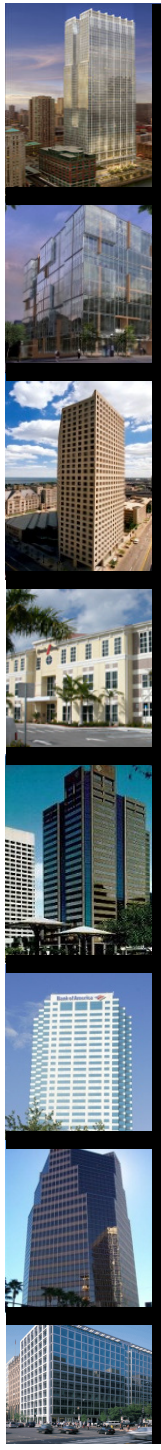

Health Care Reform in 2014 and Beyond: Action Steps for Employers

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Topics for Today

- Regulatory forecast
- Highlights from recent guidance
- Seven steps to Pay or Play Rule
- MEC/ALE reporting
- Mental Health Parity rules

Regulatory Forecast

- Large number of “open” issues
- Automatic enrollment (likely 2015)
- Nondiscrimination rules (105(h) test)
  - Fully insured plans
- Employer interaction with Exchanges
  - E.g., will employers “dump” sick employees to Exchange? HIPAA / nondiscrimination issues?
  - Can hospitals pay for Exchange coverage?
- More Pay or Play guidance

Legislative / Judicial Forecast

- No Congressional action expected before November mid-term elections
  - Growing support from Democrat for repeal / modification to “Pay or Play Rule”
  - Will 30 hours become 35? 40? Perhaps impose a “percentage of payroll” approach?
- Recent DC Circuit Court holding on no Exchange subsidies for Federal exchanges
  - Scope remains unclear (especially after 4th Circuit)
- Yesterday, another appeals court (DC Circuit) decision rejecting “origination” claim
  - 5th Circuit on appeal

Recent / Current Guidance

- New COBRA notification alerting QBs to Marketplace option
- New "orientation period" regulations
  - Allows extension of 90-day waiting period by up to one month (less a day)
    - E.g., if start on May 3, last permitted day is June 2; if start October 1, last permitted day is October 31
  - Must be "reasonable" and "bona fide"
    - Would seem to vary by position (and perhaps employee?)
  - Does not seem to "work" with a non-days-based waiting period (e.g., work 1,200 hours)
  - Compliance with orientation period does not equal compliance with Pay or Play Rule

Recent / Current Guidance

- Deductible limits – Supposed to have been $2,000 / $4,000
  - Self-insured and large group insured plans exempt
  - Now reversed!
- OOP maximums (somewhat tied to HDHP OOP maximums) apply for plan years beginning on or after 1/1/2014
  - Transitional relief for 2014 plan years if two separate TPAs are utilized – only medical must apply the MOOP. If the drug benefit has a MOOP the MOOP must meet the ACA requirements, but still can be separate
  - 2015: Get agreement confirming that TPA and PBM will coordinate?
  - Note divergence from HDHP amounts
  - 2015 HDHP maximum OOP $6,450 / $12,900
  - But, 2015 ACA OOP is $6,600 / $13,200

Recent / Current Issues

- Examine same-sex marriage issues
- Beware “inadvertent” coverage
- Some concern over retroactive recognition of same-sex marriages
  - July 2014 ruling by CT Supreme Court allowed widow of same-sex spouse to seek “consortium” benefits, by retroactively recognizing same-sex marriage
  - 2008 MA court decision went opposite way
- State tax issues difficult
- Difficult just to monitor scope of changes

Current Issues - Fees

- Patient Centered Outcomes Research Institute (PCORI) Fee
  - Effective for policy or plan years that end on or after October 1, 2012 and continue until 2019
  - Imposes $1 (later $2) fee per covered life under plan for trust fund
  - Usually paid by issuers and employers on the quarterly tax excise tax return – due annually July 31

Current Issues - Fees

- Reinsurance Fee
  - Imposes fee on insurers and employers (effective 2014, due in 2015)
  - Fees will help stabilize premiums for coverage in the individual market during the first 3 years of exchange operation
  - Required contributions will be $5.25 per covered life monthly ($63 annually for the first year; $44 annually in 2015)
  - New regulations require 10-year (!) records retention rules
    - Require TPAs to hold records for that long?
  - New guidance indicates that self-funded, "self-administered" plans will avoid 2015, 2016 fees
  - Still no forms to report the fee

Current Issues - Fees

- Health Insurer Fee
  - ACA Section 9010 – imposes annual fee on health insurance industry starting at $8 billion in 2014 and increasing to $14.3 billion in 2018
  - Excise tax and therefore non-deductible
  - Allocated to health insurers based on premium in the previous year
  - Based on market share

2014 Changes

- Plans cannot discriminate against provider acting within scope of license or certification under state law
- Plans must provide clinical trial coverage for certain "qualified individuals"
- New "preventive care" coverage – On September 24, 2013 the USPSTF issued new recommendations regarding treatment of breast cancer
  - For women who are at an increased risk for breast cancer, but low risk for adverse medication effects clinicians should now offer to prescribe risk-reducing medications at no cost
  - Effective for policy or plan years beginning one year after the recommendation (policy or plan years starting on or after September 24, 2014)

2014 Changes

- No pre-existing condition exclusions by first day of 2014 plan year (will eliminate need for Certificates of Creditable Coverage in 2015)
- Grandfathered plans can no longer prohibit adult children from enrolling in the plan when the adult children have access to their own employer sponsored coverage

HIPAA Changes

- ACA imposes "employer certification" rule for HIPAA Standard Transactions
  - Original compliance date of 12/31/2013 delayed
  - Now, certify by 12/31/2015 or 12/31/2016
  - Apparently all "health plans" must certify – overkill?
    - Risk it because penalty only applies to "major medical" plans?

