For Your Benefit

A newsletter on current legal issues impacting employee benefits and executive compensation

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Spring 2017

IRS Relieves Some of the Hardship of Hardship Distributions

By Susan Foreman Jordan, Esq.

As an exception to the general rule that elective deferral contributions to a 401(k) plan may not be withdrawn prior to termination of employment, attainment of age 59 ½ or plan termination, a participant may request an earlier distribution of elective contributions, if the plan so permits, and if the distribution is taken to relieve financial hardship. A distribution is considered to be made on account of hardship only if the distribution is necessary to satisfy an "immediate and heavy financial need" of the participant.

Under the regulations, a distribution will be deemed to be on account of such a financial need, if it is for one or more of the following:

- Expenses for medical care (deductible under Code Section 213(d)) for the plan participant or for the participant's spouse, children, dependents or primary beneficiary under the plan;
- Costs directly related to the purchase of a principal residence for the participant;
- Payment of tuition, related educational fees, room and board expenses for up to the next 12 months of post-secondary education for the participant or for the participant's spouse, children, dependents or primary beneficiary under the plan;
- Payments necessary to prevent the eviction of the plan participant from his or her primary residence or foreclosure of the mortgage on that residence;
- Payment for burial or funeral expenses for the participant's deceased parents, spouse, children, dependents or primary beneficiary under the plan; or
- Expenses for the repair of damages to the participant's principal residence that would qualify for the casualty deduction under Code Section 165.

A distribution is deemed to be necessary to satisfy the financial need if (1) the participant has obtained all other currently available distributions and non-taxable loans under the plan and all other plans maintained by the employer, and (2) the participant is prohibited, under the terms of the plan, from making elective deferral contributions and other employee contributions to the plan (and all other plans maintained by the employer) for a period of at least six months after receipt of the distribution.

Some plans mandate detailed documentation to support each hardship withdrawal request, while others dictate only that participants self-certify the existence and general nature of the hardship. Certainly, securing appropriate documentation, such as a copy of a foreclosure or eviction notice, is best practice. In many cases, however, plan administrators feel that requesting full documentation may intrude upon the privacy of employees. Additionally, providing full documentation can be cumbersome in situations in which withdrawal applications are submitted and processed electronically or telephonically.

Earlier this year, the IRS issued a memorandum setting forth substantiation guidelines to be followed by IRS auditors when examining plans and evaluating whether a 401(k) hardship distribution is deemed to be on account of an immediate and heavy financial need. A subsequent

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memorandum confirmed that the guidance also applies to hardship withdrawals from 403(b) plans.

Obviously, an auditor will start by reviewing the source documents or the summary of the information obtained from the source documents to determine whether they substantiate the existence of an immediate financial need. The guidelines make it clear, however, that when a plan administrator relies upon a summary of information in source documents, rather than on source documents themselves, additional requirements apply:

First, the plan administrator must provide notice to the participant of the following: (1) the hardship distribution is taxable and additional (early distribution excise) taxes may apply; (2) the amount of the distribution may not exceed the immediate and heavy financial need; and (3) the hardship distribution may be made only from the principal amount of elective contributions (i.e., no hardship distributions may be made from earnings on elective contributions or from qualified non-elective or qualified matching contribution accounts).

Second, the participant must agree to preserve source documents and to make them available at any time upon request of the employer or plan administrator.

Third, the plan administrator should assure that the summary of information from source documents contains the following specific information enumerated in an attachment to the IRS memorandum, and to be taken into consideration by an IRS auditor, in determining whether the existence of financial hardship has been substantiated:

General Information for All Hardship Requests

- Participant's name
- Total cost of the event causing hardship (for example, total cost of medical care, total cost of funeral/burial expenses, payment needed to avoid foreclosure or eviction)
- Amount of distribution requested
- Certification by the participant that the information provided is true and accurate

Specific Information on Deemed Hardship for Medical Care

- Who incurred the medical expenses (name)?
- What is the relationship to the participant (self, spouse, dependent or primary beneficiary under the plan)?
- What was the purpose of the medical care (not the actual condition but the general category of expense, for example, diagnosis, treatment, prevention, associated transportation, long-term care)?
- Name and address of the service provider (hospital, doctor/dentist/chiropractor/other, pharmacy)
- Amount of medical expenses not covered by insurance

