Another Benefits Grab Bag of Guidance and Reminders – Health and Retirement Plans

01.22.14

HEALTH PLAN ISSUES

Preventive Care Expansion for Calendar Plan Year 2015 for Non-Grandfathered or Non-Exempt Plans
The preventive care coverage requirements were updated in September 2013 to include a requirement that there must be coverage for clinicians engaging in shared informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk, and for the women among those who are at low risk for adverse effects, the clinician should offer to prescribe certain risk reducing medications, such as Tamoxifen or Raloxifene. The Department of Labor's Frequently Asked Questions clarify that this is effective for non-grandfathered group health plans or policies for the policy or plan year beginning one year after the date of the issuance of the recommendation and that means it is effective for policy or plan years beginning on or after September 24, 2014 for non-grandfathered group health plans. Grandfathered group health plans are not required to comply with health reform's preventive care coverage mandates and are not required to cover this recommendation.

Cost Sharing Limitations
Plans with multiple vendors have faced challenges in complying with health reform's limit on out of pocket maximums ("OOPM"). For the plan year beginning in 2014 the annual limits on OOPM are $6,350 for self only coverage and $12,700 for coverage other than self only. These limitations apply to deductibles, co-payments and co-insurance but do not apply to balance billing for non-network providers or for non-covered items. While 2014 is a transition year allowing special rules for group health plans with separate vendors processing different claims (e.g., medical v. prescription drugs), a new optional way to comply with the cost sharing limits is available to non-grandfathered plans for plan years beginning on or after January 1, 2015. The non-grandfathered group health plans may comply with the out-of-pocket maximum for all essential health benefits for in-network services in 2015 by dividing the out-of-pocket limitations among the different categories of benefits handled by different vendors (e.g., $5,000 medical, $1,350 for prescriptions for a single limit of $6,350). Plan also must define essential health benefits that will be used to calculate the amounts towards the OOPM. This permits a non-grandfathered group health plan to avoid reconciling the amounts incurred toward the OOPM limit across multiple service providers as long as the out-of-pocket limits for the year when combined for in-network essential health benefits do not exceed the annual limitation under the Affordable Care Act ("ACA") and provided the division of the out of pocket limitation is not done in a way that might impact compliance with other laws, for example, the Mental Health Parity and Addiction Equity Act final regulations.

The guidance clarifies that the out-of-pocket spending limit is only for in-network items which constitute Essential Health Benefits. Out-of-network items and payments for benefits that are not essential health benefits do not need to be counted toward the out-of-pocket maximum limitation but can be if the employer so chooses. *This will require careful coordination in a plan using multiple vendors regarding the definition to be used for essential health benefit to ensure consistency across the vendors for a benefit option as well as which items are counted towards the out-of-pocket maximum (in v. out of network The cost sharing limitations do not apply to group health plans that are grandfathered or that are exempt from the application of the ACA.*

Expatriate Health Plans
Expatriate health plan eligible for transition relief are further defined. The transition relief only applies to insured expatriate health plans which were designed for individuals who will spend at least six months out the 12-month period outside of the

United States or outside of their home country. Note, the 12-month measuring period can fall within a single plan year or across two consecutive plan years.

Wellness Programs

Tobacco cessation wellness programs are frequently offered at the beginning of the plan year and require the individual, at the time of enrollment or annual enrollment to enroll in the tobacco cessation program to obtain the discount or avoid the surcharge for tobacco use. A plan is required to offer the opportunity to take the tobacco cessation program at the beginning of the year and if the participant decides to not enroll at the beginning of the plan year and qualify for the reward under the program, the plan is not required to provide another opportunity to avoid the tobacco premium surcharge for that plan year until the open enrollment for the next plan year.

If a plan has an outcomes based or health status contingent wellness program standard for avoiding a smoking premium surcharge and it is medically inappropriate for a plan participant to meet that standard and the doctor suggests an alternative program that is an activity only program the question arises as to whether the plan has a say in which activity only program the individual may enroll in to obtain the discount. The plan has to provide a reward for the individual who qualifies by satisfying a reasonable alternative standard. If the individual's physician says the outcome based wellness program is not medically appropriate for the individual and recommends an alternative program, the plan has to provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness.

Early Retiree Reinsurance Program Update

In a couple of new FAQs, the Early Retiree Reinsurance Program confirmed that the record retention requirement for employers whose health plans received reimbursements from the program is six (6) years from the date incurred or any longer time required by law. The record retention requirement may be fulfilled by the employer, the employer's third party administrator or a data aggregator or insurer. Employers wanting to rely on a vendor's record retention for its plan should verify in writing the vendors record retention compliance with the ERRP requirements and with HIPAA Privacy and Security requirements on record retention and also on disposal of the records when their time has expired. The records that must be retained include not only the claim detail, but the anti-fraud procedures, price concession documentation, plan enrollment documents and maintenance of the employer's contribution toward the early retiree coverage early retiree lists, response files, claims lists, and claim list response. *Since many of the records required to be retained may be in the early retiree health plan's vendor's records and control, it is important to ensure that the health plan's vendor will be retaining all of these records for six years from the last claim was "incurred"- it is not clear if this is when the service was provided or if it is when the claim was incurred by submission of the claim to the ERRP.*