HIPAA Changes

- Certification date tied to whether health plan identifier (HPID) received by 1/1/2015
  - If so, due date is 12/31/2015
  - If not, due date is 12/31/2016
- HPID must be applied for by 11/2014 (11/2015 for “small plans”)
  - Use by 11/2016 for all plans
- Again, looks like all health plans apply

HIPAA Changes

- New HIPAA HITECH regulations for January 2013
- Make several important changes
  - New breach definition
  - Update policies and procedures
  - New access request provisions
  - Update business associate agreements by 9/2013 or 9/2014

MEC Reporting: Big Picture

- Requires reporting by any person that provides minimum essential coverage ("MEC") to an individual in a calendar year
  - First reports delayed to 2016 (for reporting 2015 coverage)
  - Info goes to "responsible individuals"
    - Person who enrolls one or more individuals (usually the employee)
  - Single transmittal also filed with IRS for all returns for year
  - Used by individuals and IRS for individual mandate
    - Verify months in which an individual had MEC
      - For 2014, IRS relies on other information sources

ALE Reporting: Big Picture

- Requires reporting by applicable large employers ("ALEs") (employers subject to Code § 4980H Pay or Play Rule)
  - Also delayed to 2016 (for reporting 2015 coverage)
  - Whether sponsoring insured or self-insured plan (means self-insured ALEs are subject to both types of reporting)
  - Information provided by individual statements to FT employees plus single transmittal filed with IRS
  - Determine whether Code § 4980H penalties are assessable and, if so, in what amount
  - Determine eligibility for premium tax credits for QHPs purchased in Exchanges (starting in 2014)
    - For 2014, IRS will rely on other information sources

Effective Date and Deadlines for Reporting

- Similar to Form W-2 reports
  - For furnishing statements, deadline is January 31 of following calendar year
  - For filing transmittals, deadline is February 28 of following year (March 31 if filed electronically)
  - No special deadline for non-calendar-year plans
- First returns will be required in early 2016 for coverage in 2015
  - Because 2016 dates fall on Sundays, first statements will be due 2/1/16 and first returns 3/1/16 (unless electronic)

MEC Reporting: Who Must Report?

- Health insurers to be responsible for all insured coverage
  - Includes coverage under insured employer plans
  - Exchanges do not report
- Plan sponsor responsible for reporting for self-insured health coverage
  - Note: No Code §414 aggregations; each employer reports separately
- Third parties can help with reporting but liability for reporting not transferred

MEC Reporting: Form and Method

- MEC return made uses Forms 1094-B and 1095-B (unless IRS designates others)
- ALE return uses Forms 1094-C and 1095-C
- Electronic filing and furnishing
  - Electronic filing to be required from high-volume filers
    - Those who file 250 or more returns during calendar year
    - Any entity can choose to file electronically
  - Electronic furnishing of statements to be permitted
    - But only if detailed notice, consent, and hardware or software requirements are met
    - More stringent than typical DOL/IRS rules (e.g., employees must affirmatively consent)

MEC Reporting: What Coverage Is MEC?

- MEC includes eligible employer-sponsored plan (EESP)
- EESP includes employer-sponsored group health plans
  - Employer plan (insured or self-insured) providing medical care (including grandfathered plans)
    - Appears that even a 100% employee-paid plan can be EESP
    - Certain arrangement (like HSAs) are not GHPs not MEC
    - Excepted benefits (including on-site clinics) exempt
  - No reporting for coverage that "supplements" MEC
    - Can include HRA (but spend-down period may need to report)
    - Can include wellness programs that provide reduced premiums or cost-sharing under a GHP

MEC Reporting: Information Required

- Name, address, and TIN of responsible individual and each individual enrolled in MEC
  - Reasonable efforts must be made to collect TINs
    - To be reasonable, two attempts to collect must be made after initial unsuccessful attempt (e.g., at open enrollment)
    - Birth date may be used as an alternative, if these efforts fail
    - Note: Proposed IRS rules on truncated TINs are to apply
- Months (not specific dates) of coverage for each individual (1 day of coverage = coverage for month)
- For employer coverage, identity of employer and whether coverage is through SHOP Exchange
  - Portion of premium paid by employer will not be required

ALE Reporting: Who Must Report

- ALEs are responsible for Code § 6056 reporting
  - Controlled groups: No separate line of business exception
    - Related employers are combined for purposes of counting employees for the ALE determination
      - All employees of a controlled group are taken into account when determining whether members of group are ALEs
      - If 50-employee threshold is met by group, then each member is an "ALE member"
  - Code § 6056 reporting applies separately to each ALE member
    - One group member may assist by reporting on behalf of other members

