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## FINAL RULES ISSUED ON MENTAL HEALTH PARITY

On November 8, 2013, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, released Frequently Asked Questions (FAQs) on the implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, on November 13, 2013, these Departments also released final regulations on the implementation of the MHPAEA. A summary of the FAQs and final regulations are located below.

### SUMMARY

#### Background

Previously, the MHPAEA generally required group health plans to provide parity (i.e., equal treatment) between mental health/substance use disorder benefits and medical/surgical benefits **if** the plan offers mental health/substance use disorder coverage as part of their plan. Examples of equal treatment between benefits include: the same annual and lifetime dollar limits, co-payments, co-insurance, out-of-pocket maximums, quantitative treatment limitations (e.g., number of treatments, visits, and days of coverage). In addition, plans were required to provide equal treatment for non-quantitative treatment limitations (e.g., medical management standards).

The previous requirements were implemented in response to the interim final regulations and FAQs released on February 2, 2010.

#### Application of Final Rules

The final regulations will be effective for health plans with plan years beginning on or after July 1, 2014. Prior to this time, plans must comply with the interim final regulations released on February 2, 2010. Individual policies must also adopt the MHPAEA requirements.

#### Highlighted Clarifications and Changes to the Interim Final Rules

Below are some of the highlighted changes to the interim final regulations that will affect group health plans:

- **Lifetime and Annual Dollar limits**

- The interim final regulations stated that MHPAEA permits aggregate lifetime and annual dollar limits. The final regulations clarify that this application is only for benefits that are not Essential Health Benefits (EHBs). For any mental health or substance use disorder benefits that are EHBs, there will be a prohibition against lifetime and annual dollar limits

## Final Rules Issued on Mental Health Parity (Continued)

- **Small Employer Exemption and Essential Health Benefits**

- The final regulations reiterate that under the MHPAEA's small employer exemption, group health plans consisting of 50 or fewer eligible employees are exempt from the requirements of the MHPAEA
- However, all fully-insured, non-grandfathered, small group plans must cover EHBs in compliance with MHPAEA, regardless of the exemption. Therefore, all fully-insured, non-grandfathered small group plans (and individual plans) must comply with the MHPAEA, and its requirements for parity. (A potential exemption to MHPAEA may exist with small group, self-funded plans)

- **Preventative Services Mandate**

- A group health plan that provides preventative services for mental health/substance use disorder benefits (e.g., alcohol misuse screening and counseling, depression counseling, and tobacco use screening) solely to comply with the preventative services mandate, is not required to provide additional non-preventative mental health/substance use disorder benefits in the plan

- **Tiered Networks and Sub-classifications**

- The final regulations retain the same requirements as the interim final regulations, allowing for different financial requirements and different treatment limitations in six sub-categories: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs
- In addition, sub-classifications may be further sub-classified, such as office visits and non-office visits, and plan designs that may have two or more network tier providers (e.g., an in-network tier of preferred providers with more robust cost-sharing options versus a separate in-network with less robust participating providers). However, other sub-classifications not mentioned in the final regulations may **not** be used

- **Scope of Coverage for "Intermediate Services"**

- The final regulations require that parity be applied also as to the scope of services. In particular, the final rules clarify that a plan must assign covered intermediate mental health/substance use disorder benefits (e.g., residential treatment, partial hospitalization, intensive outpatient treatment) in the same six sub-classifications, in the same manner that it is assigned to any intermediate medical/surgical benefits in those same six sub-classifications

- **Employee Assistance Plans and Parity**

- The final regulations confirm that Employee Assistance Plans (EAPs) that do not provide significant benefits related to medical care or treatment are considered HIPAA-excepted benefits, and therefore, are not subject to the rule of parity under MHPAEA

### Action Required

Employers who offer mental health and substance abuse disorder benefits as a part of their health plan must be compliant with the final regulations for plan years beginning on or after July 1, 2014.

