



# Benefits Counselor – August 2023

## HEALTH AND WELFARE PLAN DEVELOPMENTS

### Departments Unveil Proposed Guidance on Mental Health Parity and Substance Abuse

On July 25, 2023, the U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury) (collectively, the Departments) jointly issued a proposed rule (Proposed Rule) that would revise existing rules implementing the Mental Health Parity and Addiction Equity Act (MHPAEA). The Proposed Rule includes significant changes that are intended to clarify existing MHPAEA requirements and assist sponsors in complying with the nonquantitative treatment limitations (NQTL) comparative analysis requirements added by the Consolidated Appropriations Act, 2021 (CAA 2021).

Interested parties have until October 2, 2023, to submit comments on the Proposed Rule. If finalized, the Proposed Rule would apply to group health plans and issuers beginning on the first day of the first plan year beginning on or after January 1, 2025.

For additional details on the Proposed Rule, please see our recent alert titled [New Mental Health Parity Guidance – Considerations Every Health Plan Sponsor Should Know](#). We provide a brief overview of the MHPAEA and the Proposed Rule, and conclude with several key issues plan sponsors should consider prior to the proposal's effective date in 2025.

### 2023 Consolidated Appropriations Act Eliminates MHPAEA Opt-Out for Non-Federal Governmental Plans

As discussed in the [January 2023 Benefits Counselor](#), the Consolidated Appropriations Act of 2023 (CAA 2023) prohibits self-insured non-federal governmental health plans from opting out of the MHPAEA as of the statute's enactment date, December 29, 2022. For non-federal governmental health plans that have an existing election, the CAA 2023 prohibits the renewal of elections that expire on or after 180 days following the enactment date. However, non-federal governmental health plans that are subject to multiple collective bargaining agreements (CBAs) may extend their existing elections until the date their last CBA expires.

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On June 7, 2023, HHS issued new guidance that explains the process by which plans subject to the multiple CBA rule can extend their opt-out elections:

1. Plan sponsors must send an email to the HIPAA opt-out email box ([HIPAAOptOut@cms.hhs.gov](mailto:HIPAAOptOut@cms.hhs.gov)) that includes documentation of the existing CBA(s) effective date and term. The email must also demonstrate that the CBA encompasses the self-funded, non-federal group health plan for which the extension is being sought.
2. After the U.S. Centers for Medicare & Medicaid Services (CMS) has reviewed the documents and concluded that the plan sponsor is eligible for an extension, it will notify the plan sponsor.
3. The plan sponsor must then submit a renewal opt-out for MHPAEA in CMS's Health Insurance Oversight System (HIOS) to extend the plan's existing opt-out. The renewal must be filed with CMS in the HIOS before the first day of the plan year governed by a CBA, or by the 45th day after the latest applicable date of the term of the CBA if the 45th day falls on or after the first day of the plan year.

The guidance concludes with a reminder to plans that CMS may take enforcement action, including the imposition of civil monetary penalties, against non-federal governmental health plans that fail to comply with the MHPAEA requirements.

### **Agencies Encourage Plan Sponsors to Extend Special Enrollment for Participants Losing Medicaid**

CMS, the Treasury and the DOL recently released an open letter to employers and plan sponsors encouraging them to voluntarily extend HIPAA special enrollment periods for individuals who lose coverage under Medicaid and the Children's Health Insurance Program (CHIP) anytime between March 31, 2023, and July 31, 2024.

While eligibility for Medicaid must be renewed each year, most Medicaid coverage terminations were paused to minimize coverage loss during the COVID-19 Public Health Emergency (PHE). With the PHE expiring on March 31, 2023, state Medicaid agencies have begun to resume normal enrollment operations, which include terminating coverage for individuals, including children, who are no longer eligible. Citing a recent HHS study, the agencies project that approximately 3.8 million individuals who lose Medicaid eligibility will be eligible for employment-based coverage.

Given those circumstances, the agencies encourage plan sponsors to voluntarily amend their group health plans to provide an extended HIPAA enrollment period beyond the minimum 60 day period required by law. The agencies also requested that plan sponsors take additional steps to promote continuity of coverage among employees, including: (1) informing employees about Medicaid and CHIP renewals and encouraging them to update their contact information with state agencies; (2) ensuring that employees can easily enroll in their employment based plan; and (3) reminding employees that they may be eligible for exchange based coverage if they are not eligible under the employer's plan.

## **Eighth Circuit Addresses Standing Claims Against Former TPAs and Upholds Plan Exclusion for Emergency Services**

On June 7, 2023, the U.S. Court of Appeals for the Eighth Circuit published its decision in *Shafer v. Zimmerman Transfer Inc.*, 2023 WL 3857343 (8th Cir., 2023), weighing in on whether (1) a participant has standing to sue a plan's former third party administrator (TPA); and (2) a plan administrator abused its discretion in denying a participant's emergency services claims due to complications from bariatric surgery. Affirming the lower court's decision, the Court held that the plaintiff had standing to sue the former TPA, but failed to show how the denial was due to an abuse of discretion.