ALE Reporting: Information Required

- Regulations require
  - Identification of filing entity and calendar year
  - Certification whether opportunity to enroll in EESP was offered to FT employees and dependents
  - Number of FT employees for each month
  - For each FT employee —
    - The months EESP was available
    - The employee's share of the lowest-cost monthly premium for MV self-only coverage (by calendar month)
    - Employee's name, address, taxpayer identification plus months, if any, FT employee was covered under EESP
      - Note: Proposed IRS rules on truncated TINs are to apply
  - Such other information as IRS may prescribe

ALE Reporting

- Rules permit multiemployer plan to report on behalf of its covered individuals
  - Still need “single 1094-C transmittal”
  - Will plan agree? Indemnify?
- New regulations allow combined MEC and ALE reports
  - Use Forms 1094-C (transmittal) and 1095-C (return)

ALE Reporting: Information Required

- Under "general reporting" method, information to provide on each FT employee for each month:
  - Whether or not EESP providing MV was offered to the FT employee, spouse, and dependents
  - Information on why EESP was not offered for a month (employee in waiting period, not employed that month, etc.)
  - Whether EESP was offered for a month in which the employee was not a FT employee
  - Whether filer met any affordability safe harbor
  - Total number of employees by month
  - Certain other categories of information about ALE filers
  - Note: Some of this information is provided through indicator codes

ALE Reporting

- Do not need to report:
  - Length of waiting period
  - Employer's share of total allowed cost of benefits
  - Monthly premium for lowest-cost option other than self-only
  - Months in which employee's dependents were covered

ALE Reporting: Information Required

- Compliance timeline note
  - Employers wishing to use IRS safe harbors for variable-hour employees need a strategy in 2014 to identify which employees will be treated as FT in 2015
- Certain information required under language of Code § 6056 need not be reported —
  - Length of any waiting period
  - Employer's share of total allowed cost of benefits
  - Monthly premium for the lowest-cost option enrollment categories other than self-only
  - Months in which employee's dependents were covered

ALE Reporting: Alternative Methods

- Certification of "qualifying offers"
  - First alternative to general reporting method
    - ALE may certify on its Form 1094-C (transmittal form) that for all months during year in which employee was a FT employee, a "qualifying offer" was made, meaning –
      - An offer of MV coverage providing employee-only coverage at a cost of no more than 9.5% of FPL
      - And an offer to the employee's spouse and dependents
    - IRS anticipates ALE using this method will provide simplified information depending on circumstances of qualifying offer
      - Employee's name, SSN, address, and indicate via indicator code that qualifying offer made for all 12 months
      - Where qualifying offer was for less than 12 months, must use general reporting method for those months
    - Specifics expected to be addressed in Forms and instructions

ALE Reporting: Alternative Methods

- Certification of "qualifying offers"
  - For 2015 only, ALE certifying that it made qualifying offer to at least 95% of its FT employees (and to their spouses and dependents)
    - Will be able to use simplified reporting for entire workforce (even employees who do not receive a qualifying offer for the full 12 months)
    - Will also furnish simplified statements to employees
      - If qualifying offer applied to an employee for all 12 months, statement will inform that the employee (and spouse and dependent) are not eligible for a premium tax credit
      - If qualifying offer did not apply for all 12 months, statement will inform that they may be eligible to claim a premium tax credit for some of the months

ALE Reporting: Alternative Methods

- 98% offer rule
  - Second alternative to general reporting method
    - ALE may certify on its Form 1094-C (transmittal form) that it offered
      - Affordable MV coverage to at least 98% of employees on whom it is reporting
    - Such ALE is not required to identify or specify the number of FT employees at all
  - There would be follow up if an employee later claims a premium tax credit on the Exchange
    - IRS hopes that the 98% standard will avoid "excessive inquiries" as to whether particular employees claiming a premium tax credit were FT employees
      - But ALE needs to maintain adequate records to respond to IRS inquiries that may come later

MEC and ALE Reporting: Recap

	MEC Reporting	ALE Reporting
Purpose	Individual mandate and small employer tax credit	Code § 4980H and QHP tax credit eligibility
Recipient	"Responsible individual"	FT employee
Filer	• Insured for insured plan • Sponsor for self-insured	ALE (insured or self-insured)
Forms	1094-B and 1095-B	1094-C and 1095-C
Deadline	Statement: 1/31 Return: 2/28 or 3/31 (if elec.)	Same
Essential Information	Who was enrolled in MEC for which months + employer info	Who was offered what kind of EESP for which months

Comparing Different Employer Disclosures

Disclosure	Which Employees?	How	When
MEC report	Health plan enrolled	Paper or electronic (with consent)	Early 2016 (for 2015 coverage)
ALE report	Health plan eligible	Paper or electronic (with consent)	Early 2016 (for 2015 coverage)
Exchange notice	All	Mail or DOL elec. delivery rules	By 10/1/13—14 days for new hires
SBC (already applicable)	Health plan eligible	Paper or electronic (special rule in connection with open enrollment)	At open and other enrollment points and on request
Coverage tool (if requested)	Whoever requests	Employer not required to respond	Not prescribed

