
# Compliance Recap

June 2019

June was a relatively busy month in the employee benefits world. The Department of Labor (DOL), the Department of Health and Human Services (HHS), and the Department of Treasury published final rules that removed the prohibition against integrating a health reimbursement arrangement (HRA) with individual health insurance coverage and recognized certain HRAs as limited excepted benefits.

A U.S. District Court issued a permanent injunction against the Patient Protection and Affordable Care Act contraception mandate. The President signed an executive order directing federal agencies to issue guidance and regulations regarding high deductible health plans with health savings accounts, Section 213 medical care expenses, flexible spending arrangements, health plan communication of out-of-pocket costs, and surprise billing.

The Department of Health and Human Services' Office for Civil Rights (OCR) issued frequently asked questions (FAQs) regarding HIPAA compliance for health plans during care coordination and continuity.

**DOL, HHS, and Treasury Publish Final Rules on Health Reimbursement Arrangements**

On June 20, 2019, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Department of Treasury (Treasury) (collectively, the Departments) published their final rules regarding health reimbursement arrangements (HRAs) and other account-based group health plans. The DOL also issued a news release, frequently asked questions, model notice, and model attestations.

The final rules' goal is to expand the flexibility and use of HRAs to provide individuals with additional options to obtain quality, affordable healthcare. According to the Departments, these changes will facilitate a more efficient healthcare system by increasing employees' consumer choice and promoting healthcare market competition by adding employer options.

To do so, the final rules expand the use of HRAs by:

- Removing the prohibition against integrating an HRA with individual health insurance coverage (individual coverage HRA)
- Expanding the definition of limited excepted benefits to recognize certain HRAs as limited excepted benefits if certain conditions are met (excepted benefit HRA)
- Providing premium tax credit (PTC) eligibility rules for people who are offered an HRA integrated with individual coverage
- Assuring HRA and Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) plan sponsors that reimbursement of individual coverage by the HRA or QSEHRA does not become part of an ERISA plan when certain conditions are met
- Changing individual market special enrollment periods for individuals who gain access to HRAs integrated with individual coverage or who are provided QSEHRAs

The final rules will be effective on August 19, 2019, and generally apply for plan years beginning on or after January 1, 2020.

However, the final rules under Section 36B (regarding PTCs) apply for taxable years beginning on or after January 1, 2020, and the final rules providing a new special enrollment period in the individual market apply January 1, 2020.

Read more about the final rules.

**District Court Issues Permanent Injunction against ACA's Contraception Mandate**

On June 5, 2019, the U.S. District Court for the Northern District of Texas issued a permanent injunction against the Patient Protection and Affordable Care Act (ACA) contraception mandate. The injunction prohibits the federal government from enforcing the contraception mandate against an employer, group health plan, or health insurer that objects, based on sincerely held religious beliefs, to establishing, maintaining, providing, offering, or arranging for coverage or payment for some or all contraceptive services. The injunction also exempts objecting entities from the accommodations process.

The permanent injunction also prohibits enforcement of the contraception mandate for individuals who object to coverage or payments for some or all contraceptive services based on sincerely held religious beliefs and who are willing to obtain health insurance that excludes coverage for payments for some or all contraceptive services.

Employers who object to contraceptive coverage based on sincerely held religious beliefs are no longer required to comply with the ACA's contraception mandate for those contraceptives to which they object.

Read more about the contraception mandate and court case.

**Executive Order on Improving Healthcare Price and Quality Transparency**

On June 24, 2019 President Trump signed an executive order directing federal agencies to increase healthcare quality and price transparency. The executive order does not create any new laws or regulations.

The executive order directs the Department of Treasury to:

- Issue guidance that would expand individuals' ability to enroll in high deductible health plans that can be used with a health savings account to cover low-cost preventive care before the deductible is met
- Propose regulations that would treat certain expenses associated with direct primary care arrangements and healthcare sharing ministries as Section 213 medical care expenses
- Issue guidance that would increase the amount of flexible spending arrangement funds that can be carried over to the next plan year without penalty

The executive order directs the Department of Health and Human Services to:

- Seek comments on a proposal to require health insurance issuers and self-insured group health plans to provide or give patients access to expected health care out-of-pocket costs before receiving care
- Report steps that can be taken to implement principles announced in a fact sheet on protecting patients from surprise billing

**HHS Issues HIPAA FAQs**

The Department of Health and Human Services' Office for Civil Rights (OCR) issued two frequently asked questions (FAQs) clarifying how the Health Insurance Portability and Accountability Act (HIPAA) privacy rules permit health plans to share protected health information (PHI) for care coordination and continuity.

If certain conditions apply, a health plan may disclose PHI, without an individual's written authorization and subject to the minimum necessary standard, to another health plan for its own health care operations purposes, or for the other health plan's health care operations. OCR provides two examples:

- If Covered Entity A provides health insurance to a person who receives access to the provider network of another plan provided by Covered Entity B, Covered Entity A is permitted to disclose the person's PHI to Covered Entity B for care coordination.
- If a person was enrolled in a health plan of Covered Entity A and switches to a health plan of Covered Entity B, Covered Entity A can disclose PHI to Covered Entity B to coordinate the person's care.

If certain conditions are met, HIPAA permits a covered entity to use PHI in its possession about individuals to inform them about the availability of other health plans it offers, without the person's authorization. For example, when Plan A discloses a person's PHI to Plan B, Plan B is permitted to send communications to the person about Plan B's health plan options that may replace the person's current plan, if Plan B receives no remuneration for sending the communication and complies with applicable business associate agreements.

**Question of the Month**

**Q.** Which group health plans must file a Form 5500 and when is it due?

**A.** Currently, group welfare plans generally must file Form 5500 if:

- The plan is fully insured and had 100 or more participants on the first day of the plan year (dependents are not considered "participants" for this purpose unless they are covered because of a qualified medical child support order).
- The plan is self-funded and it uses a trust, no matter how many participants it has.
- The plan is self-funded and it relies on the Section 125 plan exemption, if it had 100 or more participants on the first day of the plan year.

There are several exemptions to Form 5500 filing. The most notable are:

- Church plans defined under ERISA 3(33)
- Governmental plans, including tribal governmental plans
- Top hat plans which are unfunded or insured and benefit only a select group of management or highly compensated employees
- Small insured or unfunded welfare plans. A welfare plan with fewer than 100 participants at the beginning of the plan year is not required to file an annual report if the plan is fully insured, entirely unfunded, or a combination of both.

A plan is considered unfunded if the employer pays the entire cost of the plan from its general accounts. A plan with a trust is considered funded.

A plan's Form 5500 must be filed electronically by the last day of the seventh month after the close of the plan year. The filing date is based on the "plan year," which is designated in the Summary Plan Description (SPD) or other governing document. If a plan does not have an SPD, the plan year defaults to the policy year.

For calendar year plans, the due date for Form 5500 is July 31. Employers may obtain an automatic 2-1/2 month extension by filing Form 5558 by the due date of the Form 5500.

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