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

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Topics for Today

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

Political Forecast

- Legislative divide in power results in gridlock – for 2013 and beyond
  - Minor changes possible – e.g., repeal of CLASS Act in January 2013
- Court challenges ongoing, but short-term impact unlikely
  - Most likely are employer challenges to contraceptive coverage mandate
  - Supreme Court will hear this term (2013-2014)
  - Exchange subsidies upheld in one court (Jan. 2014), pending in another

Regulatory Forecast

- Large number of “open” issues
- Automatic enrollment (likely 2015)
- Nondiscrimination rules (105(h) test)
- 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
- Note: Recent Windsor (same-sex marriage) guidance but not addressed today
- Note: New wellness regulations (June 2013) not addressed here

Recent Guidance

- New Exchange notice issued recently
  - Pages 2 and 3 can be complicated
  - Should an employer “chop it down”?
- Also affects COBRA model notices
- Health FSA “use or lose” rule changed
  - Effective immediately, can allow up to $500 “carryover”
  - Cannot have both a “grace period” and carryover
  - Effect on HSA eligibility?

Recent Guidance

- Now, stand-alone HRAs essentially illegal
  - Concern is that HRA imposes annual / lifetime limits on "essential health benefits"
  - And that HRA fails to cover "preventive care" benefits
- Wind-down amounts still ok, likely
  - Must be "integrated" and allow "permanent opt out"
- "Employer payment plan" now also essentially illegal
  - Beware any type of arrangement where employer pays for individual policies

Recent Guidance

- Deductible limits - $2,000 / $4,000
  - Self-insured and large group insured plans exempt
- OOP maximums (tied to HDHP OOP maximums) apply for plan years beginning on or after 1/1/2014
  - If self-funded, which state's definition of EHB to use?
  - Transitional relief for 2014 plan years
  - Get agreement confirming that TPA and PBM will coordinate?
- New summary of benefits and coverage ("SBC")
  - State whether plan provides "minimum value" and "minimum essential coverage"

Other 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
- See handout for complete list

New Fees

- New PCORI and reinsurance fee
- Recently released: Form 720 (to report PCORI)
  - Generally file by July 31, 2013 if plan year ended on or after October 1, 2012 (but before January 1, 2013)
- $1 per covered life for PCORI
- Generally applies to major medical plans
- In distance, “Cadillac” tax looms (2018)

Reinsurance Fee

- $63 per “belly button” fee
- First payable in December 2014 / January 2015
- Evaluate how to determine number of covered participants
- 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

Excepted Benefits

- December 2013 proposed regulations expand definition
- Dental/vision no longer require employee contribution
- EAPs excepted if no “significant benefits in the nature of medical care”
- Unclear effective date / scope

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

Seven Steps to Understanding Pay or Play

- Understand general Pay or Play Rule concepts
- Is the employer a “large employer”?
- Will any employees receive federally-subsidized Exchange coverage?
- Does the employer offer minimum essential coverage under an employer plan?
- Does the plan provide minimum value?
- Is the plan’s coverage affordable and offered to all full-time employees?
- If applicable, calculate and pay the penalty

Step 1: Understand General Rules

- Today: Employer can refuse to offer coverage without any federal penalty
- January 1, 2014: Employers are not required to provide health insurance to employees, but tax applies if full-time employee receives federally-subsidized Exchange coverage
  - No exclusion for governmental, church or non-profit employers
  - New: July guidance delays rule until 2015
    - Presumably January 1, 2015 (but "hot potato" now)
  - Employers likely must measure in 2013 / 2014 to know who is full-time as of January 1, 2015

Possible Penalties

- No Offer Penalty: If employer does not offer minimum essential coverage:
  - $2,000 (annual, but calculated on monthly basis) tax per full-time employee, if at least one full-time employee obtains federally-subsidized Exchange coverage
  - Calculated after first 30 employees; 5% de minimis
- Unaffordable Coverage Penalty: If employer does offer minimum essential coverage but at least one full-time employee obtains federally-subsidized Exchange coverage:
  - Tax is lesser of $3,000 per subsidized full-time employee, or $2,000 per all full-time employees (annual, but calculated on monthly basis)

Step 2: Is the Employer a Large Employer?