On-Site Clinics Six Issues

- Basic issue under each applicable law is whether the clinic is considered an employer health plan
- Many employers think of clinics as just another provider
  - IRS and DOL see things differently
- Subtle differences in definition of health plan under different rules could mean different treatment for different purposes
- Bottom line: For most purposes, the more extensive the services available, the more likely the Clinic is a health plan

Six Legal Considerations

- Most of the legal issues have been around for a long time
- Some recent "spotlights" on on-site clinics:
  - COBRA audit guidance (discussed below)
  - Explicitly included in W-2 reporting of health coverage
  - Included in calculation of "Cadillac tax" on high-cost health coverage
- Not addressing
  - Wellness program issues (ADA, GINA, nondiscrimination)
  - Health law requirements (application of provider HIPAA rules, nurse supervision, practice of medicine, etc.)

Legal Consideration #1: Treatment under ERISA

- Clinic subject to ERISA if group health plan
- Group health plan is employee welfare benefit plan that provides medical benefits
- Exclusion for on-site facilities "for the treatment of minor injuries or illness or rendering first aid in case of accidents occurring during working hours"
  - Many clinics provide services clearly beyond treatment of workplace minor injury and illness
  - Clinic with services limited to "urgent care" for employees while working likely meets this exclusion

Legal Consideration #1: Treatment under ERISA

- Clinic features that may make a clinic an ERISA plan:
  - Services available to dependents
  - Services available during non-working hours
  - Treatment of ongoing condition
  - Provision of minor surgery
  - Provision of physical therapy
  - Provision of preventive care services

Legal Consideration #1: Treatment under ERISA

- Result of ERISA plan status for clinic:
  - Must comply with ERISA's reporting and disclosure requirements:
    - SPDs, SMMs, SBCs
    - SARs
    - 5500s
  - Claims and appeals procedure requirements apply (probably not many denials)

Legal Consideration #1: Treatment under ERISA

- Possible approaches:
  - Limit services to urgent care for employees during work hours only – exempt from ERISA
  - Limit availability to employees enrolled in major medical and tack on to major medical through "supplement" to SPD/plan document
  - Tack on to major medical, limit services for employees not enrolled in major medical to urgent care only
  - Offer full spectrum of services to all employees and/or dependents and undertake additional reporting and disclosure burden
- Risk of noncompliance includes penalty on audit, 5500 failure penalty

Legal Consideration #2: Application of COBRA

- COBRA regulations state that on-site clinics are groups health plan subject to COBRA unless ALL of the following are met:
  - The medical care consists primarily of first aid that is provided during the employee's working hours for treatment of a health condition, illness or injury that occurs during those working hours;
  - The medical care is available only to the employer's current employees; and
  - Employees are not charged for use of the clinic.

Legal Consideration #2: Application of COBRA

- Typical clinic does not meet the exception to COBRA
  - Services available outside of working hours
  - Wide array of services available
  - Some charge for use of clinic
- March 2012 IRS COBRA audit guidance for its examiners recites rule described above and alerts auditors to look for on-site clinic COBRA compliance
- Compliance is difficult where:
  - Physical layout of clinic only allows access from inside company (no former employees on-site)
  - Clinic is available to all employees, not just those enrolled in major medical
  - Company has “no former employees” on site rule

Legal Consideration #2: Application of COBRA

- Possible approaches:
  - Limit access to only employees enrolled in major medical, include clinic in COBRA election for major medical
  - Create COBRA notice and determine premium for all employees
  - Automatically extend clinic availability for 18 (36?) months following termination of employment
- Risk of noncompliance includes:
  - Penalty of the lesser of 10% of the employer's cost for all group health plans during a year or $500,000 for each year during which there were "inadvertent failures“
  - Former employee claims
  - Larger penalty for intentional (knowing) failures

Legal Consideration #3: Impact on HSA Eligibility

- IRS guidance says if Clinic provides "significant medical care" beyond worksite injury and preventive care before applying deductible, coverage is considered non-HDHP coverage and employees with access to clinic are not eligible to contribute to an HSA
- IRS example says the following clinic services will not jeopardize HSA eligibility:
  - Dental and vision services
  - Physicals and immunizations
  - Allergy shots
  - Providing nonprescription pain relief
  - Treatment of injuries caused by accidents at worksite

Legal Consideration #3: Impact on HSA Eligibility

- Possible approaches
  - Limit services to those on permitted list above
    - Could possibly add others if not "significant" (workplace illness?)
  - Integrate with major medical for employees in HDHP
    - Must charge FMV for all services not on permitted list above
    - No guidance on FMV for this purpose
      - Percentage of Medicare rate?
      - Percentage of health plan allowed cost?
      - Flat dollar fee for all services?
      - Based on general market data?

