LEGISLATIVE AND REGULATORY UPDATE

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Agencies finalize parity rules for mental health and substance abuse benefits: Final regulations for the Mental Health Parity and Addiction Equity Act expand and clarify earlier interim rules and guidance and add details about non-quantitative treatment limits, the small-employer exemption, and the temporary relief for plans with high compliance costs. The final rules also extend parity provisions to individual policies and will indirectly impact certain Medicaid plans. Under the rules and new FAQs, any financial or treatment limits for mental health/substance abuse benefits — including residential treatment and other intermediate levels of care, if offered — must be in parity with medical/surgical benefit limits. The final rules continue to let plans exclude mental health or substance abuse benefits, but the Affordable Care Act requires individual and small-group insurers to cover these services as essential health benefits. The final rules apply for plan or policy years starting on or after July 1, 2014 (with a transitional rule for collectively bargained plans). Press release on final MHPAEA rules (DOL/HHS/IRS, 8 Nov 2013, 1 page); FAQs about ACA and mental health parity (DOL/HHS/IRS, 8 Nov 2013, 6 pages) »

Amending a retirement plan's 'spouse' definition — issues to consider post-Windsor:

Many retirement plan sponsors are awaiting IRS guidance on same-sex marriage amendments in the wake of the US Supreme Court's landmark decision in *US v. Windsor*. However, some employers may see an immediate need to adopt conforming amendments. These employers may face two rounds of amendments, given that initial efforts are unlikely to anticipate every aspect of upcoming IRS guidance. Employers choosing to forge ahead anyway may want to consider the drafting issues highlighted below.

Pressure to amend early

Same-sex couples legally wed anywhere in the US or abroad are considered married for federal tax and ERISA purposes, according to IRS and Department of Labor (DOL) guidance released after the *Windsor* ruling. From the IRS's perspective, retirement plan sponsors needn't rush to adopt same-sex marriage amendments, since regulators intend to issue further guidance on the timing and content of these changes. The amendment deadline could be a ways off, especially since the recent federal government shutdown disrupted regulators' workflow. Even Cycle C filers —facing a Jan. 31, 2014, deadline for determination letter applications —presumably can hold off on *Windsor*-related amendments without jeopardizing the plan's tax-qualified status.

Even so, some employers may face real-world pressures to act quickly. Consider these examples:

- The sponsor of a Cycle C plan might be uncomfortable signing a plan restatement that includes references to the Defense of Marriage Act (DOMA) and its now-obsolete terminology defining marriage as an opposite-sex union.

- The sponsor of a terminating plan might be updating the document to reflect all law changes in effect at the time of termination.

- An employer might be in the process of updating its summary plan description (SPD) and want to avoid discrepancies between the SPD and plan terms.

So despite the IRS delay, some employers are considering stopgap amendments, including changing the plan's "spouse" definition.

Drafting considerations

Sponsors of tax-qualified plans proceeding with same-sex marriage amendments now, before the release of further IRS guidance, would be well-advised to consider the issues below. This discussion assumes the plan is subject to ERISA; special issues for non-ERISA governmental and church plans are beyond the scope of this article.

Existing plan terms. A preliminary question is whether plan terms are already consistent with *Windsor* and subsequent IRS guidance in Rev. Rul. 2013-17. If a plan defines "spouse" as an opposite-sex husband or wife recognized by DOMA, there's little question the employer will need to change the plan terms at some point. But other cases may not be so clear-cut given the wide range of plan drafting conventions. For example:

- Some plan documents don't define the term "spouse," and it's unclear whether they must do so now.

- Some plans have self-adjusting provisions — for example, defining "spouse" as anyone recognized as a husband or wife for federal tax or ERISA purposes — and therefore could be interpreted (without amendment) as reflecting the recent IRS and DOL guidance.

- Some plans use the gender-neutral definition "spouse under applicable law," which could be interpreted to reflect *Windsor* but might leave the employer vulnerable to disputes about the applicability of federal vs. state law. Even a document referring to a "spouse under federal law" could be deemed ambiguous, since some federal laws (such as Social Security laws) define spouse more narrowly than Rev. Rul. 2013-17.

Even if relying on existing plan terms, employers should closely examine terminology used in participant-facing communications, including distribution packages and other administrative forms.

Place-of-celebration rule for mandated spousal benefits. All tax-qualified ERISA plans must offer certain rights and protections to legally married spouses (of the same or opposite gender). For these purposes, upcoming IRS guidance could require explicit language acknowledging that the place of celebration— not the place of residence — controls: A same-sex marriage is considered legal if it was validly entered into in a US or foreign jurisdiction whose laws authorize the marriage, regardless of the laws in effect where the spouses live.