- Check if employer has at least 50 full-time (including full-time equivalent (FTE)) employees during preceding calendar year
  - 6-month transitional rule for 2013
- Includes common law employees, FTE part-time, FTE seasonal, controlled group
- IRS guidance defines "employee" as: "a worker who is an employee under the common-law test" (apparently excludes independent contractors)
- For purposes of determining whether the rule applies, a "full-time" employee is an individual with 30+ "hours of service" per week
  - IRS: 130 hours of service in a calendar month = 30 hours of service per week

Step 2: Is the Employer a Large Employer?

- Steps 2(a - c): Special rules for counting full-time employees (controlled group, predecessor and new employers)
- Controlled group rules similar to those for retirement plan purposes (use Code Section 414 definition)
  - So, 100% owner usually cannot divide a 200-employee company into five 40-employee companies to avoid the Pay or Play Rule
  - Penalty *not* applied on controlled group basis
- Other “anti-abuse” rules also apply
  - E.g., XYZ Co. and Staffing Co. “divide” employee so employee works 20 hours / week for each

Step 3: Will Employees Receive Subsidized Exchange Coverage?

- Always possible for an employer (with help from insurer / TPA) to design health plan so employer never faces Pay or Play Rule penalty
  - But may require plan design changes and employer must follow three requirements
  - (a) Offer "Minimum Essential Coverage" under an "eligible employer-sponsored plan" to all its full-time employees (and, perhaps, dependents) who are eligible for subsidized Exchange coverage
  - (b) Ensure employer's plan provides "Minimum Value"
  - (c) Ensure employee's share of premium for self-only coverage for employer's lowest-cost, Minimum Value plan is "Affordable"
- Steps 4 – 6 discuss each point

Step 4: Offer Minimum Essential Coverage?

- Easy test – generally, if offer major medical coverage
- What does it mean for employer to "offer" coverage?
  - IRS regulation: Must have opportunity to enroll (or not enroll) once per year
  - Appears PEO could offer on behalf of client

Step 5: Does Plan Provide Minimum Value?

- "Minimum value" definition under ACA: "plan's share of the total allowed cost of benefits provided under the plan is less than 60 percent of such costs"
- IRS will examine typical benefits provided by other employers and use that as standard
  - Methods on next slide raise question of how to document?

Step 5: Does Plan Provide Minimum Value?

- IRS and HHS have discussed "calculators" and "checklists" to simplify determination
  - Minimum value calculator released
  - Available at cciio.cms.gov/resources/files/mv-calculator-final-2-20-2013.xlsm
  - May 3 regulation clarifies whether wellness discounts for deductibles and other cost-sharing are considered
    - Yes, if discount is tobacco-related
  - Preamble to May 3 regulation discusses certain design-based safe harbors
  - Previously, IRS indicated that 98% of employees in US covered by plan that was expected to pass this test

Step 6: Is Plan Coverage Affordable?

- Employee can obtain subsidized Exchange coverage if income at least 100% of federal poverty level ("FPL") and not more than 400% FPL (about $92,000 today for a family of four) and either:
  - Poor Plan (No "Minimum Value"): Plan pays less than 60% of total benefits allowed under plan; or
  - Costs Too Much: Employee's share of premium for employee portion of "self-only" coverage for employer's lowest-cost coverage that provides minimum value > 9.5% of employee's "household income"
- IRS: Employers allowed to use W-2 wages or two other "safe harbors"
  - Rate of pay
  - Federal poverty line

Step 7: Determine "Full-Time" Employees and Calculate the Penalty

- Must employer determine who is a "full-time" employee?
  - Theoretically "no" – but employer would need to promptly offer coverage to all employees
  - Could determine on month-by-month basis (but administratively difficult)
- Who is a "full-time" employee?
  - New guidance (IRS Notice 2012-58 and January 2, 2013 regulation) more complicated than prior guidance
    - Does provide helpful clarifications and certainties
    - Can rely on through 12/31/2014

Step 7: Determine Who is a "Full-Time" Employee?

