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HEALTH AND WELFARE PLAN DEVELOPMENTS

Supreme Court Holds States Not Prohibited from Banning or Regulating Abortion; Overrules *Roe*, *Casey* Precedent

In *Dobbs v. Jackson Women's Health Org.*, the U.S. Supreme Court has overruled prior precedent in *Roe v. Wade* and *Casey v. Planned Parenthood* and held that states may regulate or prohibit access to abortion at any stage of pregnancy. The Court's ruling specifies that the U.S. Constitution does not establish a right to abortion up to the point of fetal viability as previously set forth in *Roe* and *Casey*, and, absent such a right, abortion laws should be subject to other state laws governing health and welfare (*i.e.*, if a rational basis on which the law serves legitimate state interests, it must be upheld). As a result of the *Dobbs* decision, many states are expected to prohibit or impose more significant restrictions on abortion; plan sponsors seeking guidance on how the decision will affect health plan coverage and how best to respond to the Court's ruling are encouraged to refer to Reinhart's recent article, or consult their Reinhart attorney.

HHS Issues HIPAA Privacy and Security Guidance Regarding Reproductive Health Care and Audio-Only Telehealth Services

Following the U.S. Supreme Court's *Dobbs* ruling, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has issued guidance regarding privacy protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerning reproductive health care. OCR's guidance summarizes how HIPAA protects individuals' protected health information (PHI) regarding abortion and other sexual and reproductive health care, including the fact that covered entities (*e.g.*, plans, providers) can only use or disclose PHI as permitted or required under the HIPAA privacy rule. The guidance notes that, except in cases where a law expressly compels a covered entity to disclose PHI, HIPAA permits but does not require covered entities to disclose PHI and includes examples of situations providers may face in states where abortion is restricted or banned.

OCR has also released guidance for individuals on protection of PHI when using a personal cell phone or tablet. Unlike PHI created or maintained by covered entities and business associates, HIPAA generally does not protect privacy or security of health information stored on personal cell phones or tablets, such as

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internet search history, information shared voluntarily online or geographic information. The OCR guidance provides various tips for maintaining the privacy and security of such information, including links to outside resources.

Finally, OCR has also issued guidance with respect to HIPAA privacy and security compliance in the provision of audio only telehealth services. OCR's guidance emphasizes that health care providers and plans may use remote communication technologies to provide audio only telehealth services under the HIPAA privacy rule only, so long as such services contain reasonable safeguards to protect PHI. Services must, for example, verify an individual's identity before disclosing PHI, use auxiliary aids and services to accommodate participants with disabilities or limited English, and must be aware of security requirements when using third party services (*e.g.*, apps, VoIP technologies, electronic transcription or messaging services). However, the guidance maintains that traditional telephone landlines are not subject to these HIPAA considerations, as they do not transmit PHI electronically.

HHS, DOL and Treasury Warn Health Plans to Observe Contraceptive Coverage Mandate

The Secretaries of the U.S. Department of Labor (DOL), HHS and Department of Treasury issued a joint letter warning health plan sponsors and insurers of possible future enforcement actions for non-grandfathered plans that do not comply with the Affordable Care Act (ACA) contraceptive coverage mandate. In the letter, the Secretaries noted "troubling and persistent reports of noncompliance" with the mandate, which requires non grandfathered group health plans and insurers to cover at least one form of contraception within each category identified by the Food and Drug Administration (FDA), as well as contraceptive services or approved products deemed medically appropriate by a participant's attending provider. The Secretaries outline steps for plan sponsors and insurers to ensure compliance, including development of appropriate exceptions processes, standard forms and instructions, ensuring that information regarding the exceptions is available, clear delineation of the processes in plan documents and online resources, and eliminating non compliant medical management techniques. The letter also notes that the Secretaries will soon seek to convene a meeting with industry leaders to seek commitments to improve compliance, and warns of possible enforcement or corrective actions if non compliance continues.

