc.). If employers wish to restrict overtime, then they should include in their policies the conditions under which employees may work overtime (e.g., permission from a supervisor). However, if an employee violates the policy and works overtime anyway, the employer still must pay for the overtime, but may treat the violation as a disciplinary issue. Lastly, employers should also ensure that pay issues are covered under standalone employee complaint and investigation procedures that prohibit retaliation.

Utilize a Remote Electronic Timekeeping System

Home care companies should consider implementing a timekeeping system that employees can access remotely from their cars and patient homes so that they can accurately record their start and stop times each day. A timekeeping system that has a time stamp feature helps reduce the risk of actual start and stop times being manipulated. Employers should also require employees to certify that

they have accurately reported their time worked and taken all required rest breaks and meal periods. For example, the employee's timesheet may include language acknowledging that the employee has recorded all time worked, and a space for the employee's signature certifying the time worked. Employers should provide a mechanism for employees to report errors, including employee signatures to verify corrections, and a method to pay any extra compensation that may be due. Conducting periodic audits of time records can help ensure that employees are recording their time properly. Employers should consider having new systems in place as soon as possible, ideally several pay periods in advance of the effective date of the new rule, to allow time to resolve system issues and to ensure that the home care providers understand how to record their time properly.

Review Payroll Systems

With the implementation of the new DOL regulation, home care employers should review the company's payroll system to ensure that overtime is being calculated correctly for non-exempt employees, whether they are paid on an hourly rate, per-visit basis, a day rate, or a salary. Overtime calculation errors are easily made, especially for home care workers paid on a per-visit basis or a day rate. Another common overtime calculation error is failure to include bonuses, commissions, or other incentive compensation in the overtime calculation. Such additional compensation must be allocated across all hours worked by the home care employee during the period in which the incentive pay was earned, which effectively increases an employee's regular rate of pay and overtime pay rate. Even if a home care employer has outsourced the payroll function, the employer will be liable for incorrect overtime calculations and not the payroll company. Also,

the payroll company cannot correctly calculate overtime pay if the employer fails to identify and provide information on incentive pay that needs to be included in the overtime calculation.

Employers should also consider transitioning home care workers currently paid semi-monthly to a bi-weekly or weekly payroll to simplify the overtime pay calculation. Overtime calculation errors occur more frequently when non-exempt employees are paid semi-monthly because a workweek – the basis of both minimum wage and overtime compliance – can often cut across two semi-monthly pay periods.

Home care companies should also audit their payroll system to test for compliance with the minimum wage – especially for employees paid per visit, per day, or using the salaried fluctuating workweek method. For each workweek, the payroll system should divide all earnings by all hours worked and ensure that the result meets or exceeds the applicable federal or state minimum wage.

Provide Training on Proper Recordkeeping

Home care employers should provide training, optimally before the January 1, 2015 transition, to reclassified home care workers and their managers regarding any new policies and procedures. Many potential overtime violations may be avoided if both non-exempt employees and their managers understand what activities are considered “work” that must be recorded in the timekeeping system and are aware of their role in ensuring accurate timekeeping. It is essential that managers understand how non-exempt employees should record their time so they may answer any questions the employees have as they learn the new procedure.

Consider Implementation of an Arbitration Program

Agencies may consider implementing an arbitration program that requires the parties to resolve their

disputes in arbitration and precludes pursuing most labor disputes via litigation. Because arbitration is often less expensive, less time consuming, and more confidential than litigation, arbitration programs have become more common as a means of controlling litigation costs.⁵⁹ In particular, many companies have turned to arbitration programs that include class waivers to prevent employees from pursuing their claims via class/collective action litigation.⁶⁰ Such a provision allows employers to resolve issues directly with the impacted employee more effectively and economically than via class/collective litigation. Arbitration policies must be well-drafted and carefully implemented with consideration to state law and proper notice to employees.

Review and Update General Employee Policies

To help defend against future potential wage and hour claims, home health employers can develop and keep up-to-date timekeeping records, job descriptions, employee agreements regarding applicable pay programs, and self-evaluations. Policy and training acknowledgment forms and tracking help strengthen defenses as well. Employers may also consider strategic planning guided by counsel to identify future litigation risks, assess the strength of a company’s defenses to likely litigation, and mitigate risk through corrective measures.

