JRG ADVISORS

Your Compliance Guide for Employee Benefits

Participant Request Form Under Mental Health Parity

In June 2017, the U.S. Departments of Labor, Treasury and Health and Human Services provided guidance under the Mental Health and Parity and Addiction Equity Act (MHPAEA). Released in the form of a Frequently Asked Question, the guidance also included a model form as assistance to participants for requesting a plan's mental health or substance use disorder benefits, or to obtain documentation in support of an appeal.

Background

The MHPAEA requires that financial requirements and treatment limitations for mental health and substance use disorder be in parity with the financial requirements and treatment limitations applicable to medical and surgical benefits. In plain language this means a plan's coverage limits on mental health and substance use disorder benefits may not be more restrictive than medical and surgical benefits. Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums. Treatment limitations reference limits on the number of days or number of visits covered and/or limits on the scope or duration of treatment.

Group health plans are required to disclose certain information to plan participants regarding coverage of mental health/substance use disorder benefits under the MHPAEA. Under the disclosure requirements, plan and insurers must:

- Disclose the criteria for medical necessity determinations related to mental health/substance use disorder benefits to current participants, beneficiaries, or contracting providers on request; and
- Provide the reason for denials (often referred to as an "adverse benefit determination") of reimbursement or payment of mental health/substance use disorder benefits.

Plans that are subject to ERISA (private employer plans) include further disclosure requirements to plan participants, upon request, about the processes, strategies, evidentiary standards, and other factors used to make a determination under its claim denial procedures.

Model Participant Request Form

The Departments issued a model form in June that may be used by health plan participants and their representatives to request plan documents concerning a plan's or insurer's MHPAEA related compliance. Along with other general information, the request form reminds employers subject to ERISA that the plan must provide plan documents addressing benefits upon request from a plan participant within 30 days of receiving a written request. The form further allows for a participant to seek information on a specific condition or disorder by requesting:

- Specific plan language regarding limits;
- Identify the factors used in the development of the limitations and evidentiary standards used to evaluate the factors;
- The methods and analyses used to develop limits; and
- Provide evidence showing that the limit is applied no more stringently to mental health/substance use disorder benefits than medical/surgical benefits.

The draft form is not required to be used by a participant when requesting information and a plan/insurer must respond to information requests even if the form is not used. However, the Departments indicated that a model form is helpful to participants when asking for information, and is more uniform and streamlined.

Eating Disorders

The same FAQ issued by the Departments in June also provided that an eating disorder is a mental health condition. As such, the benefits for the treatment of an eating disorder must be in parity with a plan's medical and surgical benefits.

Conclusion

The provision of benefits for mental health/substance use disorder treatments continues to be on the radar of the regulatory Departments. Employer plans that are subject to ERISA should know that the issue of parity under the MHPAEA is a major issue under a DOL investigation. Plans may want to review the draft model request form in order to be prepared for any requests. This would also be a good opportunity for an employer to review the plan document's claims and appeals process and procedures, to ensure compliance with ERISA. The model form can be used until finalized.

EEO-1 New Pay Data Reporting Requirement Stayed

The Equal Employment Opportunity Commission (EEOC) collects workforce data from all employers with 100 or more employees through an annual EEO-1 Report. The report, in its current form, collects data about gender, race, and ethnicity of employees by 10 different job groupings. In 2016, the EEOC revised the form in order to begin requiring employers to provide employee pay data.

The EEOC's goal in gathering this additional data is to identify businesses that may have pay gaps, and then target those employers who are discriminating on the account of gender—and possibly race or ethnicity—through enforcement actions. The EEOC plans to publish reports using aggregated data and to train its investigators to identify potential indicators of discrimination warranting additional investigation.

This new information was to be provided in the 2017 form, and to give employers time to collect that data, the deadline for 2017 was extended by six months from September 30, 2017 to March 31, 2018. The "workforce snapshot period" has also changed to any payroll period of the employer's choice between October 1 and December 31, 2017 (rather than, as previously, a payroll period between July 1 and September 30).

Although the reporting deadline was extended to March 2018, there was indication that the new pay data reporting requirement may be further suspended or even canceled. As a reminder, President Trump signed an Executive Order in January addressing reducing regulation and controlling regulatory costs. Specifically the Order provided, "…it is important that for every one new regulation issued, at least two prior regulations be identified for elimination, and that the cost of planned regulations be prudently managed and controlled through a budgeting process".