Legal Consideration #3: Impact on HSA Eligibility

- Risk of noncompliance:
  - HSAs not employer plan, so employer should not be responsible for employee contributions outside of payroll
  - Payroll tax/withholding failure if employer permits pre-tax employee HSA contributions through payroll or makes employer HSA contributions
  - Employee could seek recovery from company for bad tax consequences based on misleading communications ("enroll in the HDHP and you can contribute to an HSA") or reliance on company for information

Legal Consideration #4: Taxation of Clinic Benefits

- Under Code Sections 105 and 106, "medical care" benefits under an accident or sickness plan and employer contributions towards those benefits are not taxable
- Very broad, picks up any clinic benefits as long as they qualify as medical care for an employee or his or her spouse or dependent
- Exception for benefits if clinic discriminates in favor of highly paid employees
  - Top 25% of employees by pay
  - E.g., clinic available only to executives and salaried employees, not available to "bottom 75%"
  - Discriminatory benefits are taxable income to highly paid employees

Legal Consideration #5: Application of HIPAA

- HIPAA portability rules (preexisting condition, special enrollment, nondiscrimination) apply to "group health plans" other than group health plans that are excepted benefits
  - Excepted benefits include health plan "in relation to its provision of . . . coverage for on-site medical clinics"
  - "in relation to" language suggests being part of a larger plan should not matter (e.g., if integrated with major medical)
- HIPAA "administrative simplification" rules – privacy and security rules – apply to "group health plans" as defined under ERISA
  - But, carve-out for on-site medical clinics

Legal Consideration #6: ACA Compliance

- ACA employer mandates under ERISA, the Internal Revenue Code and the Public Health Service Act (government employers) apply to "group health plans"
- IRS, DOL and HHS have confirmed via the preamble to the grandfathered plan regulations and an FAQ that the HIPAA portability excepted benefits rules apply for purposes of determining application of ACA employer mandates
- As noted, HIPAA portability rule says coverage for on-site clinic is an excepted benefit

Legal Consideration #6: ACA Compliance

- Again, excepted benefit rules apply to a group health plan "in relation to" its provision of on-site clinic benefits, should not matter if clinic is integrated with major medical
  - If employer mandates applied:
    - Integrated plan would satisfy preventive care mandate, no annual limits
    - Age 26 dependent coverage theoretical problem (if clinic not available to employees children), but again, employer mandates should not apply
- December, 2013 proposed regulations on excepted benefits did not address on-site clinics (and did not change rules)
- Apparently subject to Cadillac tax

Compliance Example 1

- Generous Co. offers clinic that provides primary care, some preventive care, PT, lab testing, prescriptions and minor surgery to all employees
- Generous Co. also offers an HDHP and PPO as health plan options
  - Generous Co. charges 100% of Medicare rate for all services other than preventive care and worksite injury and applies deductible to non-preventive care services for employees in HDHP
  - Generous Co. offers all employees COBRA for clinic upon termination of employment
  - Generous Co. includes clinic in health plan HIPAA privacy and security umbrella
  - Generous Co. distributes SPD/plan document, other ERISA-required communications for clinic and counts all employees in 5500 participant counts
- RESULT: Clinic arguably complies with ERISA, COBRA, HIPAA, ACA, employees in HDHP can contribute to HSAs

Compliance Example 2

- To avoid application of COBRA and ERISA, Generous Co. offers clinic that provides only injury treatment and "urgent care" illness treatment to employees during regular working hours, at no cost
- Generous Co. also offers an HDHP and PPO as health plan options
  - Generous Co. does not charge employees anything for services (to avoid application of COBRA)
  - Generous Co. includes clinic in health plan HIPAA privacy and security umbrella
- RESULT: Clinic arguably complies with ERISA, COBRA, HIPAA, ACA, but employees in HDHP may not be eligible to contribute to HSAs
  - Issue is whether services are "significant services" outside of dental, vision, preventive care, worksite injury
  - Aggressive employer might decide not significant, sell employees on HDHP enrollment and HSA opportunity

Mental Health Parity Overview

- Initially created by Mental Health Parity Act of 1996
- Expanded by Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)
- Enforced by Department of Labor (“DOL”), Internal Revenue Service (“IRS”) and Health and Human Services (“HHS”)

Overview (Cont'd.)

- MHPAEA effective first plan year beginning on or after October 3, 2009 (e.g., January 1, 2010 for a calendar year plan)
  - Could be delayed further for collectively-bargained plans
- Interim final regulations effective April 5, 2010, apply to plan years starting July 1, 2010
- Penalties vary
  - IRS: $100 per day per affected individual (and file Form 8928)
  - DOL: No specific penalties, but enforcement action possible
  - HHS: Usually enforced by state, but HHS can enforce if state does not

General Goals of Law

- Concern in Congress that mental health (and, later, substance use disorder) benefits were unfairly being subject to limits not applicable to medical / surgical benefits
  - E.g., plan may have previously capped medical benefits at $1,000,000 per year, but capped mental health benefits at $10,000 / year
- MHPAEA establishes three main requirements
- Annual / lifetime limits: If plan has annual and / or lifetime dollar limits for medical / surgical ("Med/Surg") must apply those same (or higher) dollar limits for mental health / substance use disorder benefits ("MH/SUD")

General Goals of Law (Cont'd.)

- Parity regarding financial requirements (e.g., deductibles, co-payments) and quantitative treatment limitations (e.g., number of treatments, visit limits, days of coverage)
- Parity regarding nonquantitative treatment limitations (e.g., medical management standards)
- Note: MHPAEA does NOT require plan to provide MH/SUD benefits in first place
  - But, if you do, subject to full scope of MHPAEA

Which Plans are Subject?

