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December 2013 Employee Benefits Update

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EMPLOYEE BENEFITS UPDATE NEW FINAL MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY RULE REQUIRE ACTION

On November 5, 2013, the Department of Health and Human Services (HHS) released final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). While the final rules generally leave unchanged the interim final rules issued on February 2, 2010, they do make certain select changes, clarify some provisions from the interim rules and also codify guidance previously provided in HHS Frequently Asked Questions (FAQ). The new final rules are effective for plan years beginning on or after July 1, 2014.

Applicability to Certain Types of Plans. The final rules clarify that Employee Assistance Programs (EAP) that qualify as excepted benefits are not subject to MHPAEA or the final regulations. However, benefits provided under an EAP will only be considered excepted benefits to the extent the program does not provide "significant benefits in the nature of medical care or treatment." Additionally, the final rules confirm that retiree-only plans are exempt from the MHPAEA requirements.

Classification of Benefits. Generally, for purposes of determining parity between medical/surgical benefits and mental health and substance use disorder (MH/SUD) benefits, plans are required to organize all benefits into one of six categories: in-patient, in-network; in-patient, out-of-network; out-patient, in-network; out-patient, out-of-network; emergency care; and prescription drugs. The final rules codify guidance the HHS previously provided in the FAQs providing an "enforcement safe harbor" permitting outpatient services to be subclassified into office visits and all other out-patient items and services. The final rules also provide that benefits furnished by a plan on an in-network basis may be sub-classified to reflect plan designs that have two or more network tiers of providers (i.e., tiered networks) if the tiers are based on reasonable factors and without regard to whether a provider is a MH/SUD provider or a medical/surgical provider.

Additionally, the final rules clarify that covered "intermediate" MH/SUD benefits (e.g., residential treatment, partial hospitalization and intensive outpatient treatments) are subject to the parity rules and must be assigned into the existing six classifications for parity comparison. Although intermediate services may not

neatly fit into the existing treatment categories, the rules provide that plans must classify the benefits in a manner that tracks medical/surgical benefits as closely as possible.

Frequency of Review. The final rules confirm that plan sponsors are required to review their plans for MHPAEA compliance only when the plan has a change in (1) plan benefit design, (2) cost-sharing structure, or (3) utilization that would affect a financial requirement or treatment within a classification. Additionally, the final rules clarify that only the affected classifications must be reviewed.

Lifetime and Annual Limits. The final rules confirm that the Patient Protection and Affordable Care Act (ACA) rules prohibiting all annual and lifetime dollar limits on "essential health benefits" trump the MHPAEA rules that permit annual and lifetime dollar limits for MH/SUD benefits, provided they are in accordance with the parity requirements. Thus, annual and lifetime dollar limits are permissible on MH/SUD benefits only if they comply with the parity rules and they are not considered essential health benefits.

Coverage of ACA-Mandated Preventive Services Does Not Cause Plan to Provide Full Scope MH/SUD Benefits. The final rules clarify that plans that provide only preventive MH/SUD services required by the ACA are not subject the general MHPAEA coverage provisions. The ACA requires nongrandfathered health plans to provide coverage for specified preventive services without participant cost sharing. This requirement extends to certain specific MH/SUD benefits (*e.g.*, alcohol misuse screening and counseling, depression counseling and tobacco use screening). This is welcome news for plan sponsors who had worried that the requirement to provide these preventive services would subject a plan to the MHPAEA provisions requiring a plan that offers medical/surgical benefits within one of the six mandated classifications to also offer MH/SUD benefits in that same classification.

