September 27, 2018

New Mental Health Parity and Addiction Equity Act (MHPAEA) Rules

Benefit Comply

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” box located on your webinar control panel.
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September 2018

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Agenda

- Background
- Who Must Comply
- Parity Requirements
  - Annual/Lifetime Limits
  - Financial Requirements & Quantitative Treatment Limitations
  - Non-Quantitative Treatment Limitations
- Plan Design Considerations
- Enforcement

BACKGROUND

MHPAEA Requirements

- Parity Requirements
  - For group health plans offering both medical/surgical benefits and mental health or substance use disorder benefits, the plans must provide mental health (MH) and substance use disorder (SUD) benefits at least equal ("in parity") to the medical/surgical benefits provided
  - MHPAEA does NOT require group health plans to provide MH or SUD benefits
    - Coverage for MH or SUD benefits might be required otherwise:
      - State law
      - Essential health benefit requirements (if the plan is small and fully-insured)
      - If the benefit is considered to be preventive coverage
      - Americans with Disabilities Act (ADA)

MHPAEA Requirements

- Parity Requirements
  - “In Parity” =
    - Same or more generous annual/lifetime limits
    - Equal financial requirements (e.g. deductible, copays, out-of-pocket maximum) and quantitative treatment limitations (e.g. number of treatments, visits or days of coverage)
    - Equal non-quantitative treatment limitations (e.g. medical management standards)
  - 2 General Rules
    1. Financial requirements and treatment limitations that apply to MH/SUD benefits can be no more restrictive than the requirements and limitations that apply to medical/surgical benefits
    2. There can be no separate cumulative financial requirements or treatment limitations that apply only to MH or SUD benefits, even if they’re equal to those for medical/surgical benefits

Source of Law

- Mental Health Parity Act of 1996 (MHPA)
  - Required group health plans with annual/lifetime limits for medical/surgical benefits to provide the same (or higher) limits to MH benefits
- Mental Health Parity & Addiction Equity Act of 2008 (MHPAEA)
  - Added provisions for SUD benefits and imposed additional parity requirements (treatment limits and financial requirements)
  - Final rules established parity standards for financial requirements, quantitative treatment limits and non-quantitative treatment limits on a classification-by-classification basis
- 21st Century Cures Act (Dec. 2016)
  - Provided additional guidance, including examples, and clarified the application of the MHPAEA to eating disorders
  - Required the agencies to take steps to promote understanding and compliance with MHPAEA, as well as audit plans and insurers

Interaction With State Laws

- State-Mandated Coverage Requirements
  - MHPAEA applies in addition to state-mandated coverage requirements
    - If a state mandates a particular level of coverage for MH or SUD benefits, a fully-insured plan must at least comply with such requirements
    - MHPAEA may require a higher level of coverage for the same benefits in order to parity requirements (i.e. if the level of coverage for medical/surgical benefits is higher than the state-mandated level of coverage)
- Summary of State-Mandated Requirements
  - http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx

Definitions

- Mental Health (MH) Benefits
  - As defined under the plan in accordance with applicable federal/state law
  - Plans may use the following to define MH benefits:
    - Current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5);
    - Current version of the International Classification of Diseases (ICD-10); or
    - State guidelines
  - Coverage for autism and eating disorders is considered MH benefits
- Substance Use Disorder (SUD) Benefits
  - As defined under the plan in accordance with applicable federal/state law
  - Must be consistent with generally recognized independent standards of current medical practice
  - Includes both items and services

WHO MUST COMPLY

Who Must Comply

- Group Health Plans
  - Most group health plans that provide MH/SUD benefits must provide such benefits “in parity” with medical/surgical benefits
  - Any combination of benefits under which coverage for medical/surgical and MH/SUD benefits may be received simultaneously is a single group health plan subject to parity requirements

Who Must Comply

- Exemptions
  - Group health plans that provide MH/SUD benefits only to meet preventive coverage requirements
  - Excepted benefits (e.g. health FSAs, limited-scope vision or dental, hospital indemnity policies or specified disease/illness policies)
  - Small employer plans (50 or less employees)
    - 100 and under for non-federal governmental plans
  - Retiree-only plans
  - Self-funded state and local governmental plans (non-federal) that choose to opt out and follow required procedures
  - Employers who experience significant cost increases (at least 1% due to coverage for such benefits)

