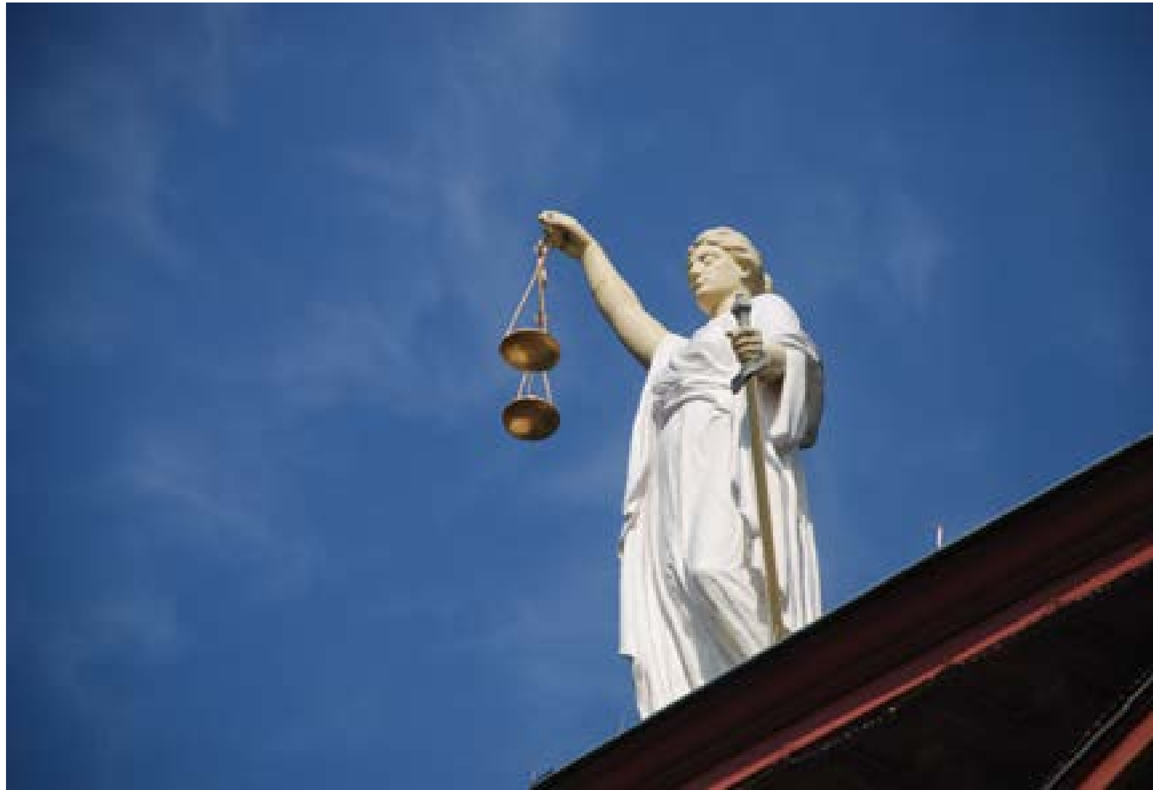

ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES:

Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

The Next Big Thing Audits Regarding The Mental Health Parity And Addiction Equity Act

Over the last six years, employers and insurers have been working diligently to adapt to the ever changing landscape under the Affordable Care Act. Meanwhile, the agencies have also issued comprehensive regulations under the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") that have gone largely unnoticed. But this is quickly changing. Over the last several weeks we have seen a significant uptick in Department of Labor ("DOL") investigation and enforcement activities with respect to the MHPAEA. Employers and insurers would be wise to redouble their compliance efforts in this area.

Background

The MHPAEA amended Section 712 of ERISA, Section 2705 of the Public Health Services Act and Section 9812 of the Internal Revenue Code, and is designed to require true benefit parity between medical benefits for physical conditions and mental health and substance abuse benefits. The MHPAEA applies to employer group health plans and insurance coverage offered in connection with group health plans. If a plan provides medical/surgical benefits and mental health or substance abuse benefits, the plan must provide parity with respect to (i) financial requirements (e.g., deductibles, copayments, coinsurance and out-of-pocket maximums) and quantitative treatment limitations (e.g., number of visits or treatments or days of coverage) and (ii) nonquantitative treatment limitations ("NQTLs")(e.g., medical management standards).