Specific Information on Deemed Hardship for Purchase of Principal Residence

- Will this be the participant's principal residence?
- Address of the residence
- Purchase price of the principal residence
- Types of costs and expenses covered (down payment, closing costs and/or title fees)
- Name and address of the lender
- Date of the purchase/sale agreement
- Expected date of closing

Specific Information on Deemed Hardship for Educational Payments

- Who are the educational payments for (name)?
- What is the relationship to the participant (self, spouse, child, dependent or primary beneficiary under the plan)?
- Name and address of the educational institution
- Categories of educational payments involved (post high school tuition, related fees, room and board)
- Period covered by the educational payments (beginning/end dates of up to 12 months)

Specific Information on Deemed Hardship for Foreclosure/Eviction from Principal Residence

- Is this the participant's principal residence?
- Address of the residence
- Type of event (foreclosure or eviction)
- Name and address of the party that issued the foreclosure or eviction notice
- Date of the notice of foreclosure or eviction
- Due date of the payment to avoid foreclosure or eviction

Specific Information on Deemed Hardship for Funeral and Burial Expenses

- Name of the deceased
- Relationship to the participant (parent, spouse, child, dependent or primary beneficiary under the plan)
- Date of death
- Name and address of the service provider (cemetery, funeral home, etc.)

Specific Information on Deemed Hardship for Repair of Damage to Principal Residence

- Is this the participant's principal residence?
- Address of the residence that sustained damage
- Briefly describe the cause of the casualty loss (fire, flooding, type of weather-related damage, etc.), including the date of the casualty loss
- Briefly describe the repairs, including the date(s) of repair (in process or completed)

This list of required information is included in an attachment to the IRS guidelines. We would recommend that plan administrators allowing substantiation through a summary of information provide the substantiation listing to participants in advance so as to enable them to assure that the summary contains the requisite information.

Apart from the documentation, the IRS memorandum directs auditors to carefully scrutinize situations in which employees have received more than two hardship distributions in a single plan year. With this in mind, employers may wish to limit the frequency with which hardship withdrawal is allowed.

Overall, the guidelines provide some flexibility to employers and plan administrators by allowing them to rely on summaries rather than requiring actual source documents in all cases. However, while employers and plan administrators often are reluctant to impose additional burdens on individuals who are experiencing financial difficulties, it is clear that self-certification of a hardship, without the necessary information and/or source documents, will not suffice and will result in a plan failure.

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A New Approach to Business Succession Planning

By Harvey M. Katz, Esq. and Seth I. Corbin, Esq.

We are regularly involved in discussions with business owners concerning succession planning, with both existing and prospective clients, and participate in a variety of seminars covering this subject matter. While the discussion is no doubt similar amongst this very general group of business owners, the seminars often fail to capture their attention in a manner likely to spring them into action. In order to protect the guilty, here is a paraphrased course description from such a recent seminar: *A way for business owners and their professionals to consider and evaluate different deal structures, to minimize taxes and use deal proceeds to satisfy spending, wealth transfer and philanthropic goals.* Therein lies the problem. Deal structures, taxation, wealth transfer – all financial and economic terms. While it may be a shock to many who put together M&A transactions, or invest the proceeds, the sale of a closely held business is far more than a mere financial transaction. While the foregoing disciplines are an essential element of any resulting business sale, focusing on those matters is not necessarily the best way to begin the succession process in our experience.

For most closely held business owners, their business constitutes far more than a collection of assets. Those who own or advise closely held businesses and their owners know that the business represents the owner's major personal – as well as professional – investment in time, effort, focus and commitment for the last 25 to 50 years. The transition from sole business owner to former business owner involves a myriad of

emotional and psychological issues that must be addressed before a business owner can think about the financial aspects of the sale. Most retirees encounter some of the issues relating to isolation, loss of work relationships and loss of the status and identity associated with a high-level position. However, these issues are particularly acute for business owners and should not be ignored when discussing succession planning.

