ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation.

Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

HIPAA SURROGACY EXPENSES

MUST SURROGACY EXPENSES OF A COVERED MEMBER/DEPENDENT BE COVERED?

The accelerated pace of advances in fertility treatments over recent years have provided solutions that were barely imaginable a couple generations ago. Surrogacy is a bridge from infertility to parenthood, and it has become increasingly available to individuals and couples trying to conceive.

Arrangements with surrogates and intended parents have raised a number of complex issues for group health plans under a variety of state and federal laws, and direction from courts and federal agencies is limited. In this article, we sort through these issues and flag some practical considerations for plan sponsors and third-party administrators.

In this article we are assuming that the surrogate is a participant/beneficiary/member/enrollee of the applicable plan (member surrogate). Pregnancy-related expenses of a non-member surrogate are typically excluded from group health plan coverage, just as other expenses of non-member are excluded.

Plans sometimes include an explicit exclusion for such benefits to avoid any confusion, rather than relying solely on a general provision that the plan does not cover benefits for non-members. Reimbursement of expenses for non-member surrogates is not excludable from gross income under current IRS guidance and a taxpayer cannot deduct the medical expenses for a surrogate who is neither the taxpayer nor a tax dependent of the taxpayer[1].

As a practical matter, the pregnancy expenses of the surrogate (as opposed to fertility expenses of the intended parent(s)) often are about the same as the expenses associated with non-surrogacy, or traditional pregnancy.

The difference, particularly under various states laws, is one of parental rights. A gestational surrogacy will involve any number of combinations of gametes, which could come from one, both or neither of the intended parents. In a traditional surrogacy, the surrogate uses her own egg (although this type of surrogacy is increasingly rare and even illegal in some states).

These combinations complicate the issue of pre-birth parental rights, and many states will not allow the rights of the intended parents to be finalized until after birth. The surrogate, in many cases, will be the legal parent of the child (or one of the legal parents) until releasing her right after the child's birth.

One question, then, is whether any of the federal laws that require the plan to cover the pregnancy of an enrolled person would allow a plan to distinguish between a traditional pregnancy and a surrogate pregnancy for purposes of coverage, even in states where a surrogate could decide against releasing her parental rights after birth.

In reviewing the Pregnancy Discrimination Act (PDA), the Newborns' and Mothers' Health Protection Act (NMHPA), and some applicable provisions of the Affordable Care Act (ACA) provisions, we found no such distinctions.

Pregnancy Discrimination Act (PDA). The PDA amended the Civil Rights Act of 1964 and makes it clear that discrimination "because of sex" or "on the basis of sex" as used in Title VII includes

"because of or on the basis of pregnancy, childbirth or related medical conditions."

Under guidance issued by the Equal Employment Opportunity Commission (EEOC), in general terms, the PDA requires that (i) if an employer offers health coverage, the coverage must include coverage of pregnancy, childbirth, and related medical conditions, and (ii) the employer must apply the same terms and conditions for pregnancy-related costs as for medical costs unrelated to pregnancy[2].

This includes, for example, covering the cost of a private room for pregnancy-related conditions if a plan covers the cost of a private room for other conditions, or pre-natal and post-natal visits where a health plan covers office visits to physicians[3].

While the EEOC has not explicitly addressed the question of coverage of pregnancy-related-expenses where a plan member is acting as a surrogate, the requirement to cover pregnancy is explicit and no exceptions are provided based on the type of pregnancy.

Further, the pregnancy-related expenses for a woman who is acting as a surrogate are not, in general, going to be very different from the type of expenses that may arise in other pregnancies, including pregnancies where the mother places the child for adoption after birth.

As already noted, in many states, the surrogate does not release parental rights until after birth, so from the perspective of the health plan, there can be no certainty until the birth mother irrevocably releases her parental rights.