**For more information regarding the final rules, go to:**

<http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27169&AgencyId=8&DocumentType=2>

**For more information regarding the Frequently Asked Questions related to the final rules, go to:**

<http://www.dol.gov/ebsa/faqs/faq-aca17.html>

# MASSACHUSETTS BULLETIN REPEALS CERTAIN INTERNAL REVENUE CODE SECTION 125 STATE REQUIREMENTS

On October 28, 2013, the Massachusetts Connector released Bulletin 03-13. The Bulletin significantly changed the rules behind the State's Internal Revenue Code (IRC) Section 125 cafeteria plan requirement, "Health Insurance Responsibility Disclosure" (HIRD), and the free rider surcharge rules. Highlights of the Bulletin are contained below.

## Background

Massachusetts currently requires employers, with at least 11 employees, to offer eligible employees the opportunity to purchase coverage under one or more health coverage options, on a pre-tax basis, through an employer-sponsored IRC Section 125 plan. Under the law, employers could allow employees to purchase coverage, on a pre-tax basis, through the Massachusetts Connector (Massachusetts' version of a State Exchange).

Under the law, an employer who fails to provide employees an opportunity to purchase medical benefits on a pre-tax basis would pay a penalty termed the "free rider surcharge."

Finally, employers were also required to submit an HIRD to the State, and inform eligible employees of their ability to purchase one or more health coverage options on a pre-tax basis.

## Future Repeal of the Law

In Bulletin 03-13, Massachusetts announced it will no longer require:

- Employers to provide employees the ability to make pre-tax contributions toward their health coverage options (including disclosure to employees regarding this benefit)
- Employers to contribute to a "free rider surcharge" to the Massachusetts Connector for failing to provide employees the ability to purchase health coverage options on a pre-tax basis; and
- Employers to submit HIRDS to the State

The Bulletin does not repeal the law, but the Massachusetts Connector has stated in the Bulletin that it has a policy of "non-enforcement" of the above employer requirements until the time the law is repealed.

## Action Required

Employers who had previously offered pre-tax benefits to employees in order to avoid the free rider surcharge, no longer need to be concerned about the free rider surcharge. Employers also should avoid paying for Massachusetts Connector coverage for employees on a pre-tax basis by the beginning of the plan year in 2014.. Employers, who previously were submitting HIRDS to the State, may stop doing so.

**For more information regarding the proposed rules, go to:**

<https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Regulations/documents/AdminBulletin03-13.pdf>

# PROPOSED RULES ON NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2015

On November 25, 2013, the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS), released proposed rules, setting forth the 2015 benefit and payment parameters related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. Highlights of the proposed rules are below.

## SUMMARY

### Reinsurance Fees

Reinsurance fees are paid to HHS to stabilize individual policy premiums. The proposed reinsurance fees for the 2015 year are \$44 per member, per year.

### Maximum Cost-Sharing Limits in 2015

The proposed regulations state that HHS expects a premium adjustment percentage for 2015 to be 6%, thereby increasing the maximum out-of-pocket cost-sharing for 2015 for self-only coverage to be \$6,750, with a maximum annual limitation on deductibles for 2015 in the small group market for self-only coverage to be \$2,150.

### Actuarial Calculator for 2015

The proposed regulations also have introduced a proposed 2015 Actuarial Value Calculator, along with the methodology for calculation of a plans actuarial value.

## No Action Required

Employers should be aware of the proposed changes to the reinsurance fee contributions, as well as the maximum cost-sharing limits for 2015.

**For more information regarding the proposed rules, go to:**

[http://www.ofr.gov/OFRUpload/OFRData/2013-28610\\_PL.pdf](http://www.ofr.gov/OFRUpload/OFRData/2013-28610_PL.pdf)

**For access to the 2015 Actuarial Value Calculator and Methodology, go to:**

<http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#PremiumStabilizationPrograms.gov>

# MARKET REFORMS AND S.H.O.P. ONLINE ENROLLMENT DELAYED

On November 14, 2013, the Centers for Medicare and Medicaid Services (CMS) published a letter providing health insurance carriers transition relief from certain market reforms that were set to take place in 2014. In addition, on November 27, 2013, CMS released Frequently Asked Questions (FAQs) on a new enrollment process that would bypass online enrollment into the Small Business Health Options Program or “SHOP” Exchanges. Highlights of each are contained below.