In our experience, the most productive discussions often start with the simple question: *What do you want to do with the rest of your life?* The reality is that most business owners are so involved with the day-to-day operation of their business that they have not seriously considered the answer to that question. To many, the subject raises uncomfortable questions about mortality and self-worth outside of the business. As uncomfortable as the question is, it is a necessary first step to any meaningful dialogue. The reality is that most owners are less concerned about squeezing the last dollar out of a third party buyer than finding a comfortable path into retirement while leaving the business in capable hands. The tendency of many business succession advisors is to put the proverbial cart before the horse and it is one of the reasons that many business owners delay and procrastinate.

We frequently counsel reluctant owners and prognosticators that there are generally three ways to exit a business: (1) a sale to a third party; (2) a sale to existing employees; and (3) horizontally. Every time they put off a succession planning decision or find another everyday problem to deal with in lieu of the transition plan, they make a decision to move closer to the third option. Obviously, this implies that the individual dies without any meaningful business succession plan, thus representing the worst option for all concerned, including both the business itself and the business owner's family.

Many owners would opt for a transition plan that would allow them to remain in control while gradually reducing their role at a time and place of their own choosing. A sale to employees either directly or through an employee stock ownership plan (ESOP) is often a palatable answer. The key difference between a sale to employees and a sale to a third party is control. Depending upon the type of third party buyer, the owner can generally expect to receive a two to five year employment contract. Make no mistake, however. This change from owner to mere employee is the first step towards the complete loss of control, a process that generally occurs on the buyer's timetable. While some owners view this as an inevitable part of the transition process, others view being in charge of the business as an essential part of their self-worth and reason for continued involvement. To these business owners, losing control of their transition timetable is simply unacceptable. By contrast, most sales to employees can easily be structured to allow the former owner to remain in operational control for as long he or she is willing and able – as this is typically mutually beneficial to both the buyer and seller.

In addition, a sale to employees will preserve the independent legacy of the business and can significantly retain more jobs for long-term, loyal employees. To many owners, these employees are like family and keeping their jobs intact is an essential part of any transition plan. Many who subscribe to this line of thinking (i.e., those who sell to third party buyers) are able to negotiate a one or two year protection for their employees – at some cost to themselves in the form of a reduced purchase price. However, in our experience, many of the employees who enjoy these protections are terminated the day after they expire as the new ownership looks to make its mark on the business.

Although a sale to employees offers certain critical advantages, it is not without challenges. The two most significant challenges involve financing and developing the next generation of leadership. In many cases, it makes sense for the owners to finance the sale, requiring them to remain with the business for some period of time. In a typical owner-financed transaction, that period is approximately five years, as this duration is generally sufficient to ensure repayment of any debt created in connection with the sale. The five year period is also the amount of time generally required to develop the right kind of talent to take the reigns from current leadership. It is more

likely than not that the owners hold those reigns tightly and the sale is the impetus to begin serious succession planning with respect to others taking operational control of the company.

It is our hope that business owners reading this article take away three critical points. First, begin the discussion of the business by examining your own needs and desires as to when and how you wish to exit from your business. Second, consider a sale to your employees as one of those options. It is not ideal in every situation, but still clearly worthy of consideration in many cases. Third, and most importantly, begin your planning early. Every day that you wait brings you one day closer to the doomsday scenario of your heirs being required to sell your business at a fire sale price.

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New Requirements Under Final Disability Claims Regulations

By Jessica Forbes Olson, Esq.

On December 19, 2016, the Department of Labor published final regulations changing the claims procedures for disability benefit claims. The new regulations are effective January 18, 2017 and apply to claims for disability benefit claims filed on or after January 1, 2018.

The new rules apply to disability benefit claims under plans such as a (1) short term disability plan that is governed by ERISA (and not a payroll practice); (2) long term disability plan; or (3) pension plan, 401(k) plan, life insurance plan, severance plan or other plan where the availability of the benefit (e.g., vesting under a pension plan or waiver of premium under a life insurance plan) is conditioned upon the participant being disabled as determined by the plan, unless the finding is conditioned on another party's determination of disability (such as the Social Security Administration or the LTD insurer).