Supreme Court Holds Plans May Limit Coverage for Outpatient Dialysis Under MSP Rules

The U.S. Supreme Court has held in *Marietta Memorial Hospital Health Benefit Plan*

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v. DaVita Inc. that a group health plan does not violate Medicare Secondary Payer (MSP) rules by imposing limits on coverage for outpatient dialysis. As background, DaVita challenged the plan's classification of all dialysis providers as "out of network," which resulted in a lower reimbursement for dialysis providers than providers of all other services. Although the relevant plan provision applied equally to all participants on its face, given that nearly all dialysis patients have end stage renal disease (ESRD), DaVita argued that the lower reimbursement rate for dialysis effectively discriminated against and had a disparate impact on participants with ESRD in violation of the MSP rules. A trial court dismissed the claim, but the U.S. Court of Appeals for the Sixth Circuit reversed, holding that MSP anti discrimination rules prohibit conduct beyond the express differential treatment of participants with ESRD. Shortly after, the U.S. Court of Appeals for the Ninth Circuit reached an opposite result in a similar case also involving DaVita, holding that the MSP rules prohibit group health plans from providing different benefits to ESRD patients, but do not bar limitations that have a disproportionate effect on such patients.

The Supreme Court ruled in favor of the plan, finding that the out of network classification of all dialysis providers did not violate MSP rules. Although the MSP rules prohibit plans from differentiating benefits or accounting for Medicare eligibility between individuals with and without ESRD, the Court nevertheless found that the plan provided the same benefits to participants regardless of whether they had ESRD or not. The Court also rejected DaVita's argument that the MSP rules authorize liability if a uniform coverage limitation has a disparate impact on ESRD patients.

Departments Release Guidance for Plan Sponsors Regarding Surprise Billing IDR Processes

The IRS, DOL and HHS have issued a checklist of federal independent dispute resolution (IDR) requirements and obligations for plan sponsors and insurers with respect to items subject to the surprise medical billing protections of the No Surprises Act. As discussed in our October 2021 and May 2022 editions of our Benefits Counselor newsletter, the IDR processes come into play for group health insurance plans when out of network providers or nonparticipating providers at in network facilities (*e.g.*, air ambulance services) do not agree with the amount the plan or insurer paid for services that the provider cannot balance bill to the patient. In the checklist, the Departments outline specific steps for plan sponsors and insurers to follow to comply with the initial payment or notice of denial, required disclosures and provision of information about the open negotiation

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period for the IDR process.

OCR has also released a chart summarizing the applicability of state or other IDR processes. The chart and related guidance explain that the federal IDR process does not apply to items and services payable by Medicare, Medicaid, the Children's Health Insurance Program or TRICARE, or in cases where a specified state law or All Payer Model Agreement provides a method to determine the total amount payable. In other circumstances, the chart notes that the federal IDR process applies to self insured plans sponsored by private employers in most states and U.S. territories except in four states where state process applies by default (*i.e.*, Alaska, Georgia, Maine and Michigan), or where a specific state law permits a plan to opt into the state's process for a specific dispute. Plans in these 18 states where a "bifurcated" process applies are encouraged to review state law and consult with appropriate state authorities to determine which IDR process applies.

RETIREMENT PLAN DEVELOPMENTS

PBGC Issues Special Financial Assistance Final Rule for Multiemployer Plans

The Pension Benefit Guaranty Corporation (PBGC) has issued its final rule providing requirements and procedures for the Special Financial Assistance (SFA) program for underfunded multiemployer plans. The SFA program was created under the American Rescue Plan Act of 2021 (see our Spring 2021 Benefits Counselor), and the final rule replaces the interim final rule implementing the SFA program previously issued in July 2021 (see our July 2021 Benefits Counselor).

The final rule contains several changes in response to public comments following the release of the interim final rule, including the following:

- Investment of SFA Funds. Under the interim final rule, plans were permitted to invest SFA funds and earnings only in fixed income securities denominated in U.S. dollars. Under the final rule, plans may now invest up to 33 percent of SFA funds and earnings in return seeking investments (*g.*, publicly traded stocks and equities). The remaining 67 percent of SFA funds is restricted in investment in high quality fixed income securities and cash.
- Interest Rate Assumptions. Under the final rule, plans that receive SFA assistance must use separate interest assumptions for calculating projections of SFA assets and non SFA assets, rather than the single rate of return utilized under the interim final rule. The SFA interest rate assumptions are limited to the lesser of (a) the rate used by the plan to fund account projections in its

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most recent certification of plan status prior to January 1, 2021; and (b) a specified rate cap (*e.*, 67 basis points over the lowest average Treasury segment rates over the four month period following the plan's initial SFA application).