- MHPAEA applies to both "group health plans" and health insurance issuers
- Broad definition of "group health plan" – essentially any plan paying for medical care
- Exception for "excepted benefits" – most dental, vision, health FSAs

Which Plans are Subject? (Cont'd.)

- Also a "small employer" exception
  - If employer employed average of at least 2 but less than 50 employees on business days during prior calendar year
  - For governmental plans, "50" changes to "100"
  - Note, though, that many of these small employers have fully-insured plans (and insurer usually would comply)
- Retiree-only plans also exempt

Which Plans are Subject? (Cont'd.)

- Also is an "increased cost" exemption
  - If changes to comply with MHPAEA would result in at least 2% cost increase in first plan year after 10/2009 OR 1% in any subsequent year
  - Limited relief, though – only "buys" you one year
  - Also need actuary to make determination and need to tell plan participants and federal government
- Self-funded, non-federal governmental plan can opt-out (file with Center for Medicare & Medicaid Services)

Lifetime and Annual Dollar Limits

- Three basic rules
- (1) One-Third Rule: If plan does not include ANY aggregate lifetime or annual dollar limit on any med/surg benefit OR includes such a limit on less than 1/3 of such benefits, plan cannot impose ANY aggregate lifetime or annual dollar limits on MH/SUD
  - E.g., plan has no annual or lifetime dollar limits on med/surg benefits. Cannot have any lifetime or dollar limits on MH/SUD benefits
  - May be typical to have no limits after Affordable Care Act

Lifetime and Annual Dollar Limits (Cont'd.)

- (2) Two-Thirds Rule: If plan DOES include an aggregate lifetime or annual dollar limit on at least 2/3 of all med/surg benefits, must either:
  - Apply that limit both to med/surg and to MH/SUD benefits in a manner that does not distinguish between the two OR
  - Apply greater limits on MH/SUD benefits (i.e., treat them more favorably than med/surg)

Lifetime and Annual Dollar Limits (Cont'd.)

- Wait—how do we determine "1/3" or "2/3" of "benefits"?
  - Based on dollar amount of all plan payments for med/surg "expected to be paid under the plan for the plan year"
  - Can use "any reasonable method" to make determination – apparently no need to hire an actuary (use historical data?)

Lifetime and Annual Dollar Limit (Cont'd.)

- (3) Middle Rule: If neither (1) or (2) applies, plan must either:
  - Impose no aggregate lifetime or annual dollar limits on MH/SUD benefits or
  - Impose an aggregate lifetime or annual dollar limit on MH/SUD that is no less than an "average limit" for med/surg
  - Average limit is also based on any "reasonable method" of employer

General Parity Rules

- If plan provides both med/surg and MH/SUD benefits, plan cannot apply any "financial requirement" or "treatment limitation" to MH/SUD in any "classification" that is more "restrictive" than "predominant" financial requirement or treatment limitation applying to med/surg
- "Financial requirement" – e.g., deductibles, copayments, coinsurance, out-of-pocket maximums

General Parity Rules (Cont'd.)

- "Treatment limitation" – limits on benefits based on frequency of treatment, number of visits, days of coverage, days in waiting period (e.g., maximum of 50 outpatient visits per year)
- "Classification" – six types, each examined separately
  - Inpatient, in-network
  - Inpatient, out-of-network
  - Outpatient, in-network
  - Outpatient, out-of-network
  - Emergency care
  - Prescription drugs

General Parity Rules (Cont'd.)

- "Restrictive" – not specifically defined, but generally means worse for participant (e.g., lower annual limit; fewer days of treatment)
- "Predominant" – If the financial requirement or quantitative limitation is a "type" that applies to at least 2/3 of all med/surg benefits in a "classification" (e.g., inpatient, out-of-network) then that is the "predominant" restriction for that classification
  - Hurdle to clear: If financial requirement or treatment limitation does not apply to at least 2/3 of med/surg benefits in the classification, CANNOT apply to MH/SUD benefits in that classification
  - The "level" of the limitation is the one that applies to more than ½ of med/surg benefits in that classification

General Parity Rules (Cont'd.)

- E.g., plan offers inpatient and outpatient benefits, no network of providers. Plan imposes $500 deductible on all benefits. For inpatient med/surg, plan imposes coinsurance requirement. For outpatient med/surg, plan imposes copayments.
  - Because no network, all benefits considered out-of-network
  - Because inpatient benefits subject to restrictions (coinsurance) which do not apply to outpatient benefits, each is a "classification" and each examined separately under MHPAEA

General Parity Rules (Cont'd.)

- Can actually be more than six classifications
  - E.g., if plan has "preferred providers" where plan imposes more generous cost-sharing, plan can divide "in-network" classification into two "sub-classifications"
- Can also have sub-classifications for office visits, separate from outpatient services
  - NOT ok to divide further
  - E.g., ok to divide "outpatient, in-network" classification into subclassifications of "in-network office visits" and "all other outpatient, in-network items and services"
  - NOT ok to divide "outpatient, in-network" classification into "outpatient, in-network general" and "outpatient, in-network specialist"

General Parity Rules (Cont'd.)