## Transition Relief for Market Reforms

Under a transitional policy, CMS has announced that health insurance carriers have the ability to continue offering individuals and small businesses health coverage that was previously cancelled due to the policy failing to meet certain market reform requirements.

The following are the requirements that must be met for the policy to qualify for transition relief:

- The policy must renew between January 1, 2014 and October 1, 2014
- The coverage was in effect on October 1, 2013
- A notice must be sent to all individuals or businesses that received, or would have received, a cancellation or termination notice with respect to the coverage, that contains all of the following information:
  - Changes in options available
  - Which market reforms are not included in the coverage
  - The right to enroll in an Exchange, along with the possibility of receiving a subsidy
  - How to access an online Exchange; and
  - The right to enroll in other coverage outside of the Exchange, that complies with market reforms

The following are the market reforms that may be delayed in 2014, due to the transition relief:

- Fair health insurance premiums
- Guaranteed availability and renewability of coverage
- Prohibition against pre-existing condition exclusions or other discrimination based upon health status
- Prohibition of discrimination against individual participants and beneficiaries based on health status
- Non-discrimination in health care
- Comprehensive health insurance coverage
- Coverage for certain individual participants in approved clinical trials

## Delay in SHOP Online Enrollment

Employers participating in the SHOP Exchanges will not be able to enroll online until November of 2014. However, the price of plans and plan offerings may still be reviewed online even prior to that time.

Small group employers may still participate in the SHOP Exchange prior to November of 2014, but coverage must be directly accessed through agents, brokers, or insurers who offer Qualified Health Plans.

## THREE STATES EXPAND SAME-SEX MARRIAGE RIGHTS

### SUMMARY

Recently, Hawaii and Illinois passed legislation approving same-sex marriage. Therefore, as of December 2, 2013, Hawaii allows same-sex marriage, and Illinois will begin allowing same-sex marriages by June 1, 2014. This increases the number of states that recognize same-sex marriage to 16, along with the District of Columbia.

Oregon, although banning same-sex marriage in the State's constitution, has announced that it will recognize same-sex marriages performed outside of the State. This was evidenced by an opinion letter from the Attorney General to the Chief Operating Officer stating that a prohibition on the recognition of same-sex marriages performed in other jurisdictions may violate the U.S. Constitution, and therefore, same-sex spouses that are in the State shall receive the same tax treatment and benefits programs as their opposite-sex counterparts.

### Action Required

Employers in Hawaii, Illinois, and Oregon should modify their policies, procedures, and their plan documents to provide benefits to same-sex spouses.

**For details, go to:**

[http://www.capitol.hawaii.gov/splsession2013b/SB1\\_HD1\\_.pdf](http://www.capitol.hawaii.gov/splsession2013b/SB1_HD1_.pdf);

<http://www.ilga.gov/legislation/98/SB/PDF/09800SB0010lv.pdf>; **and,**

[http://media.oregonlive.com/politics\\_impact/other/AG\\_Opinion.pdf](http://media.oregonlive.com/politics_impact/other/AG_Opinion.pdf)

## CALIFORNIA PASSES LEGISLATION TO EXCLUDE FROM INCOME BENEFITS PROVIDED TO SAME-SEX COUPLES

### SUMMARY

On October 1, 2013, California passed legislation to exclude from an employee's gross income any contributions by an employer for benefits received by an employee's same-sex spouse or State-registered domestic partner. This legislation is effective as of October 1, 2013, and will continue to be effective until January 1, 2019.

### Action Required

Employers in California who were previously imputing income to an employee for employer contributions to benefits for an employee's same-sex spouse or registered domestic partner should stop doing so immediately.

**For details, go to:**

[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB362](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB362)

# INTERNAL REVENUE SERVICE ANNOUNCES KEY BENEFIT PLAN LIMITS FOR 2014

The Internal Revenue Service (IRS) recently released Revenue Procedure 2013-35. This document announced the 2014 limits for qualified transportation fringe benefits, adoption assistance programs, long-term care premiums, and medical savings accounts. Highlights are as follows:

## RETIREMENT PLAN LIMIT AMOUNT CHANGES

2013	2014	
\$205,000	\$210,000	§415 defined benefit dollar maximum
\$51,000	\$52,000	§415 defined contribution annual addition maximum
\$255,000	\$260,000	§401(a)(17) annual compensation limit
\$165,000	\$170,000	§416(i) top heavy officer limit