Other Issues

Employers should be aware that the healthcare arm of the Service Employees International Union (“SEIU”), the largest healthcare union, represents 1.1 million healthcare workers and actively engages in organizing home healthcare workers.⁶¹ Recent efforts include organizing protests and petition drives advocating for higher wages, providing training relating to new laws impacting healthcare workers, and supporting legislation to secure collective bargaining rights for home care workers.⁶² For example, in

early October, home health workers organized and held the first-ever Home Care Workers Summit in St. Louis, Missouri.⁶³ This Summit comes only a month after home care workers officially began a campaign seeking a minimum wage of \$15 per hour for all home health workers.⁶⁴ The SEIU reports that additional events are currently planned in Colorado, Michigan, Montana, and Washington.⁶⁵

Conclusion

Home health employers and their attorneys must be prepared for anticipated enforcement of the DOL’s new regulations severely limiting the use of the companionship exemption by preparing for the transition of home health aides to non-exempt status now. Proper planning and implementation of the proactive steps listed above can help to minimize increased labor costs and to reduce the risk of employers being targeted for future DOL investigations and litigation.



Angelo Spinola is a Shareholder in Littler Mendelson’s Atlanta office. Mr. Spinola regularly represents management across the

country in collective, class and hybrid actions brought under the Fair Labor Standards Act (“FLSA”) and various state wage and hour laws. He represents employers in DOL and state agency wage and hour investigations, conducts wage and hour practice audits and develops compliance measures to minimize exposure to wage and hour claims. In addition to his wage and hour practice, Mr. Spinola appears on behalf of employers in federal and state courts and administrative tribunals, litigating discrimination cases, including age, disability, race, national origin, sex, harassment and retaliation. He also litigates issues related to unfair competition, misappropriation of trade secrets, breach of executive employment contract claims, and common law claims under state law. Mr. Spinola’s

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litigation and counseling experience spans multiple industries, including substantial emphasis in the healthcare sector. He may be reached at aspinola@littler.com or 1.888.Littler.



Shannon Creasy is an Associate in Littler Mendelson's Atlanta office. Ms. Creasy represents management in collective, class and

hybrid litigation brought under the FLSA and state wage and hour laws. She also conducts audits of company wage and hour practices and provides counseling relating to policies, including exemption and classification issues. In addition, Ms. Creasy represents employers in a broad range of employment matters, including discrimination, harassment, retaliation and misappropriation of trade secrets. Ms. Creasy counsels employers to ensure compliance with federal and state laws relating to wage and hour practices, anti-discrimination and anti-harassment policies, restrictive covenants, pre-employment screening and leave of absence matters. She may be reached at screasy@littler.com, or 1.888.Littler.

Endnotes

- ¹ *Application of the Fair Labor Standards Act to Domestic Service*, Final Rule, 78 Fed. Reg. 60454 (October 1, 2013) ("final rule").
- ² 29 U.S.C. § 213(a)(15).
- ³ Since 1975, numerous attempts have been made to narrow the scope of the companionship services exemption, with most focusing on limiting the exemption to cover only those home care workers employed directly by the individual or family receiving the home care services. The DOL proposed regulatory changes to limit the exemption in 1993, 1995 and 2001. None of these proposed changes became final. Bills have been introduced in Congress, but have failed to pass. In 2007, the U.S. Supreme Court rejected a challenge to section 552.109, finding reasonable and valid the DOL's interpretation that the companionship exemption extends to home care workers employed by "an employer or agency other than the family or household using their services." *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 173-74 (2007) (quoting 29 C.F.R. § 552.109(a) (2006)).
- ⁴ Both minimum wage and overtime are now required under the new regulation; however,

for competitive reasons, minimum wage is already typically paid in the home health industry. Accordingly, compliance with the new minimum wage requirement is not an issue in the industry and, therefore, is not the focus of this article.