Spousal benefits beyond those required by law. Plan terms sometimes provide spousal benefits or protections beyond those required by the Code and ERISA (for example, some 401(k) plans require spousal consent to plan loans, even when consent isn't legally required). Employers may have leeway to define spouse differently for these limited purposes, subject to any applicable civil rights laws. Of course, this approach requires a painstaking examination of each plan provision that includes terms like "spouse" or "married."

Effective date. Rev. Rul. 2013-17 applies prospectively starting Sept. 16, 2013, but doesn't say which events (termination of employment? benefit election? annuity starting date?) must occur on or after that date for the place-of-celebration rule to apply. Whether the place-of-celebration rule also applies for periods after June 26 (the date of the *Windsor* decision), or even earlier, isn't yet known. While awaiting guidance on *Windsor's* potential retroactive effect, employers can't be certain what effective date an amendment should bear. Drafting an amendment to "take effect as of Sept. 16, 2013, in accord with Rev. Rul. 2013-17" may be the best short-term way to satisfy current IRS rules without creating unintended retroactive consequences. However, employers may need to consider other factors in formulating an appropriate effective date, including prior plan communications, past administrative practice, and potential exposure to retroactive ERISA claims.

One-year marriage rule. Some plans offer spousal protections only to participants who have been married at least one year, raising the question whether a same-sex marriage is deemed as starting on the wedding date or sometime later (perhaps June 26 or Sept. 16). And if the plan uses the wedding date to mark the start of the one-year period, does that mean participants in a same-sex marriage would be treated as married on *the later of* their first anniversary or Sept. 16? Plan drafters need to consider these questions because the answers could determine entitlement to death benefits, spousal consent rights, and any charges imposed (prospectively or retroactively) for preretirement survivor annuity coverage.

DOMA workarounds. In the past, some plan sponsors adopted benefit structures intended to compensate same-sex couples for disparate treatment. Adopting a stopgap amendment to change the spouse definition, without considering corollary changes to these DOMA workarounds, could introduce drafting inconsistencies into the document.

Domestic partners. Civil unions and domestic partnerships don't have the same status as same-sex marriages under federal tax law, regardless of their status under state law. For clarity, some employers may prefer a spouse definition that explicitly excludes civil union and domestic partners (and a domestic partner definition that clearly excludes spouses).

Other employers intend to provide spousal-type rights and benefits to civil union and domestic partners — for example, treating a registered partner as a default 401(k) beneficiary if the participant fails to designate another beneficiary. But this approach demands careful drafting because federal law gives spouses certain privileges (as to rollovers, required minimum distributions, Section 415 limits, and the like) that can't be extended to other life partners.

Puerto Rican participants. Retirement plans dual-qualified in the US and Puerto Rico are subject to ERISA and the US Internal Revenue Code but often have an appendix setting out special rules under the Puerto Rico tax code for the Puerto Rican population. Puerto Rico tax laws don't recognize same-sex marriage, so plan drafters apparently must paint with a very fine brush: recognizing same-sex spouses when applying ERISA's spousal protections but denying that recognition when applying Puerto Rico tax law provisions that are beyond ERISA's scope (such as hardship withdrawals to cover expenses incurred by a participant's spouse). Similar issues arise in plans qualified solely in Puerto Rico, since these plans also are subject to ERISA and Puerto Rico tax law.

Nonqualified deferred compensation. Employers should consider whether qualified plan amendments will flow through to supplemental executive retirement plans and other nonqualified deferred compensation plans (especially since many nonqualified plans incorporate qualified plan definitions by reference).

Other benefit plans. Retiree medical and other benefit plans also may piggyback off qualified plan definitions, perhaps with unintended consequences.

Blanket amendments. Some practitioners have suggested drafting a blanket amendment that would apply to all an employer's retirement plans. That approach seems unwise, given factors that may vary from plan to plan, such as existing plan terms, past administrative practice, spousal benefits beyond those required by law, DOMA workarounds previously adopted, and domestic partner benefits.

New rules govern midyear reductions in 401(k) safe-harbor contributions: Final IRS regulations alter the conditions for reducing or suspending employer contributions to 401(k) safe-harbor plans during a plan year. For employers making safe-harbor *non-elective* contributions, the guidance immediately offers more latitude to decrease contributions midyear. However, employers relying on a safe-harbor *match* must comply with new conditions starting in 2015 if they want to cut the match midyear. Employers seeking to maximize flexibility should modify their annual safe-harbor notice to inform participants that contributions might be reduced or suspended midyear.

Reducing employer contributions midyear. Generally, safe-harbor plan provisions must be adopted and communicated before the first day of the plan year and remain in effect for the entire 12-month plan year. However, the new final regulations let an employer reduce or suspend contributions midyear if *one* of these two conditions is met:

- The employer is operating at an economic loss as described in Code Section 412(c)(2)(A).
- The annual safe-harbor notice (given 30–90 days before the start of each plan year) discloses that:
    - Safe-harbor contributions might be reduced or suspended midyear.
    - Participants will receive a supplemental notice if that occurs.
    - The change will take effect after the plan is amended to reduce contributions, but no sooner than 30 days after the supplemental notice is sent.

