WELLS FARGO INSURANCE

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Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice

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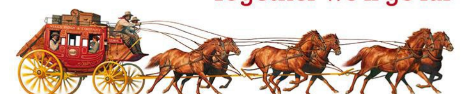
Together we'll go far



Congress considers legislation to repeal and replace the ACA

Congress is currently considering various proposals for legislation that would repeal and replace the Affordable Care Act (ACA). On March 6, 2017, the two congressional committees that have primary responsibility for health care legislation (the House Ways and Means Committee and the Energy Commerce Committee) released draft legislation called the American Health Care Act (AHCA). While this is the first step to repeal and replace the ACA, the draft legislation is fluid and subject to change. Some of the notable items for employers in the draft legislation are that the employer mandate penalty is reduced to $0 effective January 1, 2016 and the "Cadillac tax" is delayed until 2025. Once the House and Senate have solidified the legislation into a more concrete form, Wells Fargo Insurance will provide a detailed analysis of the effect that the legislation is expected to have on employers and their group health plans.

Basics of Mental Health Parity and Addiction Equity Act testing

In brief:

- The Mental Health Parity and Addiction Equity Act requires a group health plan to perform annual parity testing if it imposes any quantitative and non-quantitative financial requirements or treatment limitations on mental health and substance use disorder benefits that are more restrictive than imposed on medical/surgical benefits.
- The calculation of parity testing is data intensive and requires understanding the key terms – "substantially all," "predominant," and "classifications."
- In addition, the calculation must be based on the plan's own claims experience to the extent possible.

Although the Mental Health Parity and Addiction Equity Act (MHPAEA) was signed into law back in 2008, and final regulations became effective for group health plans beginning on or after July 1, 2014, employers continue to struggle to understand and comply with this law. Following recent guidance issued last spring (discussed in our May 2016 Employee Benefits Compliance Update), this task has become more complicated since the regulatory agencies indicated that the testing should be performed with plan-specific data to the extent possible, rather than using data based on the overall book of business of the third-party administrator (or carrier in the event of an insured plan). So, exactly how do these complicated, data-intensive parity calculations work, and what can employers do to design their group health plans to simplify or eliminate this testing?

Background

Among other things, the MHPAEA requires that the financial requirements (such as co-payments and deductibles) and treatment limitations (such as day or visit limits) imposed on mental health and substance use disorder benefits (collectively, mental health benefits) cannot be more restrictive than the "predominant" financial requirements and treatment limitations that apply to "substantially all" medical/surgical benefits in the same benefit "classification." (Similar rules apply to non-quantitative treatment limitations, but a discussion of these rules is beyond the scope of this article.) In other words, in order to apply a quantitative requirement or limitation to a mental benefit, then:

- It must first apply to "substantially all" (at least two-thirds) of the medical/surgical benefits within a given benefit "classification" and,
- If more than one level of quantitative requirement or limitation applies (such as $10, $25, and $50 co-payments), it must be the "predominant" level (more than one-half) that applies to medical/surgical benefits for a given benefit "classification."

The exclusive list of permissible benefit "classifications" for parity purposes are:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

Note, however, there are special rules that apply in certain situations. Testing may be performed at a sub-classification level if a plan maintains multiple in-network tiers (such as a narrow network within a broader in-network group of providers). There is a similar special rule for multi-tiered prescription drug benefits. Also, sub-classifications may be used for outpatient office visits as opposed to all other outpatient, non-office visit services (both in-network and out-of-network). This special rule eases certain parity compliance issues that arise where co-payments apply to office visits, but coinsurance applies for other outpatient services. No other sub-classifications are allowed, including generalist/specialist classifications. In addition, if the benefits differ, testing must also be performed separately for each coverage tier offered under the group health plan (such as self-only, single plus family, etc.).

The determination of the portion of medical/surgical benefits subject to the financial requirement or treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. Under the final MHPAEA regulations, "any reasonable method" may be used to determine the dollar amount of all plan payments for the substantially all/predominant analysis.

