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UPDATED MENTAL HEALTH PARITY GUIDANCE

AGENCIES ISSUE MORE MENTAL HEALTH PARITY GUIDANCE, INCLUDING ADDITIONAL FAQs AND A NEW DISCLOSURE FORM

The DOL, HHS, and IRS have proposed new guidance in the form of FAQs (Part 39) on mental health parity requirements as well as a revised member disclosure request form for group health plans subject to the requirements of the Mental Health Parity Act ("MHPA") and the Mental Health Parity and Addiction Equity Act ("MHPAEA") (together, the "MHP Rules").

As background, the MHP Rules require group health plans to provide parity between medical/surgical benefits on one hand and mental health or substance use disorder (mental health/SUD) benefits on the other to the extent the plans offer mental health/SUD benefits. Specifically, the MHP Rules require plans in this scenario to offer parity in the application of (1) financial requirements (such as deductibles, copayments, coinsurance, and out-of-pocket maximums); (2) quantitative treatment limitations (such as number of treatments, visits, or days of coverage); and (3) nonquantitative treatment limitations ("NQTL") (such as restrictions based on facility type).

Highlights of the FAQs include the following:

- *Experimental Limitations:* A plan's exclusion of experimental or investigational treatments constitutes an NQTL. NQTL rules require that in the plan document and in practice, the plan does not apply any processes, strategies, or evidentiary standards more stringently for mental health/SUD benefits than for medical/surgical benefits. The FAQs cite an example regarding Applied Behavioral Analysis ("ABA") therapy to treat Autism Spectrum Disorder. In the example, a plan denied claims for ABA therapy even though evidentiary support for ABA therapy met the requirements to not be considered experimental but nevertheless paid claims for medical/surgical benefits that had not meet the same requirements. The FAQs confirm this violates MHP Rules.
- *Prescription Drug Limitations:* Dosage limitations for prescription medications are NQTLs despite being expressed as a numerical limitation. Moreover, if a plan follows professionally-recognized treatment guidelines in setting dosage limitations for medical/surgical conditions, the plan must apply comparable treatment guidelines and apply them no more stringently for mental health/SUD conditions.
- *Exclusions:* A categorical exclusion of all benefits for a particular condition is not a treatment limitation that would violate the MHP Rules.

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- *Provider Reimbursement Rates:* While the MHP Rules do not require a plan to pay identical rates to mental health/SUD providers as to medical/surgical providers, a plan's standards for admitting a provider into its network is an NQTL. As such, if a plan does not reduce reimbursement rates for nonphysician providers of medical/surgical services, it cannot do so for nonphysician providers of mental health/SUD services.
- *Disclosures:* Plans that are subject to the Employee Retirement Income Security Act of 1974 ("ERISA") and use a provider network must provide a general description of the provider network in the plan's summary plan description ("SPD"). The FAQs note that an inaccurate or out-of-date provider network directory does not comply with that SPD requirement. The FAQs also noted that a plan's use of a hyperlink or web address to access the up-to-date provider directory is permissible, as long as the DOL's criteria for providing plan notices in electronic format are satisfied.

In addition, to assist members with requesting evidentiary standards and other information from their plans, the agencies also issued a revised draft model disclosure form.

Key Action Items

Mental health parity guidance continues to evolve, and HealthSCOPE Benefits will work with you to ensure that the evidentiary standards are documented and available for disclosure to members.

2019 COST SHARING LIMITS

NON-GRANDFATHERED GROUP HEALTH PLANS

Under the Affordable Care Act ("ACA"), non-grandfathered group health plans may not impose maximum out-of-pocket limits that exceed certain thresholds. These thresholds are adjusted annually using a formula described as a premium adjustment percentage. On April 17, 2018, CMS published the final 2019 Notice of Benefit and Payment Parameters. While the notice is primarily aimed at insurers that offer coverage in the Marketplace, the notice also updates the out-of-pocket maximum for non-grandfathered group health plans for 2019.