- Generally divide employees into different categories
  - Ongoing Employee
  - New Employees
  - New, Full-Time Employee
  - New, Variable Hour Employee
  - New, Seasonal Employee
  - Part-Time Employees
    - Term not used in Pay or Play Rule guidance, but is used in March 18, 2013 90-day waiting period regulation
  - Transitional Employee (our term, not an IRS term)

Step 7: Ongoing Employees

- Employer selects Standard Measurement Period
  - 3-12 month period in which employer will determine whether employee has worked on average 30 hours per week
  - Employer chooses when it starts and ends
- If Ongoing Employee is a full-time employee, he is "protected" and remains full-time employee during subsequent Stability Period
  - Stability Period must be at least 6 consecutive calendar months
    - Leads to awkward results if 3-month Measurement Period selected
  - Stability Period generally cannot be shorter than Standard Measurement Period

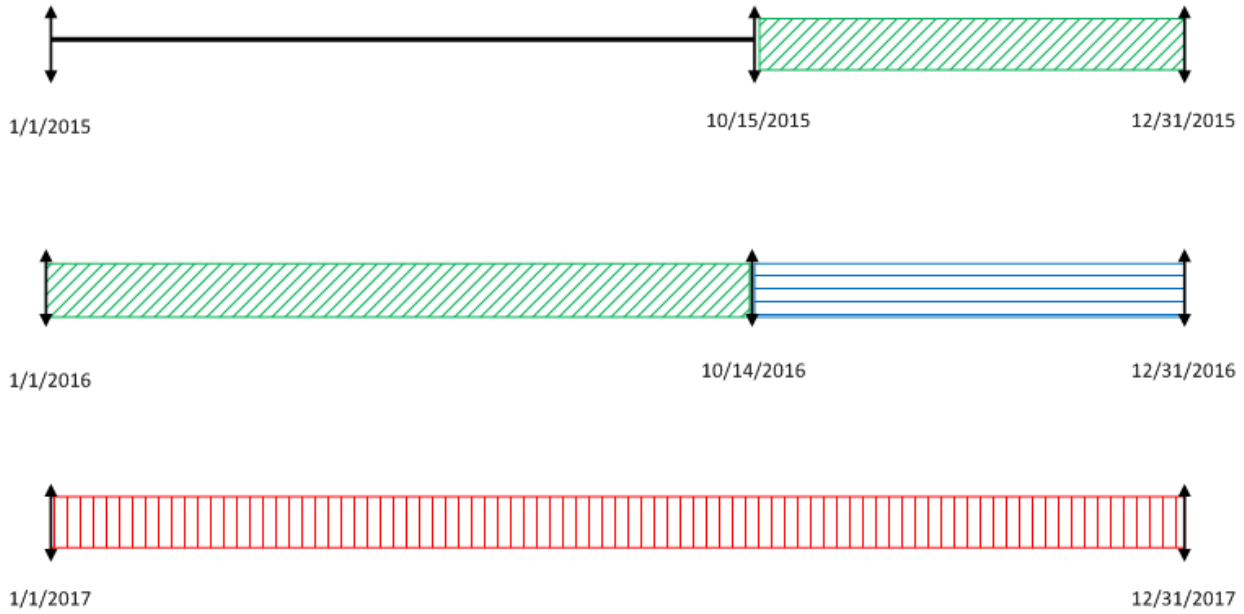
Step 7: Ongoing Employees (Cont'd.)