The new conditions for decreasing contributions apply regardless of whether the plan design is a traditional safe harbor or a qualified automatic contribution arrangement (QACA), and regardless of whether the employer makes non-elective or matching safe-harbor contributions. However, due to differences in prior law, the final rules' effective date depends on the plan's design, as described below.

Designs with non-elective contributions. For employers making safe-harbor non-elective contributions (typically 3% of pay), the final rules apply retroactively to amendments adopted on or after May 18, 2009. That date ties back to 2009 proposed regulations letting employers with a "substantial business hardship" (as defined in Section 412(c)) reduce or suspend 401(k) safe-harbor non-elective contributions during the plan year. The final regulations replace the "substantial business hardship" standard with a somewhat looser "economic loss" standard (for example, the new standard eliminates the need to determine the health of the employer's industry). As a result, some distressed employers may find it easier to suspend non-elective contributions, even if they didn't notify participants of that possibility before the year began. As for amendments reducing contributions before May 18, 2009, the IRS suggests employers consider corrective action under the Employee Plans Compliance Resolution System.

Designs with matching contributions. For employers making safe-harbor matching contributions, the effective date is delayed: The final rules will apply to plan years starting on or after Jan. 1, 2015. Employers need this lead time because the new rules are more restrictive than prior law governing safe-harbor matching contributions. Under prior law, these employers could opt out of the safe harbor during the year by prospectively reducing or eliminating the match for some or all participants —even if the employer was financially sound and hadn't warned participants of a possible reduction before the year began.

Modifying the annual notice. To maximize flexibility, employers may want to add boilerplate language to the annual safe-harbor notice alerting participants to the possibility of a reduction in contributions during the year. Given the 2015 effective date, employers making matching contributions could add this language to the annual notice sent in late 2014; they needn't rush to alter the notice going out in 2013. But employers making non-elective contributions need to modify the notice immediately if they want the option of cutting back contributions in mid-2014 (regardless of the employer's financial condition).

Other steps needed to exit safe harbor

The final rules generally don't change other steps needed to exit the safe harbor. For example, employers reducing or suspending safe-harbor contributions must satisfy all safe-harbor rules (including funding the safe-harbor contribution) with respect to compensation paid through the amendment's effective date. The plan also must pass ADP/ACP testing for the entire plan year using the current-year testing method, and satisfy the top-heavy rules of Section 416. The IRS has confirmed that employers suspending safe-harbor contributions during the year must prorate the Section 401(a)(17) compensation limit (currently $255,000).

Changing other safe-harbor features midyear

The final rules give the IRS authority to publish future guidance on other midyear changes to safe-harbor designs. Recent comments by the American Society of Pension Professionals & Actuaries highlight midyear compliance issues encountered by many safe-harbor plan sponsors. Past IRS guidance allowed employers to add certain Roth and hardship withdrawal features midyear (IRS Notice 2010-84, Q&A 18).

Internal IRS memo addresses timing of tax deductions for some bonuses: An employer can't deduct annual bonuses until the year they are paid or certain other actions are taken, according to an IRS chief counsel memorandum analyzing three common plan designs. Though taxpayers can't rely on internal IRS memos, the documents often provide insights into the agency's current views.

All-events test for deductions. Under many annual bonus plans, an employer pays bonuses for services rendered by employees in one year (Year 1) on a date occurring during the first 2½ months of the next year (Year 2). These payments are sometimes subject to contingencies that may not be resolved until Year 2. In this situation, an employer that is an accrual-basis taxpayer can take a Year 1 deduction only if the "all-events test" of Code Section 461 is met, including that the "fact" and "amount" of liability for the bonuses is established by the end of Year 1.

Memo discusses three scenarios. According to the memo, the all-events test is met — and deductions are allowable — as follows:

Plan feature	Deduction no earlier than the date
Employer has the unilateral right to modify or eliminate bonuses prior to payment.	Amounts are paid.
Amounts must be approved by a committee of the board of directors prior to payment.	Approval is obtained.
Amounts are dependent, in part, on subjective employee performance appraisals.	Appraisals are completed.

Revenue ruling is inapplicable. Rev. Rul. 2011-29explains how accrual-basis taxpayers can satisfy the all-events test — and take a Year 1 deduction — even though employees must remain employed until the bonus payment date in order to receive bonuses. To qualify for that deduction, employers must define and communicate plan terms and conditions, fix the bonus pool through a formula or corporate action by the end of Year 1, and reallocate to other bonus-eligible employees all amounts employees forfeit in Year 2 by terminating employment before the payment date. The memo concludes that the ruling does not apply to the facts in this employer's case.