Checklist of New Requirements

Below is a checklist of the new requirements that will be effective January 1, 2018:

- ❏ Disability claims and appeals must be adjudicated in a manner designed to ensure independence and impartiality of persons making the decision (e.g., decision regarding hire, compensation, termination or promotion cannot be made based on the likelihood that the individual will deny the claim or appeal).
- ❏ Additional content is required to be included in the claim and appeal denial letters (see checklists below).
- ❏ Before the plan can issue an appeal denial, the plan administrator must provide the claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the plan, insurer or other decision maker. This new evidence must be provided as soon as possible and in advance of the determination so that the claimant has a reasonable opportunity to respond before that date.
- ❏ Before the plan can issue an appeal denial based on new or additional rationale, the plan administrator must provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the appeal denial is required to be provided to give the claimant a reasonable opportunity to respond before that date.
- ❏ If the plan fails to strictly adhere to all the claims procedure requirements, the claimant is deemed to have exhausted the administrative remedies available under the plan, and can sue (with no deference to the prior decision). However, there is no

deemed exhaustion in the event of de minimis violations that do not cause harm, as long as the plan demonstrates the violation was for good cause or due to matters beyond the plan's control and the violation occurred in the context of an ongoing, good faith exchange of information between the plan or the claimant.

- ❏ If the plan violates the claims procedures, the claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted.
- ❏ The term "adverse benefit determination" will also include any rescission (retroactive termination) of disability coverage with respect to a participant or beneficiary (even if it does not impact a benefit at that time). "Rescission" does not include a failure to timely pay required contributions.
- ❏ A plan's notices must be provided in a culturally and linguistically appropriate manner. This means that if a notice of adverse benefit determination is provided in a county where at least 10% of the population is literate only in some non-English language, the notice must offer language assistance services (e.g., translation hotline), provide language assistance in connection with filing claims and appeals, provide a translated notice upon request and provide in all notices a prominent statement in the non-English language about how to access language services.

Action Items

Employers may want to take the steps listed below to be prepared to comply with the new regulations.

- ❏ Determine which of your plans are subject to the disability claims regulations.
- ❏ Discuss with insurers or appropriate personnel to ensure the plan's claims procedures will be in compliance with the new requirements as of January 1, 2018.
- ❏ Update language in the plan document and summary plan description to reflect the new claims procedure requirements.
- ❏ Update template claim and appeal denial letters to ensure they will satisfy the new content requirements. See the separate checklists below that will assist you in updating template letters.

Disability Claim Denial Letter Content Checklist

Below is a checklist of claim denial letter content requirements (those not effective until January 1, 2018 are noted).

- ❏ The specific reason or reasons for the adverse determination.
- ❏ Reference to the specific plan provisions on which the determination is based.
- ❏ A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- ❏ A description of the plan's review procedures and the time limits, including a statement of the claimant's right to sue under ERISA following denial on appeal.
- ❏ If the adverse benefit determination is based on a plan exclusion such as medical necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- ❏ Effective January 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with:
  - ❏ The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - ❏ The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - ❏ A Social Security Administration disability determination regarding the claimant.

- ❑ Effective January 1, 2018, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either (1) provide the specific rule, guideline, protocol or other similar criterion; or (2) include a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. This is a change from the current rule that either the rule, guideline, protocol or other similar criterion must be provided or a statement can be included that such a rule, guideline, protocol or other criterion was relied on and will be made available upon request.
- ❑ Effective January 1, 2018, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.
- ❑ Effective January 1, 2018, the notification must be provided in a culturally and linguistically appropriate manner, as described above.

Disability Appeal Denial Letter Content Checklist

Below is a checklist of appeal denial letter content requirements (those not effective until January 1, 2018 are noted).

- ❑ The specific reason or reasons for the adverse determination.
- ❑ Reference to the specific plan provisions on which the benefit determination is based.
- ❑ A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.
- ❑ A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures.
- ❑ A statement of the claimant's right to bring a civil action under ERISA.
- ❑ If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- ❑ Effective January 1, 2018, a description of any applicable plan deadline to sue, including the calendar date on which the deadline to sue expires for the claim.
- ❑ Effective January 1, 2018, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:
- ❑ The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant.
- ❑ The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's claim denial, without regard to whether the advice was relied upon in making the benefit determination.
- ❑ A Social Security Administration disability determination regarding the claimant presented by the claimant to the plan.
- ❑ Effective January 1, 2018, either (1) the specific internal rule, guideline, protocol or other similar criterion that was relief on must be provided, or (2) a statement must be included that such a rule, guideline, protocol or other similar criterion was not provided because it does not exist. This is a change from the current rule that either the rule, guideline, protocol or other similar criterion must be provided or a statement can be provided that such a rule, guideline, protocol or other criterion was relied on and will be made available upon request.
- ❑ Effective January 1, 2018, the notification must be provided in a culturally and linguistically appropriate manner, as described above.