- Calculation of SFA for Plans with Suspended Benefits. For plans that have suspended benefits under the Multiemployer Pension Reform Act of 2014 (MPRA), the final rule establishes a different methodology to calculate SFA funds. For MPRA plans, the maximum SFA amount is limited to the greatest of (a) the SFA amount for non MPRA plans (*e.*, plans without suspended benefits); (b) the present value of reinstated benefits, including both makeup payments for previously suspended benefits and payments of reinstated benefits expected to be paid through 2051; and (c) the amount needed for the plan to project increasing assets through 2051.
- Withdrawal Liability. Under the final rule, plans must phase in recognition of SFA funds over the projected SFA period for purposes of determining underfunding for withdrawal liability to ensure SFA funds do not subsidize employer withdrawals from SFA plans.

The final rule also includes several clarifications with respect to retroactive and proposed benefit increases, merger conditions for SFA plans with non SFA plans, and reallocation of contribution rates to related health plans under certain circumstances. The final rule will go into effect on August 7, 2022.

IRS Issues Updated Electronic Filing Determination Letter Application Forms

The Internal Revenue Service (IRS) has released updated forms and instructions to reflect the transition to all electronic filing of Form 5300. As discussed in the January 2022 edition of our Benefits Counselor newsletter, beginning July 1, 2022, all applications for determination letters using Form 5300 must be submitted electronically. Accordingly, the IRS has removed Form 5300 from the IRS forms and publications database, and filers are directed instead to the IRS's pay.gov website. The IRS has also updated instructions to the Form 5300 to include details on electronic filing and the IRS's website to reflect the electronic filing requirement. Finally, the IRS has also updated Form 8717 instructions to provide that the Form 8717 should not be used for Form 5300 unless additional payment for insufficient user fees is required.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

All Benefit Plans

Summary of Material Modifications for Calendar Year Plans

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A Summary of Material Modifications (SMM) must be distributed within 210 days of the close of the plan year in which a material amendment was adopted. For calendar year plans, all required SMMs describing amendments adopted during the 2021 plan year must be distributed by July 27, 2022.

Summary Annual Report

Plan administrators whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year end (*e.g.*, for plan years that ended December 31, 2021, the deadline is September 30, 2022). However, if a plan has received an extension for filing its Form 5500, the nine month deadline is extended by two months.

2021 Form 5500 for Calendar Year Plans

Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2021, the Form 5500 filing deadline is July 31, 2022. However, by filing Form 5558 by July 31, 2022, plan administrators can request a deadline extension to October 17, 2022.

Retirement Plans

SECURE and CARES Act Amendments

The Setting Every Community Up for Retirement Enhancement Act (SECURE Act) and Coronavirus Aid, Relief, and Economic Security (CARES) Act amendments for non governmental plans must be adopted by the last day of the plan year beginning on or after January 1, 2022. Accordingly, for calendar year plans, these amendments must be adopted by December 31, 2022.

Defined Contribution Plan Restatement Deadline for Prototype and Volume Submitter Plans

The deadline to adopt prototype or volume submitter plan restatements for retirement plans qualified under Internal Revenue Code sections 401(a) or 403(b) is July 31, 2022.

Annual Funding Notice

Calendar year defined benefit plans with 100 or fewer participants (*i.e.*, small plans) must provide an annual funding notice to required recipients by the earlier of the Form 5500 due date or the date of the Form 5500 filing, including

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extensions. Calendar year defined benefit plans with 100 or more participants (*i.e.*, large plans) must provide an annual funding notice to required recipients within 120 days after the close of the plan year.

Health Plans

PCORI Fee

Plan sponsors of self funded plans must report and pay the annual Patient Centered Outcomes Research Institute (PCORI) fee by filing IRS Form 720. Plans with plan years that end between October 1, 2021, and December 31, 2021, will need to pay the fee by July 31, 2022. For plan years that end on or after October 1, 2021, and before October 1, 2022, the fee is $2.79 per covered life.

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