Who Must Comply

- Small Employer Plan Exemption
  - Small fully-insured groups are required to provide MH/SUD benefits as part of the “essential health benefits” under the ACA
  - The parity rules must be followed in order for the offering to meet what is required under “essential health benefits”
  - Only grandfathered and self-funded groups may take advantage of the small employer plan exemption

Who Must Comply

- Fully-Insured Plans
  - Small, fully-insured plans are required to offer essential health benefits, including MH/SUD benefits
  - Subject to state-mandated coverage requirements
  - Carriers selling fully-insured group health plans will generally structure the plans to be in compliance with MHPAEA
    - Employers have very little control over the plan coverage provided
- Self-Funded Plans
  - Some flexibility to exclude or limit MH/SUD benefits (e.g. ERISA preemption from state-mandated coverage requirements, and not required to offer essential health benefits)
  - Work carefully with administrators and advisors to ensure that MH/SUD benefits are compliant with MHPAEA
  - Administrators may not allow much flexibility in regard to plan design
    - Penalties can be imposed indirectly on the TPA as a fiduciary duty to the extent the TPA has control over claims administration under the plan

PARITY REQUIREMENTS

Annual/Lifetime Limits

- Mostly Prohibited
  - Plan may only impose annual or lifetime limits on MH/SUD benefits if the plan imposes lifetime or annual limits on more than 1/3 of all medical/surgical benefits
  - Under the ACA, plans cannot impose annual or lifetime limits on essential health benefits
    - At least some MH/SUD benefits are considered to be an “essential health benefit” and may not have any annual or lifetime limits under the ACA
    - Unlikely for a plan to impose annual or lifetime limits on non-essential health benefits that would comprise more than 1/3 of all medical/surgical benefits

Annual/Lifetime Limits

- 1/3 Rule
  - If the plan includes annual or lifetime limits for less than 1/3 of all medical/surgical benefits expected to be paid under the plan, no annual or lifetime limits permitted for MH/SUD benefits
- 2/3 Rule
  - If the plan includes annual or lifetime limits for at least 2/3 of all medical/surgical benefits expected to be paid under the plan, the plan may either:
    - Apply the annual or lifetime limit and not distinguish between medical/surgical and MH/SUD benefits; or
    - Impose annual or lifetime limits on MH/SUD benefits that are no less than limits applying to the medical/surgical benefits
- Other (Plans Which Do Not Fit Either Rule)
  - Impose no annual or lifetime limit on MH/SUD benefits; or
  - Impose an annual or lifetime limit on MH/SUD benefits that is no less than the average limit for medical/surgical benefits

Classifications

- Parity by Classification
  - Parity applies on a classification-by-classification basis for financial requirements, quantitative treatment limitations and non-quantitative treatment limitations
  - Definitions for these classifications must be made uniformly for medical/surgical benefits and MH/SUD benefits
  - If a plan provides MH/SUD benefits in any classification, it must MH/SUD benefits in every category in which medical/surgical benefits are provided
    - Example - If MH/SUD coverage is provided for outpatient, in-network, the plan cannot offer medical/surgical coverage for inpatient, in-network and not provide coverage for inpatient, in-network MH/SUD benefits
  - If a plan applies different financial requirements or treatment limitations by coverage unit (e.g. single, family), then the parity requirements must be applied separately for each coverage unit

Classifications

- 6 Classifications
  1. Inpatient, in-network;
  2. Inpatient, out-of-network;
  3. Outpatient, in-network;
  4. Outpatient, out-of-network;
  5. Emergency care; and
  6. Prescription drugs

Classifications

- Sub-Classifications
  - Outpatient services may be sub-classified into (i) office visits and (ii) all other outpatient items and services
  - Multiple providers for in-network tiers may be used as a further sub-classification so long as the tiering is not based on whether a provider is a provider of medical/surgical services or MH/SUD services
  - Prescription drug coverage may be further sub-classified by tier based on reasonable factors (i.e. cost, efficacy, generic versus brand name, and mail order versus retail pharmacy pick-up) so long as they do not take into consideration whether the drug is generally prescribed with respect to medical/surgical benefits or MH/SUD benefits
  - Plans may NOT further sub-classify generalists and specialists