- Even more complicated: Financial / quantitative restrictions apply to each "coverage unit"
  - Way in which plan groups individuals – e.g., self-only, employee + one, family
- Also ok to have prescription drug classifications / allowable charges if charges apply without regard to whether drug is generally prescribed for med/surg or MH/SUD
  - E.g., ok to have generic drugs covered at 90%; preferred brand name at 80%; non-preferred brand name at 60%; specialty drugs at 50%

General Parity Rules (Cont'd.)

- Example (determining classifications and 1/3, 2/3 rule): For inpatient, out-of-network med/surg, plan has five levels of coinsurance. Plan reasonably projects following:

Coinsurance rate	0%	10%	15%	20%	30%	
Projected payments	$200,000	$100,000	$450,000	$100,000	$150,000	$1,000,000
Percent of total plan costs	20%	10%	45%	10%	15%	100%
Percent subject to coinsurance level	N/A	12.5% ($100,000 / $800,000)	56.25% ($450,000 / $800,000)	12.5% ($100,000 / $800,000)	18.75% ($150,000 / $800,000)	

General Parity Rules (Cont'd.)

- Here, 2/3 test for "type" of restriction (coinsurance) is met because 80% of all inpatient, out-of-network med/surg benefits are subject to coinsurance
  - 80% = projected benefits subject to coinsurance ($800,000) out of total benefits ($1,000,000)
  - Note that $200,000 had 0% projected coinsurance
- 15% coinsurance "level" is the "predominant" restriction because it applies to more than one-half (here, 56.25%) of inpatient, out-of-network med/surg benefits
- Thus, plan cannot impose any level of coinsurance with respect to inpatient, out-of-network MH/SUD that is more restrictive than the 15% level of coinsurance

General Parity Rules (Cont'd.)

- Second example, involving copayments
- For outpatient, in-network med/surg, plan has five copayment levels. Plan projects following:

Copayment amount	$0	$10	$15	$20	$50	
Projected payments	$200,000	$200,000	$200,000	$300,000	$100,000	$1,000,000
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25% ($200,000 / $800,000)	25% ($200,000 / $800,000)	37.5% ($300,000 / $800,000)	12.5% ($100,000 / $800,000)	

General Parity Rules (Cont'd.)

- Here, the 2/3 test is triggered because 80% of all outpatient, in-network med/surg benefits are subject to a copayment
  - 80% = $800,000 / $1,000,000
  - Note that $200,000 had $0 copayment
- Unlike prior example, no single level that applies to more than 50% of med/surg benefits (highest here was $20 copayment, which applied to 30% of benefits)

General Parity Rules (Cont'd.)

- So, plan should combine levels of copayment to determine the "predominant" level that can be applied to MH/SUD
- Here, highest copayments, if combined, would equal exactly 50% (the $50 copayment is 12.5%, while the $20 copayment is 37.5%)
  - Because they are not "more than" one-half the total
    - so we need to combine more

General Parity Rules (Cont'd.)

- Combined payments for three highest copayment levels are more than one-half ($50 copayment is 12.5%; $20 copayment is 37.5%; $15 copayment is 25%, for a total of 75%)
- So, plan cannot impose any copayment on outpatient, in-network MH/SUD benefits which is more restrictive than least restrictive "level" – here, $15 copayment
  - So, if plan wants to impose a copayment on outpatient, in-network MH/SUD benefits, copayment is capped at $15

No Separate Cumulative Financial Requirements

- Plan cannot apply a “cumulative financial requirement” for MH/SUD in a classification that accumulates separately from med/surg benefits in same classification
- Example: Plan has a combined $500 annual deductible on all benefits (med/surg and MH/SUD)
  - Ok? Yes (not a “separate” financial requirement, it’s all combined)

No Separate Cumulative Financial Requirements (Cont'd.)

- Example: Plan has a $250 deductible on med/surg benefits and separate $250 deductible on MH/SUD
  - Ok? No (cannot have "separate" cumulative financial requirement)
- Example: Plan has $300 deductible on med/surg and separate $100 (lower, better) deductible on MH/SUD
  - Ok? No – even though lower and "better" for plan enrollees, still is "separate" and violates MHPAEA

No Separate Cumulative Financial Requirements (Cont'd.)

- Example (emergency services): Plan has combined annual $500 deductible on all benefits (both med/surg and MH/SUD). However, no deductible on prescription drugs or certain other benefits (e.g., preventive care). Plan projects med/surg benefits for next year to be:

	Benefits subject to deductible	Total benefits	Percent subject to deductible
Inpatient, out-of-network	$1,000,000	$1,000,000	100%
Inpatient, in-network	$1,800,000	$2,000,000	90%
Outpatient, out-of-network	$1,880,000	$2,000,000	94%
Outpatient, in-network	$1,400,000	$2,000,000	70%
Emergency care	$300,000	$500,000	60%

No Separate Cumulative Financial Requirements (Cont'd.)