However, in FAQ guidance issued in May 2016, federal regulators indicated that the analysis on a carrier's entire overall book of business expected to be paid for the year or book of business in a specific region or state is not a reasonable method to determine the dollar amount of all plan payments under MHPAEA. Moreover, to the extent group health plan-specific data is available, each self-insured group health plan must use such data in making their projections. As a result of this FAQ guidance, we have seen some third-party administrators back away from performing parity testing as part of their routine services, even though they typically have the necessary data in their possession, forcing some self-insured employers to perform the testing themselves or pay extra to have these calculations performed by their third-party administrators or actuaries they hire.

Calculation example

To illustrate how the quantitative parity rules work, let's suppose an employer imposes three different co-payment levels for outpatient, in-network medical/surgical benefits and, based on the plan's own claims experience, the plan projects payments for the upcoming year as follows:

Co-payment amount	$0	$25	$75	Total
Projected payments	$200x	$450x	$350x	$1,000x
Percent of total plan costs	20%	45%	35%	100%
Percent subject to co-payments	N/A	56%	43.75%	N/A

This plan projects medical/surgical benefits costs of $800x that are subject to co-payments ($450x + $350x = $800x). Since 80% ($800x/$1,000x) of medical/surgical benefits are projected to be subject to co-payments, the two-thirds threshold of the "substantially all" standard is satisfied. In turn, a co-payment at the $25 level is projected to apply to 56% of medical/surgical benefits ($450x/$800x), which is greater than the one-half threshold of "predominant" requirement. Accordingly, this group health plan cannot impose any co-payment on outpatient, in-network mental health benefits that exceed $25.

Planning suggestions

The easiest way to simplify the compliance burden imposed by the MHPAEA is for an employer to design its group health plan to treat mental health benefits in the same manner as medical/surgical benefits. If that is not possible, then an employer can limit differentials to as few benefits classifications as possible. In particular, it may be particularly effective for employers to take advantage of the ability to test parity on the sub-classification level for outpatient office visits as noted above. Regardless, with the federal regulators increasing their enforcement efforts in this area, employers should take the appropriate steps to ensure they are annually testing their group health plans for compliance with the MHPAEA.

CMS extends transition relief for small group and individual health insurance yet again

In brief:

- Some ACA market reform standards do not apply to small group and individual health insurance policies, under transition relief that has been in effect since 2014.
- CMS announced a third extension of this transition relief, to policy years beginning on or before October 1, 2018. However, all insurance policies subject to this additional transition relief must end by December 31, 2018.
- States may elect to limit the transition relief to a shorter period, and may also exclude the small group and/or individual market from the extended transition relief.

On February 23, 2017, the Centers for Medicare and Medicaid Services (CMS) announced a third extension of the transition relief currently in effect for certain non-grandfathered small group and individual health insurance policies. The transition relief operates as an exemption from some of the market reform standards of the Affordable Care Act (ACA) that were otherwise required to be adopted back in 2014, such as guaranteed renewability of coverage and participation in approved clinical trials.

In short, the relief continues the so-called "grandmothering" relief for coverage that has been in place continuously from 2013, as previously discussed in Employee Benefits Compliance Update articles from April 2016, April 2014, and December 2013. According to the recent CMS Bulletin, this transition relief, if allowed by a state, allows health insurance carriers to renew grandmothered policies on or before October 1, 2018. However, all insurance policies that are subject to this transition relief must end by December 31, 2018.

States may elect to limit the transition relief to a shorter period (but not a longer one). States may also apply the extended transition relief to both the small group and individual markets, to the small group market only, or to the individual market only.

The transition relief does not apply to insurance policies in the large group market (i.e., employers with more than 50 or 100 employees, depending on the state), to self-insured plans, or to grandfathered plans. Transition relief also does not apply to all of the ACA market reform standards. For example, policies subject to transition relief are still not permitted to have a lifetime and/or annual dollar limit on essential health benefits.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.

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