- Start of Stability Period can be delayed for up-to-90-day Administrative Period
  - Allows employer to calculate employee's hours, answer questions from employees, collect materials from employee, etc.

Step 7: Ongoing Employees

Illustration of Full-Time Employee Time Periods

In this example, assume Employer uses a 12-Month, October 15-based Standard Measurement Period. Employer also uses a 12-Month Stability Period and 2½ month Administrative Period. Assume Employer hired Alex the Employee as a full-time employee in 2007 and Alex has worked continuously since then as a full-time employee of Employer.



Step 7: New Employees Expected to be Full-Time

- No Pay or Play Rule penalty if employer offers health plan coverage at or before conclusion of employee's initial three full calendar months of employment
- E.g., Goodco hires Frank on 6/15/2015. Is first month of June "ignored" because it is not a "full" month? Or does period from 6/15 – 7/14 count as first "full" month?
  - If June is ignored, Frank enrolls by October 1
  - If June "counts", Frank presumably enrolls by September 14. Would employers "round down" to September 1?

Step 7: New, Variable Hour Employee

- Usually Variable Hour and Seasonal Employees treated the same
- Technically, Variable Hour Employee involves New Employee with uncertain future hours (not known if will average 30 hours / week)
  - Employment status change requires health plan coverage by 1st day of 4th month after change
  - Effective 1/1/2015, employer must assume that although employee's hours of service may vary, employee will continue to be employed for entire "Initial" Measurement Period

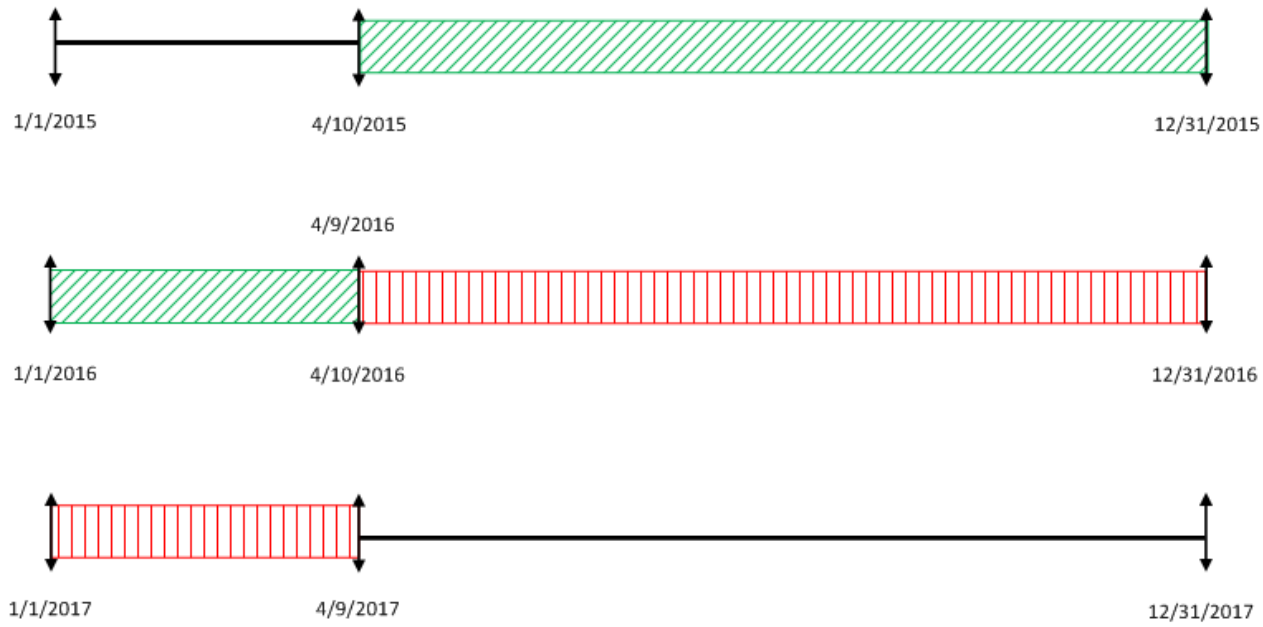
Step 7: New, Variable Hour Employee

- Employer measures full-time status using "Initial" Measurement Period (not a "Standard" Measurement Period)
  - Also a period between 3 – 12 months
  - Employers may want shorter period (e.g., 11 months) due to special rule (discussed later)