MHPAEA generally became effective for plan years beginning on or after October 3, 2009 (January 1, 2010 for calendar year plans). The effective date was delayed for some union plans until the collective bargaining agreement in place at that time terminated. For years prior to 2010, the Mental Health Parity Act (MHPA), the precursor to MHPAEA, applied. MHPA's more limited equality provisions required parity between annual and lifetime dollar limits applicable to medical benefits and mental health/substance abuse benefits.

What's Required Under MHPAEA?

The MHPAEA established complicated testing requirements to determine whether financial requirements and quantitative treatment limitations on mental health and substance abuse benefits are applied in a manner consistent with corresponding medical benefits. A full discussion of those requirements is beyond the scope of this advisory, but such testing requires a full analysis of the claims under the plan in six separate classifications:

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

If a "type" of "financial requirement or treatment limitation" (such as a copayment) applies to at least two-thirds of the medical/surgical benefits in a "classification" (or subclassification) of benefits, the application of that "financial requirement or treatment limitation" to mental health or substance abuse benefits in that same classification (or subclassification) cannot be more restrictive than the "predominant" financial requirements or treatment limitations that apply to the plan's medical/surgical benefits. By way of example, if the predominant copayment for outpatient in network visits is $25, the applicable copayment for mental health provider outpatient in network visits cannot exceed $25.

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For most plans, we understand that insurers and TPAs performed this test to determine the necessary design for compliance. We further understand that many insurers/TPAs performed this testing across their book of business, rather than on a plan-by-plan basis.

DOL Guidance and Investigation Activity

As noted above, many plans relied on data across their insurer/TPA's book of business to determine compliance. However, there was some indication that plan specific testing was required based on the final MHPAEA regulations. On April 20, 2016, DOL, IRS and HHS (the "Agencies") issued guidance in the form of FAQ 31 that addressed the practice of testing for compliance across a book of business. In Q8 of the FAQ, the agencies stated that a plan or issuer cannot base its analysis on an insurer's entire overall book of business for the year. To the extent plan-specific data is available, each self-funded and fully-insured plan must use such data in making their compliance projections.[1]

FAQ 31 can be found at https://www.dol.gov/ebsa/faqs/faq-aca31.html.

We have recently become aware of several plan investigations in which DOL has alleged compliance violations with plan-specific testing requirements. This seems to suggest that DOL will attempt to enforce the plan-specific testing requirements for prior years, notwithstanding the recent nature of its FAQ guidance.

Penalties

These enforcement actions should be cause for concern for employers and insurers, as significant penalties can result under the Code. MHPAEA violations can give rise to a **$100/day/employee excise tax** under Code § 4980D.

Certain limitations and exceptions apply, as set forth in Code § 4980D.[2] So plans that may have relied on an insurer/ASO provider's book of business calculations to set its financial requirements and quantitative treatment limitations may be at risk for significant penalties if later testing reveals that the financial requirements and quantitative limitations were not appropriate when only plan-specific claims are used. In addition to the IRS taxes, participant claims may be asserted and DOL might choose to sue employers for breach of fiduciary duty based on their failure to comply with MHPAEA. Accordingly, employers may want to begin conducting testing for the years from 2010-2015 to assess any potential liability.

But these financial requirements and quantitative treatment limitations are not the only plan design issues that should be reviewed. Plan sponsors may also want to review their plans' NQTLs to ensure they are also compliant. The Agencies recently issued guidance to assist plans with identifying NQTLs that could run afoul of the MHPAEA.

Federal MHPAEA regulations contain an illustrative, non-exhaustive list of NQTLs, which include:

• medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
• formulary design for prescription drugs;
• network tier design;
• standards for provider admission to participate in a network, including reimbursement rates;
• plan methods for determining usual, customary, and reasonable charges;
• fail-first policies or step therapy protocols;
• exclusions based on failure to complete a course of treatment; and
• restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

The Agencies' outline of potential problem practices should be carefully reviewed. That guidance can be found at https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

Summary

The DOL is actively investigating plans for compliance with MHPAEA; this is not a theoretical problem. Employers and insurers should take heed and begin reviewing their plan designs for prior years to determine whether they have any potential liability. ■

References

[1] *Insured small group and individual market plans are subject to slightly different rules with respect to conducting plan-level tests.*

[2] *Code § 4980D and the footnote should be "Code § 4980D(d) provides an exemption from the excise tax for fully insured employers with between 2 and 50 employees.*