Final parity rules feature some key changes for health plans: Final rules for the Mental Health Parity and Addiction Equity Act (MHPAEA) may require health plan sponsors to re-examine and study any "non-quantitative treatment limitations" in their plans. This review is especially important if plan provisions exclude or restrict intermediate levels of care, like residential treatment, partial hospitalization, or intensive outpatient therapy. The final rules also clarify some open issues and expand upon the interim parity rules. For example, a new sub-classification for plans with tiered networks will make it easier to vary copayments or coinsurance between different in-network tiers. The rules are generally effective for plan or policy years beginning on or after July 1, 2014, although certain collectively bargained plans have an extended effective date.

Scope of final parity rules

Enacted in 2008, the MHPAEA amended the Mental Health Parity Act of 1996 to require plans that include mental health and/or substance use disorder benefits to provide full parity with medical/surgical benefits. Interim final rules — issued in 2010, just before the Affordable Care Act (ACA) was passed — caused many plans to redesign their mental health and substance abuse benefits. The final parity rules build upon the interim rules, so plans' compliance reviews should be less challenging than in 2010.

Types of health plans and policies affected

Most employer-sponsored coverage must comply. The final rules generally apply to group health plans sponsored by private-sector and state or local governmental employers. If self-insured, however, state or local (so-called nonfederal) governmental plans still can annually opt out of parity compliance by notifying the US Department of Health and Human Services (HHS). In addition, retiree-only plans generally are exempt, as are small employers with self-funded plans (see discussion below). Otherwise, most plans — whether insured or self-insured — must comply with the parity rules.

Individual policies. Both grandfathered and non-grandfathered individual policies must comply with the final parity rules, effective for policy years beginning on or after July 1, 2014. In addition, individual policies apparently must conform to the interim parity rules, effective Jan. 1, 2014.

Comparison chart. The chart at the end of this article sets out how the rules apply to different types of health coverage.

Benefit areas where parity required

The final rules require parity in the following areas:

- Aggregate lifetime and annual dollar limits (to the extent not eliminated for ACA compliance)
- Financial requirements
    - Examples: deductibles, copayments, coinsurance, and out-of-pocket maximums
- Quantitative treatment limitations
    - Examples: annual, episode, and lifetime limits on treatment days or visits

- Non-quantitative treatment limitations
    - Examples: medical management standards; formulary or network tier design; admission standards for provider network, including reimbursement rates; methods for determining usual, customary, and reasonable charges; fail-first or step therapy protocols; exclusions for failure to complete a course of treatment; restrictions based on location, facility type, or provider specialty; and other criteria limiting the scope or duration of covered services

Six benefit classifications for testing parity. The final rules retain much of the mechanics for testing parity in a plan's financial requirements and quantitative treatment limitations. Under those mechanical rules, plans must analyze parity compliance within each of six benefit classifications:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Prescription drug
- Emergency

In general, if a plan provides a mental health or substance abuse benefit in any of the six classifications, it must provide that benefit in all classifications. Within each classification, parity must be determined for each coverage unit (e.g., employee-only, employee plus one, family).

Mental health/substance abuse benefits not required for large employers. The MHPAEA does not mandate that any plan provide benefits for mental health conditions or substance use disorders. However, if a plan does offer such coverage, the final rules require those benefits to be in parity with medical/surgical benefits. Of course, individual and non-grandfathered small group plans must offer mental health and substance abuse coverage under the ACA's essential health benefit (EHB) rules. Insured plans (including large insured plans) also must satisfy state insurance mandates, which often require coverage of certain conditions (e.g., autism).

Enforcement

In announcing the final rules, the agencies emphasized their intent to renew compliance assistance and outreach to plans, insurers, providers, and state insurance regulators. The Department of Labor (DOL) and Treasury have enforcement authority over private-sector employer-sponsored group health plans (whether self-insured or insured) and can assess

penalties. Private-sector employers also must file IRS Form 8928 to self-report and pay the excise tax for violations of the final parity rules. HHS has enforcement authority over nonfederal governmental plans. States have primary enforcement authority over insurers in the group and individual markets, but HHS has "federal fallback" authority where states are not enforcing specific standards.

Key changes in final parity rules

New non-quantitative treatment limitation standards The final rules retain the prohibition on imposing a non-quantitative treatment limitation (NQTL) for mental health/substance abuse benefits in any of the six classifications that is not in parity with the limits for medical/surgical benefits. Under a plan's terms and in its operation, any processes, strategies, evidentiary standards, or other factors imposing an NQTL for mental health/substance abuse benefits must be comparable to and applied no more stringently than for medical/surgical benefits.