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IRS Proposed Regulations Would Permit Forfeitures to Fund QNECs and QMACs

By T.J. Lang, Esq

On January 18, 2017, the IRS published proposed regulations, which amend the definitions of qualified non-elective contributions (QNECs) and qualified matching contributions (QMACs). The following questions and answers explain the importance of QNECs and QMACs and how the proposed changes are beneficial to 401(k) plan sponsors.

Q: What are QNECs and QMACs?

A: QNECs and QMACs are "qualified" employer nonelective and matching contributions to 401(k) plans. To be "qualified," a contribution must be nonforfeitable (i.e., 100% vested) and must not be distributed prior to a participant's death, disability, separation from service, attainment of age 59 ½ or the plan's termination. Qualified contributions also cannot be used for hardship distributions.

Q: Why do plan sponsors make qualified contributions?

A: Contributions to 401(k) plans may not discriminate in favor of highly compensated employees (HCEs). To ensure deferrals and matching contributions are nondiscriminatory, the plan must pass actual deferral percentage (ADP) and actual contribution percentage (ACP) tests. These tests compare the differences in the average deferral and contribution percentages of HCEs to those of non-HCEs. If the difference in average deferral or contribution percentages is too great (i.e., if the plan fails either ADP or ACP testing), the sponsor must correct the disparity by making a QNEC or QMAC to eligible non-HCEs or by distributing excess contributions to HCEs.

Sponsors of safe harbor 401(k) plans may also use QNECs and QMACs to automatically pass ADP and ACP testing.

Q: How do the proposed regulations change qualified contributions?

A: Prior to the proposed regulations, the IRS considered nonelective or matching contributions "qualified" only if they satisfied the nonforfeitability and distribution restrictions at the time the contributions were made to a plan. As a result, a sponsor could not use amounts in a plan's forfeiture account to fund QNECs, QMACs or safe harbor contributions because at the time the amounts were originally contributed to the plan they were not 100% vested. (Which is why the amounts ended up as forfeitures to begin with.) Even if the 401(k) plan permitted sponsors to use forfeitures to reduce employer contributions, sponsors had to make additional contributions to fund qualified contributions.

The proposed regulations revise the underlying definition of QNECs and QMACs so that the contributions are considered "qualified" if they satisfy the nonforfeitability and distribution restrictions at the time contributions are allocated to a participant's account.

Q: What does the change mean for plan sponsors?

A: The change to the QNEC and QMAC definition provides plan sponsors more flexibility to fund qualified contributions and potentially makes correcting plan errors and safe harbor contributions less expensive for plan sponsors. By expanding the permitted uses of forfeitures, the proposed regulations may reduce the amount of additional contributions sponsors must make to their 401(k) plans.

Q: When can plan sponsors take advantage of the change?

A: The proposed regulations generally apply to taxable years beginning on or after the date the final rule is published. The IRS, however, stated that taxpayers may rely on the proposed changes immediately.

Q: What must plan sponsors do to take advantage of the proposed regulations?

A: Plans sponsors wanting to use forfeitures to fund QNECs, QMACs or safe harbor contributions must first review their plan documents to determine whether the plan allows forfeitures to be used to:

1. Reduce employer contributions; and
2. Fund QNECs, QMACs and safe harbor contributions.

If your plan does not permit one or both of the above, the plan must be amended before you can rely on the proposed regulations. Sponsors of safe harbor 401(k) plans could adopt such an amendment mid-year without violating IRS Notice 2016-16.

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Mental Health Parity: A Guide for Compliance

By Stephanie M. Moscetti, Esq.

Mental health parity continues to be an area rich with enforcement activity and continued regulation. While the final regulations were promulgated almost four years ago, the Departments of Labor, Treasury and Health and Human Services (collectively, the "Departments") continue to release FAQs further clarifying the regulations and compliance documents aimed at helping health plans avoid noncompliance. However, many employer-sponsored plans continue to be unaware of the extent of the requirements or rely on their vendors to ensure compliance. With the recent bipartisan passage of the 21st Century Cures Act, aiming to enhance enforcement efforts, plan sponsors must be vigilant of the parity requirements as the Department of Labor's enforcement activity will only continue to increase.