Proposed Changes to Watch

A proposed new certification to the Department of Health and Human Services ("HHS") was proposed on January 2, 2014 which applies to "controlling health plans". A controlling health plan is a health plan that is controlled by an entity that is not a health plan, so as currently drafted these proposed regulations are likely to apply to employer sponsored group health plans. The new certification to HHS is one of two types of certifications which verify that the health plan complies with certain of the standard electronic health transactions that are required under the HIPAA Administrative Simplification regulations which require health plans to use standard forms of electronic transactions. The proposed regulations make this certification requirement effective as early as January 1, 2015 and impose a penalty of from $1 to up to $20 per covered life per day of noncompliance on the health plan, with a maximum of $20 per covered life. *As employers begin preparation for their 2015 plan years, they should verify with their plan's third party administrator whether it is in compliance with the applicable requirements so the employer's health plan can certify to HHS its compliance in the event this regulation is finalized in time for it to apply in 2015.*

While the proposed expansion of the definition of "excepted benefits" that avoid the vast majority of health reform's

requirements and recently the delay of the nondiscrimination requirements for insured health plans have received much press, there has been no new published guidance on the nondiscrimination enforcement delay which continues to be in effect until regulations are issued. To date no regulations or proposed regulations have been released on the nondiscrimination rules, so the nondiscrimination requirements continue to not be enforced on insured health plans. The non-discrimination requirements for self-insured health plans continue to exist, as they have for many years. As the press pushes on this issue, we may see developments in this area.

RETIREMENT PLAN ISSUES

Retirement Plan Delayed Disclosure Deadline Reminder

401(k) and other defined contribution plans that permit participants to direct the investment of the funds in their retirement plan accounts need to *remember that the extended due date for issuing the "annual comparative chart" on the fund alternatives under the plan and related fees is February 25, 2014 for the 2013 comparative chart requirement.* This deadline applies to plans which took advantage of the enforcement delay on providing the annual comparative chart disclosure for up to 18 months after the initial comparative chart disclosure and finished the first chart comparison by August 25, 2012. This is just one of the requirements that must be met for the plan's fiduciaries to be relieved from liability for the participant investment elections. Plans should carefully review all the disclosures in the applicable requirements to be certain they are compliant to protect the plan fiduciaries from liability for the participant's investment decisions under ERISA.

Certain FBAR Filings for Plans with Foreign Accounts Delayed Again

Some retirement plans have foreign investment accounts and some have investments in funds that have foreign investment accounts that may trigger the FBAR (foreign bank and financial account reporting) reporting requirements. *For persons who have signatory authority over a foreign bank account but do not have a financial interest in certain types of accounts, the extended filing due date of June 30, 2014 has been moved again to June 30, 2015 by FinCEN.* FinCEN Notice 2013-1 provides additional details.

OPERATING YOUR PLAN TO BE PREPARED FOR GOVERNMENTAL AUDITS AND OTHER CHALLENGES

It appears there has been an increase in governmental audits of health, welfare and retirement plans. There are a number of new requirements that are being imposed in 2014, including the additional disclosures for participant directed investment plans, as well as all of the Affordable Care Act changes to both health plans and COBRA continuation coverage. The IRS is structuring its audits by starting with a review of compliance procedures to determine where they will focus their efforts. The DoL also reviews your plan's (health and retirement) procedures and your documentation of following its procedures.

If your plan does not have compliance procedures to comply with the various requirements, implementing such procedures may help with your plan's compliance, its ability to use self-correction for errors, and to be in a better strategic position in the event of an audit. A plan that has compliance procedures that are followed helps the plan sponsor to minimize its risks related to the plan's operations and positions the employer to argue it should be eligible for reduced penalties for COBRA and HIPAA violations.

To limit years at risk, employers should ensure their plans file all of their tax returns which start the statute of limitation on the plan's years. Retirement plans file a Form 5330 to report delinquent contributions and other violations and also file Form 5500 which start the clock running to limit years subject to challenge in audits.

Employers should also be considering whether they have HIPAA portability or COBRA violations for which they may want to file on the Form 8928 for the most recently completed plan year so that the statute of limitations will start running with respect to that plan year for IRS audits and imposition of excise taxes for violations. Without Form 8928 being filed for a

year, the IRS argues that there is no limit on how many years back it may audit for COBRA or HIPAA violations. Can you document your plan's compliance with all of the COBRA notice requirements for every year? Do you want to save your plan's records forever?

While the U.S. Supreme Court's decision permitting plans to impose a reasonable limitation period on bringing claims by placing a limitation period in the plan document would protect the plan from a participant's late filed claims, it would not protect the plan sponsor from being required to produce records for an IRS audit on COBRA compliance. Reviewing your plan's records for potential COBRA or HIPAA portability violations and filing a Form 8928 may save record retention costs.

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