- ⁵ In *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158 (2007), the United States Supreme Court analyzed the competing policy considerations reflected in the legislative history leading up to the promulgation of the home health exemption, finding that "satisfactory answers" regarding the reasoning behind the DOL's decision to include third party agencies were uniquely in the ambit of the DOL because of its thorough knowledge of the issues. *Id.* at 167-68 (comparing 119 Cong. Rec. 24801 (statement of Sen. Burdick) ("I am not concerned about the professional domestic who does this as a daily living," but rather about "people who might have an aged father, an aged mother, an infirm father, an infirm mother, and a neighbor comes in and sits with them"), with, e.g., 119 Cong. Rec. 24798 (statement of Sen. Johnston) (expressing concern that requiring payment of minimum wage to companionship workers might make such services so expensive that some people would be forced to leave the work force in order to take care of aged or infirm parents)).
- ⁶ Wage and Hour Division, News Release No. 10-0411-NAT (Apr. 1, 2010), at www.dol.gov/opa/media/press/whd/WHD20100411.htm.
- ⁷ *Id.*
- ⁸ *Health Care Industry and Hours Worked*, www.dol.gov/whd/regs/compliance/whdfs53.htm; *Health Care Industry and Calculating Overtime Pay*, www.dol.gov/whd/regs/compliance/whdfs54.htm; *Home Health Care Industry*, www.dol.gov/whd/regs/compliance/whdfs25.htm.
- ⁹ See, e.g., Wage and Hour Division, Press Release No. 12-1578-CHI (Aug. 13, 2012), available at www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=Midwest/20120813.xml; Press Release No. 11-1737-CHI (Dec. 28, 2011), available at www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=Midwest/20111228.xml; Press Release No. 11-377-DAL (Mar. 30, 2011), available at www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=Southwest/20110330.xml; Press Release No. 12-45-ATL (017) (Jan. 23, 2012), available at www.dol.gov/whd/media/press/whdpressVB3.asp?pressdoc=Southeast/20120123.xml.
- ¹⁰ See 29 U.S.C. 216.
- ¹¹ *Opinion Letter Fair Labor Standards Act (FLSA)*, 2014 WL 1276986 (Cir. Ct. Mar. 27, 2014); Wage and Hour Division, Administrator's Interpretation No. 2014-1 (Mar. 27, 2014) at www.dol.gov/WHd/opinion/adminIntprtn/FLSA/2014/FLSAAI2014_1.htm.
- ¹² *Id.*
- ¹³ 29 C.F.R. § 785.23.
- ¹⁴ *Id.*
- ¹⁵ 78 Fed. Reg. 60,477, 60,557 (to be codified at 29 C.F.R. §§ 552.102(b), 552.110(b)).
- ¹⁶ David Weil, *The Fissured Workplace: Why Work Became So Bad for So Many and What Can Be Done to Improve It* (2014).
- ¹⁷ Wage and Hour Division, *We Count on Home Care: Time-Limited Non-Enforcement*, available at www.dol.gov/whd/homecare/non-enforcement_policy.htm.
- ¹⁸ *Id.*
- ¹⁹ www.nasddds.org/news/dol-announces-time-limited-non-enforcement-of-home-care-rule.
- ²⁰ *Id.*
- ²¹ Statement of U.S. Secretary of Labor Hilda L. Solis in GAO Investigation Regarding Past Wage & Hour Division Enforcement, at www.dol.gov/opa/media/press/esa/esa20090324.htm.
- ²² *Id.*; Steven Greenhouse, *At Labor Gathering, Luxury, Jockeying and Applause for Secretary*, N.Y. TIMES, Mar. 7, 2009, at A22, available at www.nytimes.com/2009/03/08/us/08labor.html?_r=1& (Solis vowing to add 250 investigators to the DOL's Wage and Hour Division).
- ²³ Statement of U.S. Secretary of Labor Hilda L. Solis in GAO Investigation Regarding Past Wage & Hour Division Enforcement, at www.dol.gov/opa/media/press/esa/esa20090324.htm.
- ²⁴ The Wage and Hour Division recovered a record \$280 million dollars in back wages in 2012. Fiscal Year Statistics WHD, available at www.dol.gov/whd/statistics.
- ²⁵ *Home Care Association, et al. v. David Weil*, Case No. 1:14-cv-00967 (D.D.C. June 6, 2014).
- ²⁶ DOL Opinion Letter, Sept. 8, 2006 (Withdrawn), available at www.dol.gov/whd/opinion/FLSA/2006/2006_09_08_31_FLSA.htm.
- ²⁷ *Id.*
- ²⁸ DOL Opinion Letter, March 24, 2010, available at www.dol.gov/whd/opinion/adminIntprtn/FLSA/2010/FLSAAI2010_1.htm.
- ²⁹ *Mortgage Bankers Ass'n v. Harris*, 720 F.3d 966, 968 (D.C. Cir. 2013) cert. granted sub nom, *Nickols v. Mortgage Bankers Ass'n*, 134 S. Ct. 2820 (2014).
- ³⁰ *Nickols v. Mortgage Bankers Ass'n*, 134 S. Ct. 2820 (2014); *Perez v. Mortgage Bankers Ass'n*, 134 S. Ct. 2820 (2014).
- ³¹ 29 U.S.C. § 207(a).
- ³² The Day Rate and Fluctuating Workweek compensation methods allow for payment of overtime at half-time when other requirements are met. 29 C.F.R. §§ 778.112, 778.114. These compensation methods are permissible in some, but not all states.
- ³³ 29 C.F.R. §§ 778.111, 778.113, 778.114.
- ³⁴ 29 C.F.R. § 778.111.
- ³⁵ *Id.*
- ³⁶ *Id.*
- ³⁷ For example, in California, the visit rate can only cover the time spent in the actual visit, and the home care aide must be paid at least the minimum wage for hours spent traveling, training, etc. See *Gonzales v. Downtown LA Motors, LP*, 2013 Cal. App. Unpub. LEXIS 1728 (Mar. 6, 2013) (finding auto mechanics