Financial Requirements & Quantitative Treatment Limitations

- General Rule
  - A group health plan that provides both medical/surgical benefits and MH/SUD benefits must ensure that the financial requirements and quantitative treatment limitations are no more restrictive for MH/SUD benefits than the predominant financial requirements and treatment limitations that apply for substantially all of the medical/surgical benefits
- Within Each Classification:
  - If a financial requirement or treatment limitation does not apply to “substantially all” of the medical/surgical benefits in that classification, it cannot be applied to MH/SUD benefits in that classification
  - If a financial requirement or treatment limitation does apply to “substantially all” of the medical/surgical benefits in a classification, that financial requirement or treatment limitation may be applied to MH/SUD benefits in that classification at the “predominant level” of that requirement or limitation for medical/surgical benefits

Financial Requirements & Quantitative Treatment Limitations

- Definitions
  - *Financial requirements* – includes deductibles, copays, coinsurance and out-of-pocket expenses, but excludes annual/lifetime limits
  - *Quantitative treatment limitations* – limits on the frequency of treatment, number of visits, days of coverage or other limits on the scope or duration of treatment (annual, episode, and lifetime day and visit limits)
  - *Substantially all* – applies to at least 2/3 of all medical/surgical benefits in that classification (based on the dollar amount of all plan payments for the medical/surgical benefits that are expected to be paid under the plan)
  - *Predominant* - the most common or frequent type of limit or requirement
  - *Predominant level* – the level that applies to more than half of medical/surgical benefits in that classification (if there is no single level that applies to more than half, the plan may combine levels until the combination applies to more than half, the least restrictive level within the combination is the predominant level)
    - Ex. Copays of $50, $25 and $15 may apply to ½ of medical/surgical benefits…the $15 copay is the predominant level

Financial Requirements & Quantitative Treatment Limitations

- 3-Step Process for Assessing Parity
  1. Determine if the financial requirement or quantitative treatment limitation applies only to MH/SUD benefits
     - If Yes, it is not allowed
     - If No (it applies also to medical/surgical benefits, then go to step 2
  2. Determine if the financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits
     - If No, it is not allowed for MH/SUD benefits
     - If Yes, then go to step 3
  3. Determine the predominant level of financial requirement or quantitative treatment limitation that may be applied to MH/SUD benefits

Non-Quantitative Treatment Limitations (NQTLs)

- General Rule
  - A group health plan that provides both medical/surgical benefits and MH/SUD benefits may only impose processes, strategies, evidentiary standards or other factors used to apply NQTLs to MH/SUD benefits that are comparable and not any more stringent than those applied to medical/surgical benefits within a classification
    - Restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration must comply with the parity rules

***Interim final rules allowed variation to the extent that “recognized clinically appropriate standards of care” permitted a difference, but this exception was eliminated in the final rules

Non-Quantitative Treatment Limitations (NQTLs)

- NQTLs Defined
  - Limitations that affect the scope or duration of benefits under the plan that cannot be expressed numerically
- Examples of NQTLs:
  - Medical management standards limiting/excluding benefits based on medical necessity/appropriateness or based on if treatment is experimental/investigative
  - Formulary design for prescription drugs
  - Standards for provider admission to participate in a network, including reimbursement rates
  - Plan methods for determining usual, customary and reasonable charges
  - Refusal to pay for high-cost therapy until it is shown that a lower-cost therapy is not effective
  - Exclusions based on failure to complete a course of treatment
  - DOL list of limitations that might be an issue - https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

Non-Quantitative Treatment Limitations (NQTLs)

- 3-Step Processing for Assessing Parity
  1. Does the NQTL apply solely to MH/SUD benefits?
     - If Yes, it is not allowed
     - If No, then go to step 2
  2. Is the NQTL “comparable” to the NQTL imposed on medical/surgical benefits?
     - If No, it is not allowed
     - If Yes, then go to step 3
  3. Ensure the NQTL as applied to MH/SUD benefits is not more “stringent” than the NQTL imposed on medical/surgical benefits

Non-Quantitative Treatment Limitations (NQTLs)