To that end, on August 29th, the EEOC was informed that a review as to the new burdens that would be placed on employers under the pay data reporting regulations is being initiated. Furthermore, an immediate stay (suspension) was placed on the requirement for an employer to report pay information.

Therefore, *the previously approved EEO-1* form which collects data on race, ethnicity and gender by occupational category remains in effect. However, employers may still plan on complying with the previously set filing date of March 2018.

Employers with 100 or more employees are required to file an annual EEO-1 report. A 2016 revision to the form would require an employer to report pay data information. However, this pay data reporting requirement has been suspended as of August 29th. However, employers should continue to monitor any further guidance from the EEOC.

Grandfathered Versus Grandmothered Plan

Under the Affordable Care Act (ACA) "grandfathered plans" are group health plans (or health insurance coverage) that were in existence on March 23, 2010, and have not undergone certain prohibited design changes since then. Those prohibitions, in summary fashion, are: an elimination of benefits, an increase in percentage cost-sharing requirements, and an increase in a fixed-amount cost-sharing requirement other than a copayment (with some limitations) or a decrease in employer contributions by more than 5% of its established contribution on March 23, 2010. Needless to say not many grandfathered plans remain. In the Kaiser Health Organization 2016 Employer Benefit Survey it was noted that only 23 percent of employers nationally,

maintain at least one grandfathered benefit option.

Grandfathered plans are excused from some of the requirements under the ACA, such as coverage of preventive health services without any cost-sharing and the expanded appeals process and external review. However, they still must comply with other provisions, including: (1) provide a uniform explanation of coverage, (2) report medical loss ratios and provide premium rebates if medical loss ratios are not met, (3) prohibit lifetime and annual limits on essential health benefits, (4) extend dependent coverage to age 26, (5) prohibit health plan rescissions, (6) prohibit waiting periods greater than 90 days, and (7) prohibit coverage exclusions for pre-existing health conditions.

Employers of grandfathered plans have a notice requirement where the plan must provide, in any plan materials describing benefits for participants or beneficiaries, (a) a statement that the plan or coverage is believed to be a grandfathered plan, and (b) contact information for questions or complaints. Failure to provide this notice can result in loss of grandfather status. Another condition of retaining grandfather status is that as long as the status is asserted documentation must be maintained to show that the coverage in effect as of March 23, 2010 has not made any of the prohibited changes. This requirement reinforces the importance of a plan sponsor having and keeping an updated plan document, which must be available for review upon request. Grandfathered status can be maintained indefinitely as long as no prohibited plan changes are made, however, once lost, it cannot be regained.

In contrast, the ACA did not make any particular allowances for individual and small group plans that became effective after March 23, 2010. It was expected that these plans would terminate at the end of 2013 and be replaced with ACA compliant coverage. However, due to multiple problems for small groups with ACA implementation, the Department of Health and Human Services (HHS) issued transitional relief that allowed states to permit non-grandfathered plans to renew their pre-ACA plans.

Therefore, a “grandmothered plan” (also referred to as a transitional health policy) is a non-grandfathered health plan that is subject to a HHS transition policy. This policy allows insurers to extend coverage which are free from certain ACA reforms, basically, they are noncompliant plans. The main insurance market reforms to which grandmothered plans are not required to comply are the premium rating rules, guaranteed availability and renewability and the requirement to provide the ten Essential Health Benefits.

Originally issued in 2013, transition relief for grandmothered plans has been extended several times with the most recent extension permitting insurers that have continually renewed grandmothered plans since January 1, 2014, to renew such coverage again for any policy year beginning on or before October 1, 2018 (However, the insurance policies must not extend past December 31, 2018). As a reminder whether a plan can be grandmothered is governed by state insurance law, and not all states have adopted the transitional relief. Additionally, an insurer that renews a grandmothered plan is required to provide an annual notice explaining the right to retain existing coverage to affected individuals and small businesses.

Conclusion

If you have a grandfathered plan you can keep it indefinitely, as long as your plan does not make any of the certain prohibited plan design changes which causes the loss of grandfather status. Likewise, if you have a grandmothered plan, you can keep it (at least in Pennsylvania) through December 31, 2018. You should continue to stay updated on the status of the ACA and how your grandfathered or grandmothered plan can be affected.

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