Non-quantitative Treatment Limitation. The final rules remove an exception contained in the interim final rules which had provided an exception to the parity requirement that allowed for the application of non-quantitative treatment limitations (NQTL) within a classification "to the extent that recognized clinically appropriate standards of care may permit a difference." The final rules provide that the NQTL requirements already provide plans with sufficient flexibility to take into account clinically appropriate standards of care, as long as the standards used are comparable to and applied no more stringently than the standards applied to medical/surgical benefits. Additionally, the final rules clarify that the

standards used for MH/SUD benefits need not be the same standards used for medical/surgical benefits. Rather, if the standards applicable to MH/SUD benefits are comparable to and applied no more stringently than the standards applied to medical/surgical benefits, differing standards are acceptable.

SELECT COMPLIANCE DEADLINES AND REMINDERS

2013 End-of-Year Compliance Checklist

Reinhart has prepared a 2013 end-of-year compliance checklist that provides an overview of new compliance items for health and retirement plans that should be addressed before 2014. The checklist also includes important ongoing year end requirements.

Cycle C Determination Letter Filings Due January 31, 2014

Remedial Amendment Period Cycle C individually designed plans must be submitted for a favorable IRS determination letter no later than January 31, 2014. Cycle C plans include those sponsored by employers with tax identification numbers (EINs) ending in a three or an eight, as well as governmental plans.

IRS Form 1099-R Must Be Distributed by January 31, 2014

IRS Form 1099-R, Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc., must be sent to recipients of retirement plan distributions during the prior plan year by January 31, 2014.

Annual Limit Waiver Update and Notice

Any plan that has received a waiver from the annual limits requirements from the HHS under section 2711 of the Public Health Services Act is required to advise HHS that it wants to extend its waiver for the 2014 plan year. Plan sponsors should provide HHS with their "annual update" by December 31, 2013. A plan sponsor must also provide an annual notice to its eligible participants and subscribers if its plan or policy does not meet the minimum annual limits for essential benefits and has received a waiver of the requirement. This notice must be sent to participants after the beginning of the plan year, or after January 1, 2014 for calendar-year plans.

RETIREMENT PLAN DEVELOPMENTS

PBGC Maximum Insurance Benefit Increases for 2014

On November 6, 2013, the PBGC announced that the maximum insurance benefit for participants in underfunded pension plans terminating in 2014 will be $59,318.16 per year for those who retire at age 65. The amount the PBGC pays retirees is based on a formula prescribed by federal law. The amount is higher for those who retire later and lower for those who retire earlier or elect survivor benefits. The increase is not retroactive. The maximum guarantee limit for participants in multiemployer plans has not changed, remaining at $12,870 with 30 years of service.

PBGC Announces 2014 Premium Changes

The Pension Benefit Guaranty Corporation (PBGC) issued a notice outlining premium changes for 2014. The flat premium rate for the PBGC's single-employer plan termination insurance program will be $49 per participant in 2014, up from $42 in 2013. The premium rate for multiemployer plans will remain unchanged at $12 per participant in 2014. The variable-rate premium is increased from $9 for 2013 to $14 per $1,000 of unfunded vested benefits for 2014. The variable-rate premium is capped at $412 times the number of participants, up from a 2013 cap of $400 (plans sponsored by small employers (generally fewer than 25 employees) may be subject to an even lower cap).

IRS Finalizes Regulations on Permitted Reduction or Suspension of Nonelective Contributions for Employers Sponsoring 401(k) Safe Harbor Plans

The Internal Revenue Service (IRS) issued final regulations under Internal Revenue Code (the Code) sections 401(k) and 401(m) providing employers that cannot afford to make safe harbor nonelective contributions with an alternative to terminating their 401(k) plans (revising the proposed regulations issued in May 2009).

As background, a 401(k) plan must satisfy certain nondiscrimination tests, including the actual deferral percentage (ADP) test and, if applicable, the actual contribution percentage (ACP) test. To automatically satisfy the ADP/ACP testing requirements, a 401(k) plan sponsor may opt for a safe harbor design, which requires certain employer contributions and participant notices. Employers can satisfy the safe harbor contribution requirement with either matching contributions or nonelective contributions. Subject to some exceptions, a safe harbor plan must be adopted before the beginning of a plan year and maintained throughout a full 12-month plan year. Under final IRS regulations, an employer

may amend a plan during a plan year to reduce or suspend safe harbor matching contributions on future employee elective contributions if certain criteria are met. In addition, if certain requirements are satisfied, an employer may terminate its safe harbor plan during the plan year.