Step 7: New, Variable Hour Employee

Illustration of New, Variable Hour Employee (No Administrative Period)

For New Employees, the Employer uses an initial Measurement Period which begins on the first day of employment and ends 12 months later. Employer also uses a 12-Month Stability Period and no Administrative Period. Assume Employer hired Betty the Employee as a Variable Hour Employee on April 10, 2015.



Betty's Initial Measurement Period – Employer checks to see if Betty is full-time

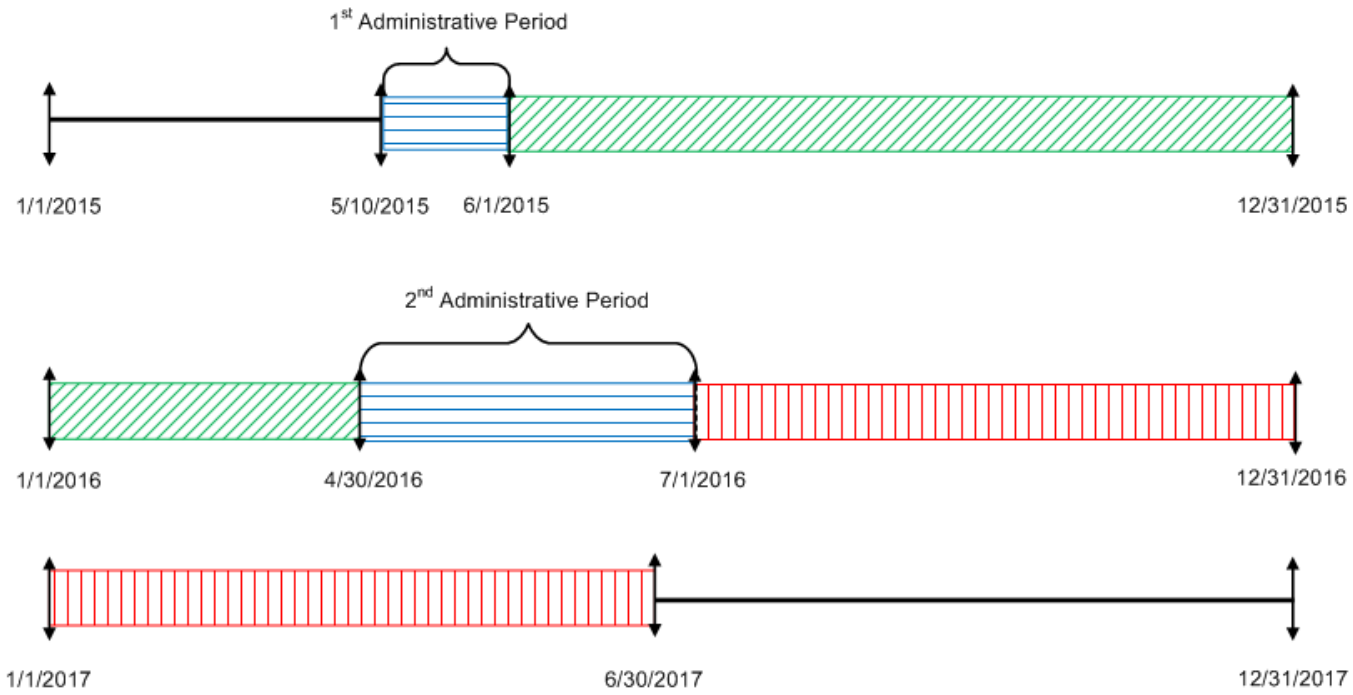
Betty's Stability Period – If Betty enrolls for coverage effective 4/10/2016, Betty is covered during this time, until her Stability Period ends after 12 months (here, 4/9/2017)