- NQTL Considerations
  - No numerical tests for NQTLs as there are for quantitative treatment limitations, so there is less clarity
    - Plans should ensure no arbitrary limits are placed on MH/SUD benefits
    - Based on facts and circumstances
  - Many of the court cases have focused primarily on differences in coverage for residential treatment facilities and medical management limitations

Non-Quantitative Treatment Limitations (NQTLs)

- Agency Guidance (Proposed FAQs – April 2018)
  - Parity is required for the following:
    - Medical management standards (specific example includes coverage of applied behavioral analysis (ABA), used to treat autism, and dosage limits for prescription drugs)
    - Step therapy or fail-first policies (refusing to pay for a higher-cost therapy until it is shown that a lower-cost therapy is not effective)
    - Standards for admitting a provider to participate in a network (including the plan's reimbursement rates for providers)
    - Applying factors such as distance standards and waiting times for appointments for services to measure network adequacy
    - Plan or coverage restrictions based on facility type (specific example addresses residential facilities for eating disorders)
  - While treatment limitations cannot be more restrictive, a plan is allowed to completely exclude benefits for a particular condition or disorder without violating MHPAEA

Non-Quantitative Treatment Limitations (NQTLs)

- Disclosure Requirements
  - Criteria for medical necessity determinations or the reasons for denial of benefits must be made available within 30 days upon request
  - Under the ACA, individuals must be provided reasonable access (free of charge) to all documents, records and other information relevant to claims
    - Model form for requesting information about treatment limitations
  - If a plan utilizes a network, its SPD must provide a general description of the provider network, and, the list of providers must be up-to-date, accurate, and complete (using reasonable efforts)
  - Provisions governing the use of network providers, the composition of the provider network, and whether any coverage is provided for out-of-network services may be provided electronically if DOL electronic distribution safe harbor requirements are met
  - SBCs must include an Internet address (or other contact information) for obtaining a list of in-network network providers

Plan Design Considerations

Plan Design Considerations

- Is It Possible to Exclude MH/SUD Benefits Completely?
  - State-mandated coverage requirements
  - Essential health benefit and preventive coverage requirements
  - Americans with Disabilities Act (ADA) coverage requirements
  - If a plan provides MH/SUD benefits in any classification of benefits, it must provide MH/SUD benefits in every category in which medical/surgical benefits are provided
  - Carrier and TPA requirements
- Claims Administration
  - While claims administration is typically handled by the carrier or TPA, the employer should consider whether the processes are compliant
- Cost Impact
  - Increased coverage requirements are likely to increase the cost of plan coverage