The guidance notes that the maximum annual out-of-pocket limit for all non-grandfathered group health plans starting in 2019 will be:

- $7,900 for self-only coverage (compared to $7,350 for 2018)
- $15,800 for family coverage (compared to $14,700 for 2018)

The existing rule requiring plans to have an embedded out-of-pocket maximum for individuals with other than self-only coverage remains unchanged.

As a reminder, the maximum out-of-pocket limit for high deductible health plans coupled with a Health Savings Account (an "HSA-qualifying HDHP") is subject to different statutory rules which are published by the IRS under Code s. 223 and discussed further below. Non-grandfathered group health plans that are also HSA-qualifying HDHPs must comply with the lower out-of-pocket limit.

To view the notice in its entirety, please click here.

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HSA-QUALIFYING HIGH DEDUCTIBLE HEALTH PLANS

On May 10, 2018, the IRS release Revenue Procedure 2018-30 announcing the official 2019 inflation adjusted amounts for HSAs as determined under IRC § 223. This includes the maximum annual HSA contribution amount, the minimum annual deductible for an HSA-qualifying HDHP, and the maximum annual out-of-pocket expense limits for an HSA-qualifying HDHP. These amounts are updated annually to reflect the cost-of-living adjustments.

Calendar year 2019 for HSAs and HSA-qualifying HDHPs with the plan year starting during 2019

Self-only Coverage	2018	2019	Change
Maximum annual HSA contribution	$3,450	$3,500	+$50
Minimum annual deductible for HDHP	$1,350	$1,350	+$0
Maximum annual out-of-pocket expense limit for HDHP	$6,650	$6,750	+$100
Family Coverage	**2018**	**2019**	**Change**
Maximum annual HSA contribution	$6,900	$7,000	+$100
Minimum annual deductible for HDHP	$2,700	$2,700	+$0
Maximum annual out-of-pocket expense limit for HDHP	$13,300	$13,500	+$200

To review Revenue Procedure 2018-30 in its entirety, please click here.

Key Action Items

1. For employers sponsoring HSA-qualifying HDHPs, this information will impact benefit plan administration and communication materials for 2019.
2. The information may also influence an employer's HDHP design and employer or employee HSA contribution strategies in 2018.

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PCORI FEE REMINDER

The Comparative Effectiveness Research Fee ("CERF"), commonly referred to as the Patient-Centered Outcomes Research Institute ("PCORI") Fee, is one of a number of fees introduced by the ACA. The ACA established the PCORI with the purpose of conducting research to evaluate and compare health outcomes and assess the clinical effectiveness, risks, and benefits of medical treatments. This research is partially funded by a fee on health insurers and self-funded group health plans.

2018 CERF Payment Details

As a reminder, plan sponsors of self-insured group health plans must complete the filing process themselves using IRS Form 720. The fee is based on the average number of covered lives (*i.e.*, employees, spouses, and dependents) for the applicable 12-month policy or plan year ending in the preceding calendar year.

The chart below outlines the amount to be paid by July 31, 2018 based on the plan year start date.

Plan Year End Date	Fee Due on July 31, 2018
On or after October 1, 2016 and before October 1, 2017	$2.26 per average covered life
On or after October 1, 2017 and before October 1, 2018	$2.39 per average covered life

Key Action Items

Plan Sponsors are required to file IRS Form 720 by July 31, 2018. HealthSCOPE Benefits can support you with this filing by providing you with the average number of covered lives.

IRS Notice 2016-64, which addresses the PCORI fees for plan years ending on or after October 1, 2016 and before October 1, 2017 is available here .

IRS Notice 2017-61, which addresses the PCORI fees for plan years ending on or after October 1, 2017 and before October 1, 2018 is available here.

IRS Form 720 is available here, with instructions available here.

Please contact your Account Manager if you have any questions or to request your plan's average number of covered lives for your Form 720 filing.