- Here, 2/3 threshold met with respect to each classification EXCEPT emergency care
  - Emergency care expected to be 60% (less than 2/3 standard)
- $500 deductible is "predominant" restriction in each classification (it's the only one, actually)
- Can emergency care for MH/SUD benefits be subject to $500 deductible? No, because it does not apply to substantially all emergency care med/surg benefits
- Note: This problem is NOT apparent from terms of plan
  - Simply reviewing the plan's terms does NOT reveal the problem – Need to "dig deeper"

Non-Quantitative Treatment Limitations (NQTL)

- A NQTL is a non-numeric limit on the scope or duration of benefits for treatment. Examples include:
  - Medical management standards limiting/excluding benefits based on medical necessity or appropriateness, or whether treatment is experimental or investigative
  - Formulary design for prescription drugs
  - Network tier design (e.g., preferred and participating providers)

Non-Quantitative Treatment Limitations (NQTL) (Cont'd.)

- Additional types of NQTLs:
- Standards for provider admission to participate in a network (e.g., reimbursement rates)
- Plan methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher-cost therapies unless lower-cost therapies are not effective (e.g., step therapy protocols)
- Exclusions based on failure to complete a course of treatment
- Restrictions on the scope or duration of benefits that are based on geographic location, facility type, provider specialty or other criteria.

General Parity Rules for NQTLs

- Any processes, strategies, evidentiary standards, or other factors ("Processes") used in applying the NQTL to MH/SUD benefits within a classification must be comparable to, and applied no more stringently than, the Processes used in applying the NQTL to Med/Surg benefits in the same classification ("Comparable Processes Rule")

General Parity Rules for NQTLs (Cont'd.)

- Cannot have separate NQTLs that are applicable only with respect to MH/SUD benefits.
  - But, not required to have same NQTLs for MH/SUD and Med/Surg benefits
  - Application of the Comparable Processes Rule can have disparate results
- Each NQTL for MH/SUD benefits within a classification must comply with the plan as written and in operation
- No mathematical calculations involved

General Parity Rules for NQTLs (Cont'd.)

- Appears that a 2-part analysis is required:
  - First, the Processes used in applying any NQTL to MH/SUD benefits must be identified and compared to Processes used for Med/Surg benefits
  - If comparable, must "dig deeper" to make sure that the Processes are not applied in a more stringent manner for MH/SUD benefits than for Med/Surg benefits
- Review of plan documents probably is not enough

Example 1: Different Penalties for Failure to Get Prior Approval

- A GHP requires prior approval that a course of treatment is medically necessary for outpatient, in-network benefits and uses comparable criteria in determining whether a course of treatment is medically necessary. If a participant does not obtain prior approval for MH/SUD outpatient in-network benefits, no benefits are paid, but if a participant does not obtain prior approval for Med/Surg treatments, 75% of the benefits are paid (there is just a 25% reduction in the benefits the plan would otherwise pay).

Example 1: Different Penalties for Failure to Get Prior Approval (Cont'd.)

- Although the same NQTL -- medical necessity -- is applied to both MH/SUD and Med/Surg benefits, this arrangement violates the Comparable Processes Rule because the NQTL is not applied in a comparable way due to the differing penalties for failure to obtain prior approval.
- For an ERISA plan, this type of benefit reduction typically would be described in the plan document and may be relatively easy to identify

Example 2: Prior Authorization and Routine Approval Periods

- Group health plan (GHP) requires prior authorization for inpatient Med/Surg benefits and inpatient MH/SUD benefits. In operation, inpatient benefits for Med/Surg conditions are routinely approved for 7 days while MH/SUD benefits are routinely approved for only 1 day. Following the routine approval period, participants must submit a treatment plan from their physician for continued inpatient benefits.

Example 2: Prior Authorization and Routine Approval Periods (Cont'd.)

- This arrangement violates the Comparable Processes Rule because it is applying a stricter NQTL in operation to MH/SUD benefits (just one day) than is applied to Med/Surg benefits (7 days).
- Example demonstrates the need to "dig deeper" into the benefits; this sort of difference in routine approval periods typically would not appear in plan documents or SPD, but should be known by the plan's TPA or insurer

Example 3: Exclusions for MH/SUD Drugs

- A GHP covers medically appropriate treatments, but automatically excludes coverage for antidepressant drugs that are given a black box warning label by the FDA. For other drugs with a black box warning label (including those prescribed for other MH/SUD conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate based on clinically appropriate standards of care.

Example 3: Exclusions for MH/SUD Drugs (Cont'd.)

- Although the standard for applying the prior authorization requirement is the same -- whether a drug has a black box warning – this arrangement violates the Comparable Processes Rule because the plan unconditionally excludes antidepressant drugs given a black box warning.
- This example shows how special rules that only apply to MH/SUD benefits may be problematic
  - Other examples address EAP exhaustion requirements for MH/SUD benefits, exclusion of inpatient SUD treatment facilities, and geographic limitations that only apply to MH/SUD benefits

NQTL Parity Compliance Strategies

- Examine plan documents to identify NQTLs
- Address NQTLs that are non-compliant on their face, and for all others, dig deeper:
  - Review medical necessity criteria used for MH/SUD and Med/Surg benefits
  - If employer, verify TPA is complying with parity rules and conducting the appropriate analyses (if TPA, be prepared)
- For self-funded plans, it appears penalty falls on employer, so coordination with TPA is essential
- Less clear where penalty falls for fully-insured plans

Questions

Thank you!