ENFORCEMENT

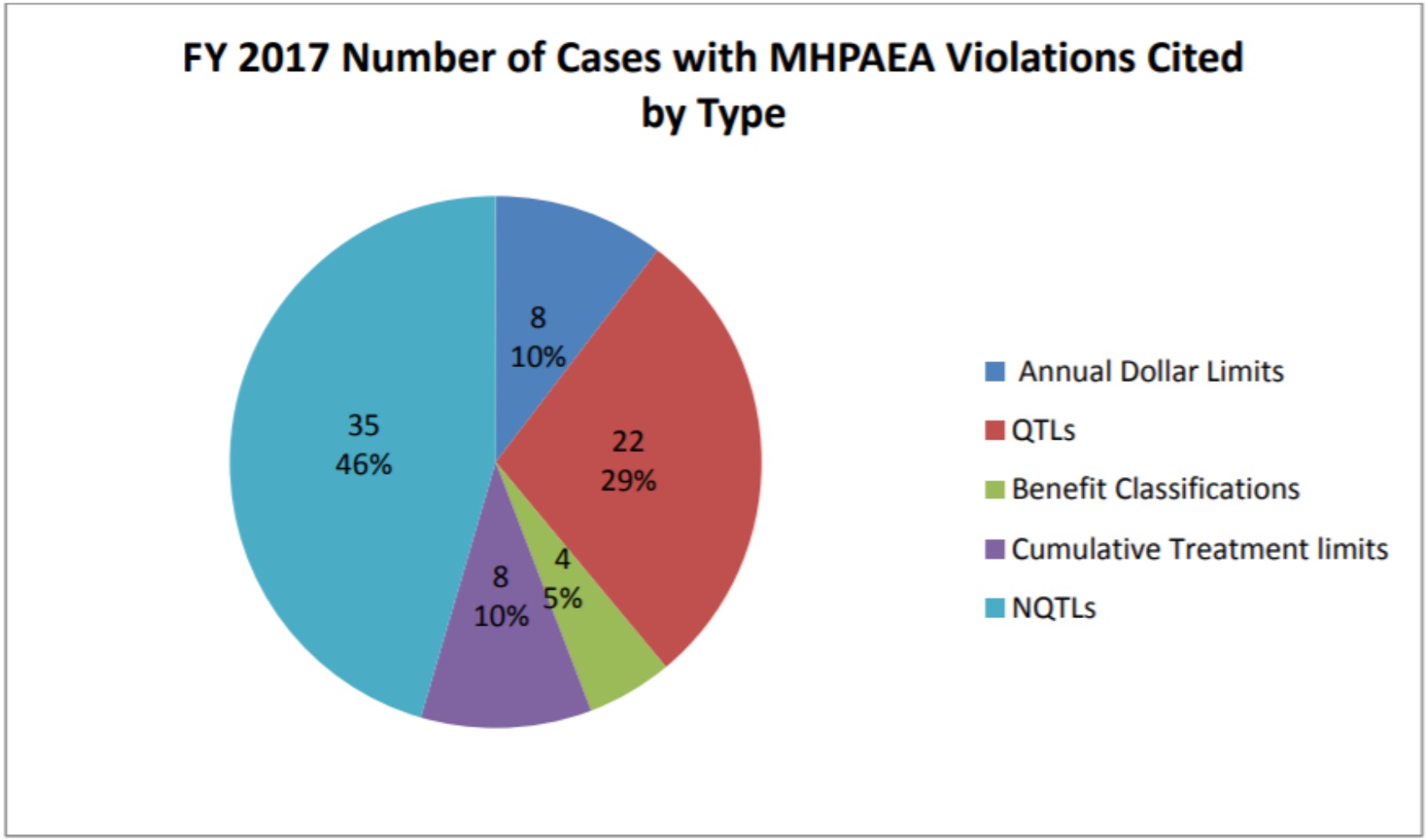
Enforcement

- Penalties
  - DOL enforcement
    - No specific ERISA penalties for violations
    - "… penalties for parity violations are limited to equitable relief, which generally means requiring the offender to provide reimbursement to and/or coverage for participants and beneficiaries whose past claims were improperly denied"
    - Currently no way to enforce requirements on insurance carriers directly
  - IRS excise taxes of $100 per day for each affected individual
  - Individuals may bring civil lawsuits under ERISA for breach of fiduciary duty for failure to comply with MHPAEA and damages for unpaid benefits, interest and attorney's fees

Enforcement

- DOL Enforcement Activity
  - In 2016 and 2017, EBSA closed 671 health plan investigations, 378 of which included reviews of MHPAEA compliance, and 136 resulted in citations for MHPAEA violations
  - 5 most common violations:
    - Non-quantitative treatment limitations
    - Quantitative treatment limitations
    - Cumulative financial requirements, such as separate deductibles or out-of-pocket limits
    - Impermissible annual limits
    - Not offering benefits in all classifications

Enforcement



Enforcement

- DOL Enforcement Activity
  - Required corrections include the following:
    - A plan that imposed an impermissible annual day limit on residential treatment for substance use disorders was required to issue a special notice to all participants alerting them of a 30-day window for submission of claims affected by the limitation ($74,165 for 4 claims paid by the plan)
    - A plan that charged a higher specialist copayment of $25 for in-network mental health and substance use disorder outpatient visits compared to $20 for primary care in-network medical and surgical outpatient visits was required to refund the difference for plan years 2010 through 2016 ($11,340 to more than 200 participants)
    - A plan that failed to provide out-of-network coverage for inpatient and outpatient mental health and substance use disorder benefits was required to reprocess mental health and substance use disorder claims ($24,152 for 52 denied claims)

Enforcement

- Ongoing Enforcement
  - It is likely that we will continue to see focus on enforcement of MHPAEA
  - Although insurance carriers or TPAs will assist in making sure that plan offerings are in compliance with MHPAEA, it is worthwhile for employers to be aware of these requirements
- Self-Check Tool
  - The tool is the same audit checklist that is used by the EBSA's investigators, and it has also been shared with HHS and State regulators
  - https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf

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