Less variation allowed in final rules. The interim rules contain an exception that allows variation between medical/surgical and mental health/substance abuse benefits if the difference reflects recognized clinically appropriate standards of care. Citing the possibility of abuse, the final rules eliminate this exception. Some variation between mental health/substance abuse benefits will be permitted under the NQTL standards, but plans will no longer have a broad-based exemption for differences based on recognized clinical standards.

How to test NQTLs for parity. The regulations provide an example of a plan that considers a wide array of factors in designing medical management techniques for mental health/substance abuse benefits and medical/surgical benefits. Items considered include the cost of treatment, high cost growth, variability in cost and quality, licensing and accreditation of providers, and several other factors. After applying these factors in a comparable fashion (and documenting evidence supporting parity), the plan decides to require prior authorization for some (but not all) mental health/substance abuse benefits and medical/surgical benefits.

As the example illustrates, plan sponsors, working with their vendors, should use a wide variety of factors to thoroughly analyze each NQTL — especially any exclusions for intermediate levels of care — for medical/surgical benefits and mental health/substance abuse benefits. This effort should conclude by documenting the results of the NQTL parity testing. Conducting this type of analysis, however, may be particularly challenging for plans that use one vendor for mental health/substance abuse benefits but another vendor for medical/surgical benefits.

New sub-classification for tiered networks. The final parity-testing rules retain the six benefit classifications and special sub-classification for tiered prescription drug coverage found in the interim rules. The final regulations also incorporate the sub-classifications for office visits and other outpatient services allowed under existing guidance. In response to comments, regulators have added a new sub-classification for tiered networks. However, sub-classifications are not permitted for anything else (e.g., specialists).

The new sub-classification for tiered networks will help plans with different copayments or coinsurance for different network benefits, such as services from preferred providers versus other participating providers. By analyzing parity only within a specific network tier, plans should find it easier to show that financial requirements or quantitative treatment limits imposed on mental health/substance abuse benefits are in parity with those imposed on medical/surgical benefits.

Full parity not required for preventive care benefits offered only to meet ACA

If a mental health or substance abuse benefit is provided in any classification, that benefit generally must be provided in all six classifications. The final rules, however, provide a new exception for benefits provided only to comply with the ACA's preventive care rules. For example, the preventive care rules require providing certain smoking-cessation benefits free of cost sharing but leave the specific design of those benefits to a plan's discretion. If a plan decides to offer only counseling by telephone as the preventive care benefit for smoking cessation, the plan will not have to provide smoking-cessation benefits in each of the six classifications. For example, the plan will not have to cover prescription drugs that ease smoking cessation.

Disclosure

Although agency press releases about the final regulations mention increased transparency protections, the rule doesn't include any new disclosure requirements. But regulators have highlighted how the parity requirements affect existing disclosures under other laws.

Medical necessity criteria, claim denials. Under the parity law, plans must provide the criteria used to determine the medical necessity of mental health and substance abuse benefits when a current or potential participant, beneficiary, or contracting provider requests this information. The final parity rules point out that ERISA Section 104 already requires plans to provide their governing instruments upon a participant's or beneficiary's request. According to the parity rules, governing instruments include medical necessity criteria for all benefits — medical/surgical and mental health/substance abuse — as well as the processes, strategies, evidentiary standards, and other factors that apply to NQTLs. The required notices of claim denials under the parity rules likewise are consistent with existing ERISA rules for internal claims and appeals.

Request for comments. Employers and other entities may want to evaluate what they or their service providers disclose concerning medical necessity criteria, as these disclosures probably will draw heightened scrutiny once the final rules take effect. The agencies have asked for comments on whether the rules should ensure greater transparency and, if so, how to do this.

Exemptions

Two exemptions from the parity requirements continue to apply, but regulators have clarified the definition of small employer and added a formula for determining eligibility for the cost exemption.

Small-employer exemption. The parity rules do not apply to a group health plan sponsored by a small employer. Because insured, non-grandfathered small group plans must cover EHBs in compliance with the parity rules, the exemption is really available only to self-funded plans and small group plans that have not yet lost grandfather status. For private-sector plans governed by

ERISA, a small employer generally means one with no more than 50 employees, on average, on all business days during the prior calendar year. For nonfederal governmental plans, a small employer means one with no more than 100 employees during the prior calendar year (but a state can choose to use a lower limit of 50 employees in 2014 and 2015). This exemption is automatic; qualifying small employers don't need to apply for it.

Cost exemption. Plans can apply for a temporary exemption if compliance causes total costs of all coverage to increase by 2% or more in the first plan year that the parity rules apply and by 1% in later years. The final rules provide, for the first time, a formula for calculating whether the cost exemption applies.

Plans must implement the parity rules for at least six months before seeking the exemption and can only apply for the exemption every other plan year. In other words, even a plan that qualifies for the cost exemption can only take advantage of this exemption every other year. According to the economic analysis that accompanied the final rule, no plan has ever applied for the cost exemption.