The dispute began when the plaintiff started work with the defendant, Zimmerman Transfer Inc., months after undergoing bariatric surgery. While employed at Zimmerman, the plaintiff participated in the company's group health plan, for which Benefit Plan Administrators (BPA) served as TPA. Several years later, the plaintiff received emergency treatment to remedy complications related to the bariatric surgery. Although BPA initially pre-certified the claim, it later issued a denial because the Plan excluded coverage for weight reduction procedures and treatment related to complications from a non-covered procedure.

The Court first considered whether the plaintiff had standing to sue BPA, as it no longer served as TPA for the Plan and could not redress the plaintiff's claimed injury—being denied benefits. Relying on the U.S. Supreme Court's decision in *Arbaugh v. Y & H Corp.*, 546 U.S. 500, 511 (2006), the Court distinguished between claims-processing rules and limitations on subject matter jurisdiction. It further concluded that "the fact that a plan participant might not be able to enforce a money judgment against a third party administrator does not mean he lacks standing to sue that defendant."

Turning to the merits of the plaintiff's claim for benefits, the Court considered whether BPA abused its discretion in denying coverage for emergency services related to a non-covered procedure. The plaintiff argued that Zimmerman Transfer Inc. and BPA were required to cover the emergency treatment under Iowa state law, as well as the implementing regulations of the Affordable Care Act (ACA). The Eighth Circuit disagreed, finding that the ACA regulations do not require coverage for *all* emergency procedures but instead require plans that cover emergency treatment to satisfy additional requirements such as covering out-of-network treatment. Ultimately, the Court found that because the Plan specifically excluded coverage for complications related to bariatric surgery, neither Iowa state law nor the ACA could mandate coverage.

### **DOL Files Suit Against UnitedHealth Group for Improperly Denying Emergency Claims**

On July 31, 2023, the DOL filed suit against UMR, a TPA and subsidiary of UnitedHealth Group, alleging it improperly denied claims for emergency services and urinary drug screenings for thousands of patients. According to the complaint filed in the U.S. District Court for the Western District of Wisconsin, UMR provides TPA services to more than 2,136 self-funded welfare benefit plans that provide medical benefits to participating employees. For many of those plans, UMR was contractually obligated to act as named fiduciary with respect to adverse benefit determinations.

Acting in this role, the complaint alleges that UMR violated ERISA and ACA by denying emergency services claims based solely on diagnosis codes, not the prudent layperson standard required under ACA rules, and by denying drug screens without reviewing for medical necessity.

In addition to the improper denials, the DOL alleges that UMR provided participants with deficient explanations of benefits (EOBs) with "very limited information." The DOL emphasized that the relevant EOBs did not reference specific plan provisions or the prudent layperson standard, nor did they state whether the claim denial was due to a lack of documentation.

The DOL hopes to compel UMR to reform its emergency services and urinary drug screening procedures and to re-adjudicate denied and partially denied claims from January 1, 2015, to present.

## **RETIREMENT PLAN DEVELOPMENTS**



## **IRS Delays Effective Date for Final Rule on Required Minimum Distributions to 2024**

The Internal Revenue Service (IRS) announced in Notice 2023-54 that final regulations related to required minimum distributions (RMDs) will apply for calendar years beginning no earlier than 2024. The IRS also provided relief for plans and certain individuals related to RMDs for 2023.

As we previously discussed [here](#) and [here](#), the IRS published the proposed regulations on RMDs early in 2022 to implement changes mandated by the Setting Every Community Up for Retirement Enhancement (SECURE) Act. While the proposed regulations, when finalized, were to apply with the 2023 calendar year, the enactment of the SECURE 2.0 Act further raised the RMD age from 72 to 73 for participants who turn 72 after 2022 (and to 75 for participants who turn 74 after 2032). Due to these changes, commentators advised the IRS that additional time would be required to update automated payment systems.

In response, the IRS confirmed that final regulations regarding RMDs will apply no earlier than the 2024 calendar year. Additionally, the IRS provided transition relief for distributions made during 2023 that were mischaracterized as RMDs due to the changes in SECURE Act 2.0. For example, the IRS extended the 60-day rollover period for any mischaracterized RMDs to September 30, 2023. This relief applies to distributions made between January 1, 2023, and July 31, 2023, to participants born in 1951 (or such participant's surviving spouse).

## **UPCOMING COMPLIANCE DEADLINES AND REMINDERS**

### **General Benefits**

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. 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, 2022, the Form 5500 filing deadline was July 31, 2023. However, for plans that obtained an extension, the Form 5500 must be filed by October 16, 2023.

Summary Annual Report Deadline for Calendar Year Plans. 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, 2022, the deadline is October 2, 2023). However, if a plan receives an extension for filing its Form 5500, the nine-month deadline is extended by two months.



## **Retirement Plans**

Annual Funding Notice. Calendar year defined benefit plans with 100 or fewer participants generally must provide an annual funding notice by the earlier of the Form 5500 due date or the date of its filing, including extensions.

## **Health and Welfare Plans**

Health Reimbursement Arrangements. Plan sponsors of health reimbursement arrangements (HRAs) integrated with other group health plan coverage must offer participants an annual opportunity to opt out of and waive all future reimbursements from their HRA. An opt out notice can be provided with open enrollment materials to satisfy this requirement.

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