Step 7: New, Variable Hour Employee

- For Variable Hour Employee, employer can "split" Administrative Period
- Helpful to make dates "easier" (e.g., start counting as of first of month)
- However, special rule: combined Initial Measurement Period and Administrative Period may not extend beyond last day of first calendar month beginning on or after one-year anniversary of employee's start date
  - Totals, at most, 13 months and a fraction of a month
  - Prevents employer from having 12-month Measurement Period and 90-day Administrative Period

Step 7: New, Variable Hour Employee

Acceptable Split Administrative Period (11-Month Measurement Period)



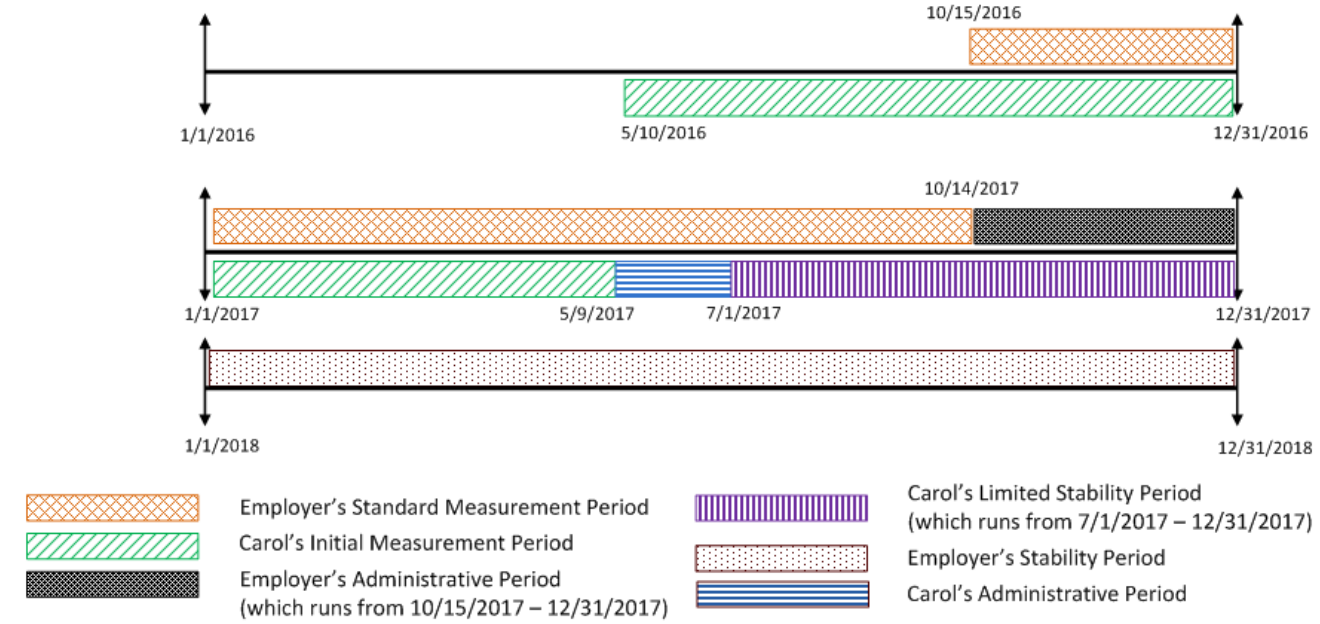
Step 7: New, Variable Hour Employee

- If Variable Hour Employee not treated as full-time during Initial Measurement Period, employer can treat employee as not "full-time" for a "Limited" Stability Period
- Limited Stability Period:
  - Must not be longer than one month longer than the Initial Measurement Period
  - Must not exceed remainder of Standard Measurement Period (and any associated Administrative Period) in which Initial Measurement Period ends
  - Appears to be designed to allow employee to "re-qualify" quickly for full-time status