The IRS's final regulations allow an employer that is operating at an economic loss (as described in Code section 412(c)(2)(A)) and meets certain procedural requirements to amend its plan during a plan year to reduce or suspend a plan's safe harbor nonelective contributions. This "operating at an economic loss" standard replaces the "substantial business hardship" standard in the proposed regulations.

The final regulations procedural requirements require, among other things, that employers: (a) adopt the relevant plan amendment before the end of the plan year, effective no earlier than its adoption date or 30 days after the participant receives the supplemental notice; (b) provide participants a supplemental notice explaining the consequences of the amendment, among other things; and (c) provide participants a reasonable opportunity after they receive the supplemental notice and before the change is effective to change their salary deferral elections (and their employee contribution elections, if applicable). In addition, the employer must make all safe harbor contributions through the effective date of the amendment. Lastly, the plan must satisfy the top-heavy requirements. The final regulations also permit an employer to reduce or suspend safe harbor nonelective contributions without regard to the financial condition of the employer if notice is provided to participants before the beginning of the plan year disclosing the possibility that the contributions might be reduced or suspended mid-year.

Finally, to achieve uniformity, the final regulations modify the rules that apply to mid-year amendments reducing or suspending safe harbor matching contributions so that the requirements that apply to a mid-year reduction or suspension of safe harbor nonelective contributions are not stricter than those that apply to a mid-year reduction or suspension of safe harbor matching contributions. Thus, safe harbor matching contributions may be reduced or suspended under a mid-year amendment only if either (a) the employer is operating at an economic loss as described in Code section 412(c)(2)(A), or (b) the notice provided to participants before the beginning of the plan year discloses that the contributions might be reduced or suspended mid-year, that participants will receive a supplemental notice if such redemption or suspension occurs, and that the reduction or suspension will not apply until at least 30 days after the

supplemental notice is provided. Because this requirement is a new limitation on the ability of an employer to amend its plan to reduce or suspend safe harbor matching contributions, the change is first effective for plan years beginning on or after January 1, 2015.

Reporting Change in Identity of Responsible Party for Retirement Plans

The IRS highlighted in its November 18, 2013 Employee Plan News newsletter a change in the reporting requirement in its August 2013 version of the Form 8822-B, which now requires that "[b]eginning January 1, 2014, any entity with an EIN, such as a plan sponsor, must report a change in the identity of their plan's responsible party on Form 8822-B, *Change of Address or Responsible Party - Business*, within 60 days of the change." The newsletter further noted that the Form 8822-B should be filed prior to March 1, 2014 if any changes were made prior to 2014 and such changes had not been previously reported. The instructions to Form 8822-B define a "responsible party" to a retirement plan as the person who has an entitlement to or a level of control, directly or indirectly, over the funds or assets in the retirement plan to manage or direct the dispositions of its funds and assets.

HEALTH AND WELFARE PLAN DEVELOPMENTS

HHS Releases Guidance Relating to Reinsurance Program

On November 26, 2013 the HHS released a proposed Notice of Benefit and Payment Parameters for 2015 (Notice). Among other things, the Notice provides clarification and supplemental information regarding various previously announced changes to the reinsurance program.

The reinsurance program requires all insurance providers and sponsors of self-insured plans to pay a yearly fee for each life covered by "major medical coverage" (Reinsurance Fee). The funds collected will then be disbursed to qualifying insurers covering high-risk individuals (reinsurance payments are not available for self-insured plans). The Reinsurance Fee is payable only for the 2014, 2015 and 2016 calendar years. As reported in the November EB Update, the HHS previously indicated that it was considering potential changes to the reinsurance program. The Notice proposes and further clarifies these changes and also sets the contribution rate for 2015.