Requirements

Passed in 1996, the Mental Health Parity Act (MHPA) required annual or lifetime dollar limits on mental health benefits to be no less than the limits on medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded on MHPA and required that plans offering mental health or substance abuse disorder benefits offer them in parity with medical/surgical benefits. The regulations issued by the Departments separated the limitations into two categories: quantitative and non-quantitative.

For quantitative treatment limitations, such as cost-sharing or numerical treatment limits, any limitation on mental health/substance use disorder (MH/SUD) benefits must be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all medical/surgical benefits covered by the plan. According to the regulations, in order to apply a quantitative limit on a MH/SUD benefit, the general limitation, such as a copayment, must apply to at least two-thirds of all medical/surgical benefits in the classification. The specific limitation, for example $25, must apply to more than 50% of the medical/surgical benefits either as a single amount or in combination with higher cost-sharing amounts.

For non-quantitative treatment limitations (NQTLs), such as prior authorizations or fail-first protocols, any processes, strategies, evidentiary standards or other factors used in applying NQTLs in MH/SUD benefits must be comparable to, and applied no more stringently than, those used with respect to medical/surgical benefits.

When reviewing for parity, plans must review the benefits and limitations within the following six categories. If a plan offers MH/SUD benefits in any of the six categories, the plan must offer benefits in all six: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

Judicial Enforcement

While the focus is often on federal regulatory enforcement activity, participants are turning to the courts to enforce parity requirements under ERISA's civil enforcement provisions. In one case, a federal district court in Illinois denied a health plan's motion to dismiss stating that excluding residential treatment centers for mental health services but not for other medical conditions would violate MHPAEA since no other similar exclusion was used for medical/surgical benefits. In another case, the federal district court in Oregon determined that a developmental disability treatment exclusion, which in practice excluded certain autism treatments, applied only to mental health conditions. Since it did not also apply to medical/surgical treatments, the exclusion ran afoul of MHPAEA.

Checklist for Compliance

In light of the increased regulatory and judicial activity, plan sponsors should review their health plans for compliance with MHPAEA. The following checklist should assist plan sponsors when conducting the compliance review.

- Review service agreements with vendors, including TPAs and PBMs:
  - What is the vendor's responsibility for compliance?

- What is the vendor doing to ensure compliance with MHPAEA?
- Is the vendor required to notify the plan sponsor if they discover a MHPAEA violation?
- Is the vendor contractually liable to correct the violations at its expense?
- Does the agreement limit the vendor's liability for MHPAEA?

- Review the quantitative calculations
  - Who is responsible for performing the calculations?
  - If the vendor, is it using plan-specific data?
  - Is the test considering each type of cost-sharing, e.g., coinsurance, copayments?
  - Is there documentation of the calculations?
  - For prescription drugs, when assigning drugs to different tiers, are reasonable factors applied without regard to whether the drug is used to treat MH/SUD conditions?
  - If a plan has a deductible, does it encompass both MH/SUD and medical/surgical benefits?
- Review the NQTLs
  - Are there written policies for determining which services receive medical management (e.g., prior authorizations)?
  - In practice, are a higher percentage of MH/SUD benefits subject to medical management?
  - Regarding formularies, does the TPA/PBM use fail-first protocols (step therapy) or apply additional requirements in order to receive MH/SUD prescription drugs?
  - Are residential treatment services, including those for eating disorders, categorized consistently, with respect to both quantitative treatment limitations and NQTL, in one of the six categories? Are there blanket preauthorization requirements on residential treatment services?
  - How does the TPA determine which providers are in-network?
  - Are the criteria for a provider to be in-network more stringent for MH/SUD providers?
- Determine who is responsible for responding to any participant or contracting provider requests for disclosures (vendor, plan sponsor)
  - Are they aware of the responsibility and the requirements?
  - Is the information easily accessible and written in a format easily understood by a participant?
- When was the last time the plan tested for compliance with MHPAEA? Has the plan design, cost-sharing or utilization changed requiring additional testing?

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