- paid on a piece-rate basis were entitled to separate hourly compensation for any time not spent performing auto repairs).
- 38 29 C.F.R. § 778.112.
- 39 29 C.F.R. § 778.114.
- 40 *Id.*
- 41 A handful of states have questioned or entirely prohibited the use of fluctuating workweek pay plans either through specific statutory authority or by judicial decisions. These states are Alaska, California, Connecticut, Hawaii, New Mexico, and Pennsylvania.
- 42 29 C.F.R. § 778.325. The fixed salary for fixed hours method likely would not be compliant in states such as Alaska, California, Connecticut, Hawaii, New Mexico, and Pennsylvania, which require that a non-exempt employee's salary always be divided by 40 hours for purposes of calculating the regular rate and overtime pay.
- 43 Final Rule, 78 Fed. Reg. 60454, 60491; *Opinion Letter Fair Labor Standards Act (FLSA)*, 2014 WL 1276986, *14 (Cir. Ct. Mar. 27, 2014).
- 44 Trends in Wage and Hour Settlements: 2013 Update. *Trends by Allegation*, p. 11, 13, available at www.nera.com/publications/archive/2013/trends-in-wage-and-hour-settlements-2013-update.html (Data for January 2007–September 2012 reflect that overtime claims were the most common (40%), followed by “off-the-clock” claims (16%) and misclassification claims (16%). Multiple allegations are asserted in more than half of the cases. Overtime claims can include “off-the-clock” and meal break claims.).
- 45 These states include: California, Colorado, Connecticut, Delaware, Illinois, Kentucky, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New York, North Dakota, Oregon, Rhode Island, Tennessee, Washington, and West Virginia. In Nevada, the meal break requirements do not apply where only one person is employed at a place of employment (an exception that should frequently apply in the home care industry). Nev. Rev. Stat. § 608.019.
- 46 California, Colorado, Kentucky, Minnesota, Nevada, Oregon, and Washington require employers to provide employees with rest breaks. The most common requirement is a paid 10-minute break for every four hours of work or major fraction thereof.
- 47 Many of the recent class and collective actions have asserted claims against hospitals for work allegedly performed during meal breaks automatically deducted from pay. Many in the industry are moving away from timekeeping systems that automatically deduct meal breaks. See e.g., *Hintergerger v. Catholic Health Sys.*, 2009 U.S. Dist. LEXIS 97944 (W.D.N.Y. Oct. 20, 2009); *Gordon v. Kaleida Health*, 2009 U.S. Dist. LEXIS 95729 (W.D.N.Y. Oct. 13, 2009); *Cavallaro v. UMass Memorial Health Care, Inc.*, 2011 U.S. Dist. LEXIS 61003 (D. Mass. June 8, 2011); *Campbell v. Reliance Healthcare, Inc.*, Case No. 4:12-CV-00176-DPM (Mar. 22, 2012); *Blaney v. Charlotte-Mecklenberg Hospital Authority, d/b/a Carolinas Healthcare Syst.*, Case No. 3:10-CV-FDW-DSC (W.D.N.C. Nov. 18, 2010); *Speraneo v. BJC Health System Inc., d/b/a BJC HealthCare*, Case No. 1322-CC09701 (Cir. Ct. City of St. Louis, Mo. Oct. 21, 2013).
- 48 *Brinker Rest. Corp. v. Superior Court*, 53 Cal. 4th 1004, 1052, 273 P.3d 513, 544 (2012) (holding that under California labor law, an employer has an obligation to provide a meal period to its employees, where the employee is relieved of all duty, no later than the end of the employee's fifth hour of work. Employers who fail to do so must pay a one-hour premium penalty to the employee, unless the employee is only scheduled to work six hours and waives the meal period. See also *Brinker*, 273 P.3d at 353 (concurring Cantil-Sakauye, C.J.; Kennard, J.; Corrigan, J.) (finding that where records show no meal period was taken, a rebuttable presumption arises that the employer did not provide the meal period)).
- 49 29 C.F.R. § 785.35.
- 50 29 C.F.R. § 785.38.
- 51 *Application of the Fair Labor Standards Act to Domestic Service*, Final Rule, 78 Fed. Reg. 60454, 60506 (Oct. 1, 2013); Jeffrey A. Eisenach and Kevin W. Caves, *Estimating the Impact of Repealing the FLSA Companion Care Exemption*, NAVIGANT ECONOMICS, pp. 14-18, 28-29 (Mar. 6, 2012), LAB. L.J., vol. 63 (Fall 2012), available at ssrn.com/abstract=2017109.
- 52 Under the FLSA, travel costs cannot reduce an employee's pay below minimum wage. Some states, such as California, also require that employees be reimbursed for travel costs. The I.R.S. standard mileage rate is available at www.irs.gov/2014-Standard-Mileage-Rates-for-Business,-Medical-and-Moving-Announced.
- 53 CAL. LAB. CODE § 2802.
- 54 29 C.F.R. § 778.217.
- 55 29 U.S.C. 213(b)(21); Final Rule, 78 Fed. Reg. 60454, 60557; 29 C.F.R. pt. 552.102(a).
- 56 29 C.F.R. § 785.20.
- 57 29 C.F.R. § 785.21.
- 58 The requirements are that (a) the employer and employee must agree to exclude sleep time from hours worked; (b) the sleeping period must be bona fide and regularly scheduled; (c) the employee must have adequate sleeping facilities; (d) the employee can usually enjoy an uninterrupted night's sleep; (e) if the sleeping period is interrupted by a call to duty, the interruption must be counted as hours worked; and (f) the employee must get at least five hours of uninterrupted sleep or the entire sleeping period must be paid. 29 C.F.R. § 785.22.
- 59 In 2012, 55% of companies reported that they had some type of arbitration program. In 2013, this increased to 72%. In 2012, 16% of those arbitration agreements had class waivers. In 2013, this increased to 40%. Article “Survey shows cost of class action increased in 2013”; 2014 Carlton Fields Jordan Burt Class Action Survey” *Best Practices in Reducing Cost and Managing Risks in Class Action Litigation*, available at www.classactionsurvey.com (346 general counsels were interviewed; 52% of the larger companies have at least one current class action).
- 60 *Id.*
- 61 SEIU Healthcare, available at www.seiu.org/division/healthcare/healthcare-workers-uniting.
- 62 These efforts are having an impact. For example, the Minnesota House recently passed a bill extending collective bargaining rights to self-directed home care workers in public agencies. *Id.*
- 63 SEIU, www.seiu.org/2014/10/home-care-workers-launch-fight-for-15-demand-polit.php.
- 64 *Id.*
- 65 *Id.*