Newborns' and Mothers' Health Protection Act (NMHPA). The NMHPA imposes on group health plans requirements relating to the length of time a mother and newborn child must be covered for a hospital stay in connection with childbirth.

Under the mandate, group health plans cannot restrict benefits for mothers and newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. Neither the statute nor the relevant regulations contain any exception to this requirement based on whether the pregnancy is a surrogacy.

Thus, excluding coverage for pregnancy related expenses for members who are acting as surrogates would appear to be a violation of NMHPA requirements. These requirements are imposed through ERISA, the Internal Revenue Code (the "Code"), and the Public Health Service Act (PHSA)[4].

ACA Requirements. Certain ACA requirements may also be involved depending on the scope of any exclusion for pregnancy-related services of a

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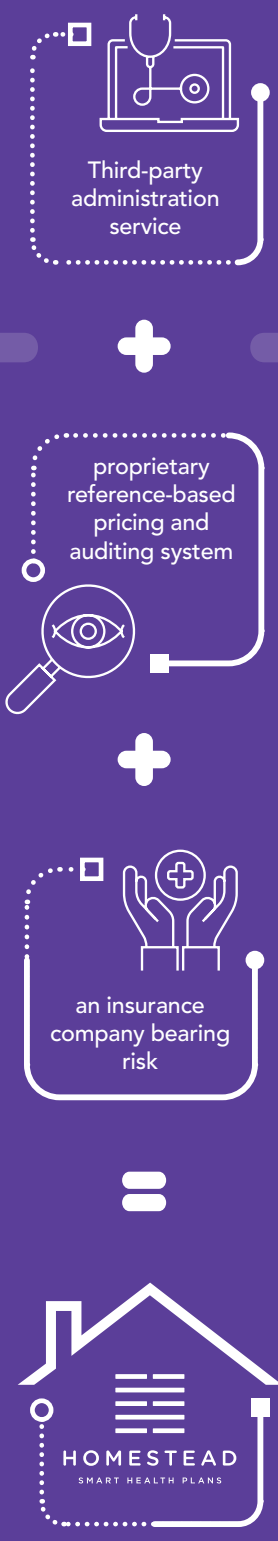

Don't settle for a traditional health benefits plan

What are you waiting for?

woman acting as a surrogate.

For example, non-grandfathered health plans are required to cover certain preventive care services without cost-sharing. Certain of the required preventive services relate to pregnancy.

As another example, the ACA, as amended by the No Surprises Act, imposes certain coverage requirements on group health plans that cover any services in an emergency department of a hospital or emergency services in a freestanding independent emergency department.

If a member acting as a surrogate required emergency medical care covered under the No Surprises Act for treatment related to the pregnancy, there is no exception that would allow the plan to refuse to cover the expense.

Cases. Even though these federal laws and regulations make no distinctions between traditional pregnancies and surrogate pregnancies, there are group health

plans that make such distinctions (or plan documents have been interpreted by the plan administrator to make such distinctions) even for member surrogates.

There have been a few cases that address the issue of coverage of pregnancy expenses for members acting as surrogates. The limited cases address only whether benefits for members acting as surrogates were properly excluded based on the terms of the ERISA plan, which is a contractual issue. Each of the cases conclude that the benefits were properly excluded.

No mention of the PDA, NMHPA, or any of the other requirements discussed above is made in the cases.

Thus, this case law is not precedent with respect to the core issue as to whether it is permissible to exclude pregnancy related expenses for members. The case law, however, does provide some insight into issues that can arise from potential ambiguities in plan provisions regarding benefits for surrogates.

In *Moon v. Tall Tree Adm's, LLC*[5], the plan contained a catch-all exclusion for all non-traditional medical services, treatments and supplies which "are not specified as covered under this Plan, including, but not limited to pregnancy charges acting as a surrogate mother."

The plaintiff argued that this exclusion should be limited to non-traditional medical expenses associated with acting as a surrogate mother and that the traditional expenses relating to the pregnancy of a surrogate mother should be covered.