Step 7: New, Variable Hour Employee

Illustration of New, Variable Hour Employee (Limited Stability Period)

In this example, assume Employer uses a 12-Month, October 15-based Standard Measurement Period for Ongoing Employees. For New Employees, the Initial Measurement Period begins on the first day of employment and ends 12 months later. An Administrative Period is used for these New, Variable Hour Employees, where the Period runs until the end of the month after the Initial Measurement Period ends. For Ongoing Employees, Employer uses a 12-Month Stability Period which begins on January 1 and a 2½ - month Administrative Period. Assume Employer hired Carol the Employee as a Variable Hour Employee on May 10, 2016. Assume Carol only averages 28 hours during the Initial Measurement Period of May 10, 2016 – May 9, 2017, but 30.0 hours during the 10/15/2016 – 10/14/2017 Standard Measurement Period.



Thus, the net effect is that:

- Carol is not offered coverage from the start date (May 10, 2016) through all of 2017
- Because Carol was not deemed full-time during her unique Initial Measurement Period, Carol receives another chance to qualify for full-time status. Employer must count the hours Carol worked from October 15, 2016 – October 14, 2017 (the Standard Measurement Period which applies to Ongoing Employees – even though Carol is not an Ongoing Employee as of the start of that Standard Measurement Period).
- Although Employer may want to "lock in" Carol as a Part-Time Employee who is not eligible for plan coverage from July 1, 2017 – June 30, 2018 (the typical 12 months) Employer cannot do this. Carol's average of 30 hours during the overlapping Standard Measurement Period of October 15, 2016 – October 14, 2017 "controls." Carol becomes a Full-Time Employee on January 1, 2018 and receives plan coverage.

Step 7: Seasonal Employees

- E.g., Little Ski Hill has a 3-month Initial Measurement Period from 11/15/2015 – 2/14/2016. Administrative Period lasts until first of month following end of Initial Measurement Period.
  - Little Ski Hill hires Ted on 11/15, who works 60 hours per week entire time
  - Ted's Initial Measurement Period ends 2/14/2016
  - Ted's Administrative Period ends 2/28/2016
  - Ted seems to be "full-time" as of 3/1/2016 (before he terminates employment on 3/15)

Step 7: Seasonal Employees (Cont'd)

- E.g., Little Ski Hill has a 3-month Initial Measurement Period from 11/15/2015 – 2/14/2016. Administrative Period lasts until first of month following end of Initial Measurement Period.
  - Little Ski Hill hires Ted on 11/15, who works 60 hours per week entire time
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Examples of Penalties (Pay AND Play)

- Generous Co. has 1,000 full-time employees. Generous Co. offers excellent health plan to 940 employees. However, a group of 60 employees in remote locations have never received coverage. All employees are full-time. Could Generous Co. face a penalty? If so, how much?
- Penalty is possible. 5% de minimis rule likely does not apply.

Examples of Penalties (Pay AND Play) (Cont'd)

- 60 full-time employees may be eligible for Exchange subsidy
  - Could be some exceptions (e.g., all 60 may have been recently hired and in 3-month "free look" for New, Full-Time Employees; all 60 may be above 400% of poverty level)
- If penalty applies, Generous Co.'s annual penalty would be:
  - ((1,000 – 30) = 970) x $2,000 = $1,940,000
  - Large penalty considering Generous Co. is providing rich health plan coverage to 94% of workforce
  - Worst of all worlds for employer – want to avoid this through plan design (or hope to be lucky!)