Applicability date and next steps

The new rules generally take effect for plan or policy years beginning on or after July 1, 2014. For group health plans maintained under one or more collective bargaining agreements ratified before Oct. 3, 2008, the effective date is the first plan year beginning on or after the latest termination date of the collective bargaining agreements (disregarding any extension after Oct. 3, 2008). Until the final parity rules become applicable, plans and issuers must continue to comply with the interim final rules.

Employers should review their plans for compliance with the new rules, focusing particularly on non-quantitative treatment limits. Testing methods may need adjustment, and plan design changes may be required. Plans that use different vendors to administer medical/surgical benefits and mental health/substance abuse benefits may need to develop new approaches to coordinate compliance with the non-quantitative treatment limits. Sponsors that already have or are considering tiered networks will want to review the different copays and/or coinsurance for the different tiers and evaluate how the parity tests will apply to those financial requirements. Finally, sponsors should review plan disclosure processes in light of the parity rule's new emphasis on those requirements.

Chart: Which plans must comply?

Type of plan	Does MHPAEA apply?	Who enforces?
Private-sector employer-sponsored group plans		
Self-insured plan	Yes, grandfathered & non-grandfathered *Exemptions:* • Retiree-only plans • Small employers (1 to 50 employees)	DOL/Treasury • Plans or plan sponsors also must file IRS Form 8928 to self-report violations.
Insured plan	Yes, grandfathered & non-grandfathered • Despite MHPAEA's small-employer exemption, non-grandfathered small group policies must meet ACA's EHB standards, which incorporate the parity rules. *Exemptions:* • Retiree-only plans	DOL/Treasury • Plans or plan sponsors also must file IRS Form 8928 to self-report violations. State oversees insurance policy with, HHS as fallback.
Nonfederal (state/local) governmental plan		
Self-insured plan	Yes, grandfathered and non-grandfathered *Exemptions:* • Any plan that annually chooses to opt out • Retiree-only plans* • Small employers (1 to 100 employees)**	HHS
Insured plan	Yes, grandfathered and non-grandfathered *Exemptions:* • Retiree-only plans* • Small employers (1 to 100 employees)**	State oversees insurance policy, with HHS as fallback.
Individual or small-group insured policies (on or off exchanges)		
Individual policy	Yes, grandfathered and non-grandfathered • Also must cover mental health and substance abuse as EHBs, consistent with state's benchmark plan	State, with HHS as fallback
Small group policy	Yes, non-grandfathered policies • Also must cover mental health and substance abuse as EHBs, consistent with state's benchmark plan	State, with HHS as fallback

Type of plan	Does MHPAEA apply?	Who enforces?
Medicaid or Medicare plans		
Medicaid	The final regulations don't address Medicaid, but the ACA applies MHPAEA to Medicaid "Alternative Benefit Plans" (ABPs). More guidance is expected on ABPs.	State/HHS
Medicare	No	HHS

* HHS won't enforce provisions for nonfederal governmental retiree-only plans.
** State may lower threshold to 50 employees for 2014 or 2015.

Cases seek to limit ACA subsidies to state-run exchange coverage: Four separate cases assert that the Affordable Care Act (ACA)'s premium tax credits and cost-sharing reductions apply only to coverage from a state-run exchange. If successful, this claim would eliminate subsidies for residents in the 34 states that now have federally facilitated or partnership exchanges, affecting the viability of the public exchanges. No court has ruled yet on the merits of this challenge to the IRS rule extending ACA subsidies for all types of exchange coverage. However, this ACA litigation may eventually lead to another Supreme Court showdown. **IRS rule on premium tax credit (Federal Register, 23 May 2012, 24 pages) »**

HHS proposes changes to reinsurance, cost-sharing limits, and public exchanges: An HHS notice proposes 2015 reinsurance fees, cost-sharing limits, and other annually indexed figures for Affordable Care Act provisions. In 2015, the reinsurance fee would decrease to $44 per covered life, and non-grandfathered plans would have annual cost-sharing limits of $6,750/$13,500 for self/family coverage. Starting in 2014, other proposed changes to the reinsurance program would split the annual payment into two installments and require payments only for coverage that meets 60% minimum value. The notice also would adjust the 2015 open enrollment period for public exchanges. **HHS proposed notice of benefit and payment parameters (Federal Register, 2 Dec 2013, 72 pages) »**

IRS maps out rules for 401(k) in-plan Roth rollovers: Just-issued IRS Notice 2013-74 explains how sponsors of 401(k), 403(b), and governmental 457(b) plans can allow participants to use in-plan Roth rollovers to convert non-Roth accounts to Roth accounts, even though the amounts aren't yet eligible for distribution. The notice also includes several clarifications for in-plan Roth rollovers of distributable amounts.