The court disagreed, finding that the plan language in question unambiguously excluded all medical coverage related to surrogate pregnancy. The court also found that the plaintiff's contention that the exclusion was ambiguous was not supported by the language of the plan and required addition of language to the provision, which was not warranted.

Finally, the court found that the plaintiff's interpretation was not reasonable, and she did not raise any other interpretation that would render the provision ambiguous.

As another example, the plan involved in *Roibas v. EBPA, LLC*[6], listed "[e]xpenses for surrogacy" under a section of the plan titled "General Medical Exclusions

and Limitations". The plaintiff argued that she was a not a surrogate, because a surrogate supplies the egg. Rather, she was a "gestational carrier" because she hosted the fertilized egg of someone else.

Because she was not a "surrogate" the exclusion should not apply in her situation. The court found that the plan was ambiguous regarding the definition of "surrogate" but given the deferential standard of review for a plan administrator's determination found that the plan's interpretation was not unreasonable[7].

Potential sanctions for noncompliance. Potential sanctions and the potential responsible persons will vary based on the particular provision involved as well as the facts and circumstances: A violation of the PDA could result in a requirement that the benefit be paid, along with applicable attorney fees and consequential damages.

Violations of the NMHPA are subject to the same enforcement regime as requirements under the ACA (such as preventive care requirements). The employer may be subject to an excise tax penalty under the Code of $100 per person per day for each violation.

ERISA authorizes plan participants and beneficiaries to bring suit to enforce the provisions of ERISA. Participants and beneficiaries may also bring actions for claims for benefits under the plan. The Department of Labor is authorized to bring a variety of enforcement actions as well.

Practical considerations. A variety of practical issues may arise when the sponsor of a self-funded plan is considering excluding pregnancy-related expenses for a plan member acting as a surrogate, including the following:

- The plan sponsor should review with their own legal counsel the relevant applicable law and potential implications, such as coordination of benefits possibilities.
- The scope of any exclusion (e.g., coverage of mental health services that may be needed during the course of the pregnancy, emergency services, or complications that arise during the course of the pregnancy)
- Clarity of drafting the intended scope of the exclusion.
- Determining whether any exclusion applies--existence of a surrogate arrangement may not be evident until after the birth, and the plan would need to know what action, if any, to take at that time.

Some plan sponsors of self-funded plans have chosen to exclude from coverage pregnancy related expenses for a plan member acting as a surrogate mother.

However, there are clearly risks with such exclusions, given the lack of distinction between a surrogacy and traditional pregnancy in PDA, NMHPA, and ACA requirements.

While in most cases the consequences will fall on the plan sponsor, the TPA or ASO administrator may also be involved, for example in claims disputes. In some cases, the TPA/administrator may be a plan fiduciary based on the scope of their authority, presenting additional risks. ■

References

1) Code § 105(b) See also Magdalin v. Comm., 105 AFTR 2d 2010-442 (1st Cir. 2009); Morrissey v. United States, 871 F.3d 1260 (11th Cir. 2017) (expenses did not affect a structure or function of the taxpayer's body); Longino v. Comm'r, T.C. Memo 2013-80 (2013) (IVF expenses of an unrelated person (here, the taxpayer's former fiancée) were not medical care expenses of the taxpayer where no defect prevented him from naturally conceiving children), aff'd 114 AFTR 2d 2014-6910 (11th Cir. 2014); IRS PLR 202114001 (Jan. 12, 2021).

2) EEOC Enforcement Guidance on Pregnancy Discrimination and Related Issues, I.A.4(a) (last visited on April 18, 2022). See also, 29 CFR Part 1604, Appendix – Questions and Answers on the Pregnancy Discrimination Act, Q&A 23-24.

3) Id., Q&A 25
4) ERISA §711, Code §9811, PHSA §2725.

5) 814 Fed. Appx. 371 (10th Cir. 2020).