Practical Considerations

- Will almost certainly require insurers / TPAs / employers to make some plan changes
  - E.g., if employer sets eligibility using "expected to work 30+ hours per week", have Pay or Play Rule risk
  - Thus, many employers may choose to "sync up" eligibility provisions with Pay or Play Rule
    - Not legally required, but only way to "guarantee" no Pay or Play Rule risk
    - Perhaps could rely on 5% de minimis exception
  - Even employers with "generous" eligibility provisions may have risk
    - E.g., Acme Co. allows employees into plan if "scheduled" to work 20 hours per week (prospective standard)
    - Standard would not catch those who work, e.g., 15 hours currently but who are "full-time" due to prior high hours
    - Acme also may not take into account unpaid leave (e.g., FMLA, USERRA, jury duty) in way provided by Pay or Play Rule

Employer Strategic Considerations

- Soft Factors (e.g., loss of control over employee health; morale)
  - Comparison to competitors
  - Risk of increased penalties
  - Focus on removing “high risk” employees?
- Hard factors
  - Start with $2,000 / $3,000 penalties
  - Extra compensation to pay employees?
  - Tax impact (savings from employer-sponsored system)
- See summary of Truven Health Analytics white paper

Employer Strategic Considerations

- Examine collective bargaining issues
- If "managing down" hours, consider:
  - ERISA Section 510
  - "Whistleblower" provisions – riskier in 2014?
  - State law
- Offer "skinny" plan?
  - Provide free, bare-bones coverage. If employee elects it, no Pay or Play Rule penalty.
    - If employee declines it, $3,000 penalty possible (plan fails "minimum value" test)

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
  - Note: Combined MEC/ALE report not possible (at least for now)
- 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 of any type during the 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 exempt
    - HRA that “supplements” exempt (but spend-down period may need to report

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
    - Special reporting method for FT employees eligible under a multiemployer plan

ALE Reporting: Information Required

- Proposed 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: Information Required

- Per preamble, additional information also expected for 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 expected to be provided through indicator codes

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

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

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”)

Mental Health Parity 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

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

Lifetime and Annual Dollar Limit (Cont'd.)

- Not technically part of MHPAEA, but remember that Affordable Care Act ("ACA") prevents lifetime or annual dollar limits on essential health benefits ("EHBs")
  - So, many plans have already eliminated dollar-based lifetime or annual limits on many benefits
  - Makes it more likely that 1/3 Rule, above, applies

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 (We refer to this requirement as the "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

Important Change

- Exception eliminated for variations in NQTLs based on “clinically appropriate standards of care”
- But, a plan can “take into account” clinically appropriate standards of care when applying the Comparable Processes Rule
- Appears that reason for this change is that some plans attempted to apply a NQTL to all MH/SUD benefits while applying NQTLs to a limited number of Med/Surg benefits in same classification

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

Example 4: Medical Management Techniques

- A GHP uses a variety of factors when designing medical management techniques for both MH/SUD and Med/Surg benefits and applies them to both types of benefits in a comparable fashion. This results in prior authorization being required for some (but not all) MH/SUD benefits, as well as for some (but not all) Med/Surg benefits. The evidence considered in developing the medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is well documented by the plan.

Example 4: Medical Management Techniques (Cont'd.)

- This arrangement satisfies the Comparative Processes Rule
- High standard for documentation
  - E.g., may need to document specific literature and standards and protocols considered and document specifically how they were used to develop the plan's medical management techniques
- Importance of more objective measures
  - More objectives measures mentioned in the regulations include recognized medical literature, professional standards and protocols, recommendations by expert panels, mathematical formulas, state licensing requirements

Additional Parity Rules

- Criteria for medical necessity determinations for MH benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request
- The reason for any denial of reimbursement or payment for services with respect to MH benefits must be provided in compliance with ERISA's claims and appeals procedures. For plans that are not subject to ERISA, the plan can follow the ERISA rules or provide the reason for the denial within a reasonable time and in a reasonable manner upon a participant's or beneficiary's request.

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
  - Verify that TPA is complying with parity rules and conducting the appropriate analyses
- 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 for attending!

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