In-plan Roth rollovers are an optional design feature available to plans that accept regular Roth contributions. Individuals are taxed at the time of rollover, but later distributions from the Roth account are generally tax-free after age 59-1/2 if the account has been in place at least five years. From 2010 to 2012, only distributable amounts were eligible for an in-plan Roth rollover; starting in 2013, non-distributable amounts became eligible as well.

Here are some highlights of the new guidance, which answers some of the questions raised by industry groups:

- Nonvested amounts are ineligible for in-plan rollover.
- If nondistributable amounts are rolled over, any original (prior source) distribution restrictions imposed by law will continue to apply after the rollover.
- A plan may restrict the sources available for (and frequency of) in-plan rollovers.
- Federal income tax withholding doesn't apply at the time of the rollover; even voluntary withholding is prohibited for nondistributable amounts.
- Administrators don't need to send a Section 402(f) rollover notice to participants who elect an in-plan Roth rollover of nondistributable amounts.
- For calendar-year 401(k) plans adding in-plan rollovers of nondistributable amounts in 2013, the deadline for this amendment (and related changes) is extended to Dec. 31, 2014. During 2013 and 2014, safe harbor 401(k) plans can make a midyear change to offer in-plan rollovers of nondistributable amounts, as long as the plan is formally amended by Dec. 31, 2014.
- Employers offering this feature may later discontinue it without violating anti-cutback rules.

The guidance may help employers evaluate compliance risks, but the decision to offer this feature ultimately may come down to weighing administrative costs against participant demand.

Closed pension plans get narrow, temporary nondiscrimination testing relief: Just-issued IRS Notice 2014-5 provides temporary nondiscrimination testing relief for defined benefit (DB) pension plans that have closed to new entrants. The narrowly crafted relief doesn't waive testing but permits testing an eligible DB plan together with non-elective (but not matching) contributions to a defined contribution (DC) plan — even if the plans couldn't be combined for testing under current rules. The relief applies only to plan years beginning before 2016, which presumably gives the IRS two years to study the issue further and craft permanent relief.

Testing Catch-22. The relief targets employers that have closed their DB plans to new entrants and instead give new hires a non-elective DC plan contribution. Existing participants continue to earn DB benefits in the closed plan, which may initially pass nondiscrimination testing. Several years after closure, however, the DB plan often fails testing because its remaining participants become disproportionately highly compensated. At that point, the DB plan would satisfy testing if it could be combined with the non-elective DC plan for new hires, but current regulations impose certain stringent conditions for such DB/DC combinations. This creates a Catch-22: A DB plan often can meet the stringent conditions while it's still able to pass testing on a stand-alone basis, but not once it starts to fail testing on its own (and needs to combine with a DC plan to pass).

Plans eligible for relief. For eligible DB plans, the temporary relief waives — until 2016 — the conditions on combining DB/DC plans for testing. To be eligible, the DB plan must have closed to new entrants under an amendment adopted before Dec. 13, 2013, and must have either:

- Satisfied coverage and nondiscrimination testing without aggregation with any DC plan for the 2013 plan year
- Been part of a DB/DC combination for the 2013 plan year that either was primarily DB in character or consisted of broadly available separate plans

Narrow scope of relief. The notice appears to provide no relief to closed DB plans that could not pass nondiscrimination testing in 2013 under current rules. The relief also doesn't cover situations where employees excluded from the DB plan receive matching rather than non-elective DC plan contributions.

Comments sought. The IRS is soliciting comments on permanent relief and outlines a number of possible approaches to crafting such relief. Some of these approaches would permit testing DB plans with DC plans that provide matching contributions. **Comments are due by Feb. 28, 2014.**

Budget deal limits access to SSA death file, but benefit plans' needs recognized: Retirement plans, disability and medical plans, life insurance companies, and others will soon face new conditions for accessing Social Security Administration death records, under Section 203 of the budget deal (H.J. Res. 59) passed by Congress Dec. 18. Intended to crack down on tax fraud and identity theft, the program will limit access to death records for a three-year period starting on the date of an individual's death. However, an important exception covers "certified" entities that need the information sooner for fraud prevention or another legitimate business purpose. To apply for certification from the US Commerce Department, entities will pay a user fee, identify their legitimate need for access, and demonstrate their ability to safeguard the data. Penalties will apply for misuse or improper disclosure of the information.

Death records used in plan administration. The Social Security Death Master File contains the name, SSN, date of birth, and date of death for deceased persons. Many retirement, disability, and other benefit plans use this information to conduct periodic "death audits" or to search for missing participants.