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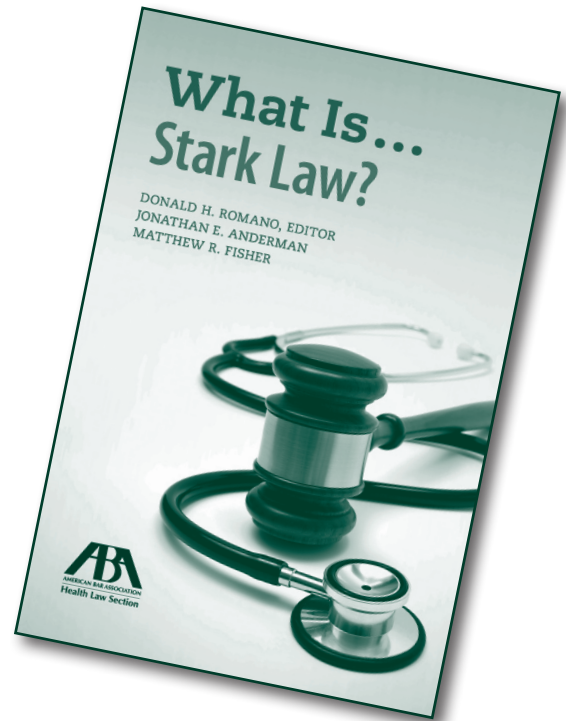
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- ✓ An overview of enforcement mechanisms and consequences for violations of the Stark Law
- ✓ A list of resources to further assist attorneys as they research and analyze Stark issues

This book is a "must have" for any individual working with healthcare entities needing a general introduction to the statute and regulations governing financial relationships between healthcare entities.