Exemption for Self-Insured, Self-Administered Plans. HHS intends to exempt self-insured plans that do not use a third-party administrator (TPA) in connection with

claims processing or adjudication or with plan enrollment from liability for the Reinsurance Fee. The Notice departs from HHS's prior interpretation and now provides that the Reinsurance Fee does not apply to group health plans unless the group health plan uses a third party to administer "core health insurance functions of claims management and plan enrollment."

The preamble to the Notice also provides that HHS will consider a TPA to be an entity that is not "under common ownership or control with the self-insured group health plan or its sponsor" and that provides services "in connection with claims processing or adjudication (including the management of appeals) or plan enrollment." HHS recognizes that this definition of TPA may continue to evolve and HHS has requested comments on potential issues such as whether an "attorney providing legal advice in connection with claims adjudication" would disqualify a plan from the Reinsurance Fee exemption. HHS has also requested comments on whether third-party administration of other services outside of claims processing and adjudication should disqualify a plan from the exemption. For example, HHS questions whether third-party administration of "medical management services, provider network development, or other support tasks" should remove the exemption.

Finally, the preamble to the Notice clarifies that the exemption will apply only to 2015 and 2016 because, as a "public policy matter," it is too late to make the change for 2014.

Reinsurance Fee Collection Schedule. The Notice provides that the Reinsurance Fee will be collected in two installments. Contributing entities are still required to report enrollment counts by November 15 of each applicable year. HHS will then notify the contributing entity "in December" of the amount of the first payment due. Payment must be remitted within 30 days of receiving the notice. A contributing entity will then receive a second payment notice "in the fourth quarter" of each applicable year showing the amount due for the second Reinsurance Fee installment. This payment is also due within 30 days of receipt of the notice. HHS has determined that for 2014, the first installment will be $52.50 per covered life and the second installment will be $11.50.

The Notice notes that HHS is also considering allowing a contributing entity to make a single payment with the first installment.

Definition of Major Medical Coverage. The Notice codifies a definition of "major medical coverage" for Reinsurance Fee purposes. Under the new definition,

"major medical coverage" is "health coverage for a broad range of services and treatments provided in various settings that provides minimum value in accordance with [the ACA minimum value calculations]." HHS reasons that adopting the "minimum value" standard will result in eased administrative burden on plans because under the ACA, plans are already required to determine whether their plans provide minimum value.

Definition of Covered Life. The Notice clarifies that even if an individual is covered by multiple arrangements that would be considered "major medical coverage," the Reinsurance Fee must only be paid once for that person. Specifically, the Notice provides that for any individual who, in addition to employer-provided plan coverage also has coverage through (1) the individual market or (2) another employer-provided plan which pays primary to the employer provided plan, the employer-provided plan will not be responsible for paying a Reinsurance Fee for that individual. For example, if a participant's spouse is covered both by the Plan and the spouse's own policy through his/her employer, the employer-provided plan would not be required to pay the Reinsurance Fee for the spouse because the spouse's employer-provided coverage would pay. The Notice also provides that if it is unclear from the terms of the group health plans which plan is primary and which is supplemental, "the group health plan that offers the greater portion of inpatient hospitalization benefits is deemed the primary plan" and is responsible to pay the Reinsurance Fee for that person.

We note that if an employer-provided plan wishes to exclude these covered lives from Reinsurance Fee contributions, it appears that the plan sponsor would not be able to use the Form 5500 counting method for determining covered lives. Rather, the plan sponsor would be required to use the Actual Count or Snapshot Count methods.

2015 Reinsurance Fee Contribution. The Notice sets the 2015 Reinsurance Fee contribution at $44 per covered life. HHS indicates that this fee will translate to $33 per covered life due in early 2016 and $11 per covered life due in late 2016 (according to the two-part payment schedule).