Effective date issue. Pension plan sponsors and life insurers had voiced concern that the effective date — 90 days after the budget agreement is enacted — could temporarily block their ability to confirm annuitant deaths. In an effort to allay those concerns, Sen. Patty Murray (D-WA) stated during floor debate that the provision should not interrupt access to the records. "There is nothing in the law that prevents the continued public release of the death master file while the Commerce Department sets up the certification program," according to Murray, one of the bill's key brokers.

Next steps. Congressional approval of the two-year budget agreement clears the way for House and Senate lawmakers to complete spending legislation before current government funding expires Jan. 15, 2014.

Other changes for pension plan sponsors in the budget deal include significant hikes in PBGC premiums (By 2016, the flat-rate premium ($49 per participant in 2014) would climb to $64; the variable-rate premium ($14 per $1,000 of unfunded vested benefits in 2014) would rise to at least $29; and the cap on variable-rate premiums ($412 per participant in 2014) would climb to $500. All three rates would be indexed for inflation after 2016).

Retirement plans may seek IRS closing agreements to resolve unique tax issues: Employers and plan service providers may voluntarily request an IRS closing agreement to resolve certain income or excise tax issues involving tax-favored retirement plans, including qualified and 403(b) (but not 457) plans, according to a Dec. 19 IRS posting. Closing agreements offer a way to address unintentional errors that can't be resolved under the IRS Voluntary Correction Program (VCP) or other parts of the Employee Plans Compliance Resolution System. In informal remarks, an IRS official offered these examples of problems that might be appropriate for a closing agreement:

- A plan recordkeeper that engages in an ERISA prohibited transaction involving dozens of plans normally would have to go through the cumbersome process of filing dozens of Forms 5330 to pay the associated excise taxes. The recordkeeper could fix the violation under the Labor Department's Voluntary Fiduciary Correction Program, then seek an IRS closing agreement to make a single tax payment that will efficiently resolve the excise tax issues.
- A Subchapter S corporation sponsors an ESOP that violates the stock allocation restrictions in Code Section 409(p). The sponsor can use VCP to fix the plan's tax-qualification defects (failure to follow plan terms, which incorporate the 409(p) requirements). But the sponsor may seek a closing agreement to address related tax issues, such the sponsor's Subchapter S status and penalties for failure to pay prohibited transaction excise taxes under Section 4975.
- A small company maintains a pension plan that violates tax-qualification rules. If fixing the defects under VCP would bankrupt the company, the employer might seek a closing agreement instead.

Limited relief. The IRS generally "won't bargain or negotiate over any income or excise tax amounts, including interest, but may discuss penalty abatement." Thus, plan sponsors and service providers shouldn't expect tax relief but may qualify for penalty waivers or see other advantages in terms of administrative convenience. A request for a voluntary closing agreement may be initiated on a "John Doe" basis.

Centralized staffing. The IRS has a long history of entering into closing agreements on an *ad hoc* basis. The new procedures are designed to centralize administration and improve consistency for matters falling in the Employee Plans division's jurisdiction. The same personnel who process VCP submissions will handle closing agreements, making it likely IRS staff will uphold VCP principles, if possible, while working out solutions for plans with unique problems.

ACA rules proposed for vision, dental plans, EAPs, and 'limited wraparound coverage:
Proposed rules would allow self-insured stand-alone vision and dental benefits that don't require employee contributions to be excepted benefits; an opt-out feature would still be needed. Employee Assistance Programs (EAPs) would have to meet four criteria to be excepted, including a requirement that the EAP not provide significant medical benefits. The rules propose a new excepted benefit for 2015 — limited wraparound coverage for employees with non-grandfathered individual health insurance. Excepted benefits avoid many ACA and HIPAA group health plan mandates. Comments are due in late February.

An IRS notice confirms that after US v. Windsor employers could let employees make midyear enrollments of same-sex spouses in cafeteria plans, even if these employees were married when Windsor was decided. The guidance also discusses changing after-tax to pretax salary reductions, flexible spending account reimbursements for same-sex spouses' expenses, and joint contribution limits for dependent care and health savings accounts. Employers may need to take certain actions in response to the new guidance. .Notice 2014-1 (IRS, 16 Dec 2013, 11 pages) »

PBGC eliminates estimated flat-rate premium filings for 2014 and later plan years:
Large pension plans (500+ participants) will no longer pay flat-rate premiums early, thanks to a new PBGC rule effective for the 2014 plan year. This means large calendar-year plans won't owe estimated 2014 flat-rate premiums on Feb. 28; instead, flat- and variable-rate premiums will be due Oct. 15. Because employers urgently need guidance on estimated premiums, PBGC split its July 2013 proposal for simplifying premium filings into two parts. PBGC expects to finalize other elements of the proposal, including an accelerated due date and lookback rule for small plans, later this year. **Final PBGC regulation on large-plan flat-rate premiums (Federal Register Public Inspection, 2 Jan 2014, 14 pages) »**