Product Code: 5630122

Editor and Authors: Donald H. Romano, Jonathan E. Anderman, Matthew R. Fisher

Publication Date: January 2014 (*first in a new series!*)

Page Count: 66 **Trim Size:** 6" x 9"

\$49.95 / \$35.95 for Health Law Section members

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The Editorial Board of *The Health Lawyer* is pleased to provide this update of presentations made at the Annual Emerging Issues in Healthcare Law Conference, held in Litchfield Park, Arizona, February 2014. This is an additional benefit provided to Section members to keep you apprised of new developments in healthcare law. We hope that you find this update useful.

UPDATE TO: TRENDS IN EMPLOYER AND PROVIDER OBLIGATIONS: THE DEMISE OF DOMA AND THE RISE OF NEW HIPAA WELLNESS PROGRAMS RULES

Submitted by
Howard Bye-Torre, Esq.
Stoel Rives, LLP
Seattle, WA

In June of 2014, (1) The Centers for Medicare & Medicaid Services (“CMS”) issued guidance addressing the treatment of same-sex spouses under the Medicare secondary payer rules (“MSP Rules”) (“Place of Celebration” rule to determine whether same-sex couples are “spouses” under the MSP Rules, effective 1/1/2015), *available at* www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Downloads/Same-Sex-Marriage-Alert-6-3-2014.pdf; and (2) the Department of Labor (“DOL”) proposed a “Place of Celebration” rule for same-sex couples for the definition of “spouse” in the Family and Medical Leave Act (“FMLA”) regulations. (Fact sheet *available at* www.dol.gov/whd/fmla/nprm-spouse/factsheet.htm). In October, HHS’s Office for Civil Rights (“OCR”) issued similar guidance adopting the “Place of Celebration rule” for determining status as a spouse (and family member) under the HIPAA privacy rules.

www.hhs.gov/ocr/privacy/hipaa/understanding/special/same-sexmarriage/index.html

In October, 2014, the United States Supreme Court refused to take up the constitutional validity of state bans on same-sex marriage, letting stand the unanimous decisions of four federal courts of appeals (4th, 7th, 9th and 10th) that such bans violate the Federal Constitution. www.supremecourt.gov/orders/courtorders%5C100614zor.pdf. Same-sex marriages are now legal in more than 30 of the United States. However, since the Supreme Court order, a divided panel of the Sixth Circuit has upheld state bans on same-sex marriage, making a Supreme Court decision on this issue more likely in the future.

<https://s3.amazonaws.com/s3.documentcloud.org/documents/1354856/6th-circuit.pdf>

Although HIPAA provides concrete (if complex) rules that wellness programs must follow, it has remained an open issue for sponsors of wellness programs as to what is required to comply with the Americans with Disabilities Act (“ADA”), because the Equal Employment Opportunity Commission (“EEOC”) has consistently refused to issue any guidance on this topic. However, the EEOC has now filed three lawsuits alleging that employer-sponsored wellness programs violate the ADA.

www.eeoc.gov/eeoc/newsroom/release/8-20-14.cfm

www.eeoc.gov/eeoc/newsroom/release/10-1-14b.cfm

www.benefitslawadvisor.com/wp-content/uploads/sites/172/2014/10/EEOCvsHoneywellPetition-3.pdf

These lawsuits target wellness programs that require medical examinations and ask disability-related inquiries that are not job-related and consistent with business necessity. In these types of wellness programs, employees do not earn the reward (such as a lower health plan premium) unless they submit to a health risk assessment, which usually requires the employees to answer non-job related medical questions and to submit to medical tests such as blood pressure and blood work (e.g., cholesterol and diabetes screenings). Under the ADA, certain types of wellness programs that are “voluntary” are legal, but the EEOC takes the position in these lawsuits that the companies’ practice of imposing penalties on employees (such as an additional premium cost) makes these types of wellness programs involuntary, and thus illegal under the ADA. The outcome of these lawsuits (and the possibility of finally obtaining regulatory guidance from the EEOC on wellness programs and the ADA) could have a major impact on a large number of similar wellness programs throughout the country.



Health Law Section

321 N. Clark Street
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Volume 27, Number 2,
December 2014

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