2013	2014	
\$17,500	\$17,500	§401k/403(b) elective deferral maximum
\$17,500	\$17,500	§457(b) nonqualified deferred compensation limit
\$115,000	\$115,000	§414(q) highly compensated employee limit
\$5,500	\$5,500	§414(v) catch-up contribution limit

## QUALIFIED TRANSPORTATION FRINGE BENEFITS

2013	2014	
\$245	\$130	Commuter highway vehicle and transit pass
\$245	\$250	Qualified parking

## ADOPTION ASSISTANCE PROGRAMS

2013	2014	
\$12,970	\$13,190	Excludable Amount

2013	2014	PHASE OUT INCOME THRESHOLDS
\$194,580	\$197,880	Phase out begins
\$234,580	\$237,880	Phase out complete



## LONG-TERM CARE PREMIUMS

2013	2014	
\$360	\$370	Age 40 or Under
\$680	\$700	41–50
\$1,360	\$1,400	51–60
\$3,640	\$3,720	61–70
\$4,550	\$4,660	Over 70

### Action Required

Employers should modify their benefit limits pursuant to the new guidelines for 2014.

**To see Revenue Procedure 2013-35, go to:**  
<http://www.irs.gov/pub/irs-drop/rp-13-35.pdf>



## QUESTION OF THE MONTH

**Q:** If my business elects to no longer allocate funds to an HRA, what are my options to satisfy the Healthy San Francisco Ordinance's (HCSO's) Employer Spending Requirement in 2014?

**A:** The options available to your business for satisfying the HCSO's Employer Spending Requirement in 2014 and beyond remain the same.

The HCSO requires Covered Employers to make Health Care Expenditures to or on behalf of their covered employees each quarter. A Health Care Expenditure is any amount paid by a Covered Employer to its Covered Employees or to a third party on behalf of its Covered Employees for the purpose of providing health care services for Covered Employees or reimbursing the cost of such services for its Covered Employees.

Some examples of Health Care Expenditures that meet the requirements of the HCSO include:

- Payments to a third-party to provide health care services for the Covered Employee, such as payments for health insurance or payments to a health care provider
- Payments on behalf of the Covered Employee to the City Option
- Contributions on behalf of the Covered Employee to a reimbursement program
- Payments to the Covered Employee to reimburse the employee for costs incurred in the purchase of health care services
- Costs incurred by the employer in the direct delivery of health care services for the Covered Employee

City & County of San Francisco.

## IMPORTANT DATES

### PLAN YEARS ENDING ON / AFTER 10/01/2013

- **Comparative Effectiveness Fee** Fully-insured carriers and self-funded plan sponsors will be subject to a fee in the amount of \$2 per covered life. The Fee is due 07/31 of each year using Form 720 "Quarterly Federal Excise Tax Return"

### PLAN YEARS ON / AFTER 01/01/2013

- **Flexible Spending Accounts** limited to \$2,500 for employee contributions

### 60 DAYS AFTER THE BEGINNING OF THE PLAN YEAR

- **Employer Creditable Coverage Reporting to CMS** due (e.g., if a plan effective date is 01/01, reporting must be completed by 03/01)

### NOVEMBER 2013

- **11/14/2013** – **Barney & Barney's Legislative Compliance 2014 Outlook Seminar** in San Diego, CA
- **11/15/2013** – **Reinsurance Fee** reporting due for carriers and self-funded plans (including plan sponsors who have not integrated their HRA with their self-funded plan)

### JANUARY 2014

- **01/01/2014** – Federal **90-Day Waiting Period** effective for calendar year plans; California state **60-Day Waiting Period** effective for calendar year plans. For non-calendar year plans, the Waiting Period effective date should be implemented on the first day of the plan year in 2014
- **01/01/2014** – **Individual Mandate Penalty** Individuals will be penalized for failing to have Minimum Essential Coverage. Transition relief provides that individuals (employee, employee's spouse, employee's dependents) who were eligible for non-calendar year, employer-sponsored coverage in 2013, will not be subject to penalties until the end of the plan year in 2014