Online Access to SHOP Marketplace Delayed by HHS until November 2014

The HHS announced on November 27, 2013 that online access to the Small Business Health Options (SHOP) Marketplace will be delayed until November 2014. The ACA requires each state that chooses to operate an Exchange to also establish a SHOP to assist eligible small businesses in providing health insurance

options to their employees. Some states have elected to implement their own SHOP system, while the federal government will establish the Federally Facilitated SHOP (FF-SHOP) system in others. HHS provided that, for 2014, small employers will instead be able to directly enroll their employees in coverage through an agent, broker or insurer that offers a certified SHOP plan and has agreed to conduct enrollment according to HHS standards. Employers using the direct enrollment process will be eligible to claim an expanded Small Business Tax Credit in 2014 (assuming they meet the other necessary eligibility requirements). Furthermore, employers using direct enrollment can opt not to wait for an eligibility determination from the SHOP Marketplace before enrolling in a qualified health plan, although they might not be eligible for the Small Business Health Care Tax Credit if the FF-SHOP later determines you were not eligible to participate in the SHOP.

Supreme Court to Hear Contraceptive Mandate Case

The Supreme Court announced that it will review whether the contraceptive mandate imposed by ACA impermissibly violates the free exercise rights of the religious owners of a for-profit corporation under the First Amendment and the Religious Freedom Restoration Act. The circuit courts have previously issued numerous rulings on this issue and there is no consensus among the lower courts. It is expected that the Supreme Court will hear oral arguments in March 2014 with a ruling likely by late June 2014.

CMS Releases Revised Proposed Notice and Certification of Contraceptive Coverage Accommodation

The Centers for Medicare & Medicaid Services (CMS) released a revised proposed model notice form and self-certification form related to certain group health plans exempt from the ACA requirement to cover certain contraceptive services, available here. Under ACA, non-grandfathered health plans are required to offer in-network contraceptive services to women free of charge. Employers that meet a narrow definition of religious employers are exempt from this requirement. Each organization seeking accommodation must self-certify that it meets the definition of eligible organization and provide a copy to a group health insurance coverage issuer. A health insurance issuer providing separate payments for contraceptive services at no additional cost to participants and beneficiaries in plans of eligible organizations must provide a written notice to plan participants and beneficiaries regarding the availability of the separate payment for contraceptive services. To satisfy the notice requirement, issuers may use the model language set forth in the final regulations or substantially similar language.

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2014 Limits for Archer Medical Savings Accounts High Deductible Health Plan

The IRS issued Revenue Procedure 2013-35 providing inflation-adjusted dollar amounts for welfare benefits in 2014. For Archer medical savings accounts (MSA), a high deductible health plan (HDHP) will include a health plan with an annual deductible for self-only coverage of at least $2,220 ($4,350 for family coverage) and not more than $3,250 ($6,550 for family coverage), with an out-of-pocket maximum of $4,350 ($8,000 for family coverage). The annual dollar limit on employee contributions to employer-sponsored health care flexible spending arrangements (FSA) remains unchanged for 2014 at $2,500.

GENERAL DEVELOPMENTS

Social Security Wage Base Increases to $117,000 for 2014

The Social Security Administration announced that the wage base for computing the Social Security tax (OASDI) in 2014 increased to $117,000. The wage base for 2013 was $113,700.

IRS Reveals that Certain Form 5500 Filers Receiving Erroneous Late Penalty Letters

The IRS has revealed that Form 5500 filers that file their return before their extension Form 5558 has had a chance to post are receiving penalty letters assessing them a late filing penalty. The IRS stated that proposed changes to the penalty program will allow time for extensions to post before penalty notices are generated. The IRS has instructed its tax examiners and telephone assistors to abate these penalties as service errors until these changes can be implemented. Accordingly, filers that believe they have erroneously received a penalty letter should call the IRS as soon as possible.