EMPLOYEE BENEFITS MANAGEMENT
Directions

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INSIDE

Nearly all group health plans must consider mental health parity compliance, expert says

JESSICA WALTMAN

As the COVID-19 pandemic enters its tenth month in the U.S., many companies have expressed concern over the mental health of their employees and have considered adding or expanding company-provided mental health services. Companies that do so must comply with mental health parity laws to avoid expensive litigation in the future. To find out more about mental health parity compliance, **Wolters Kluwer** reached out to Jessica Waltman, senior compliance consultant at MZQ Consulting.

WK: What do the federal mental health parity laws require?

Waltman: There are several federal laws that address mental health care, but the main one is the Mental Health Parity and Addiction Equity Act (MHPAEA) which became law in 2008. This federal law applies to employers with more than 50 employees who offer group health coverage and related health insurance carriers. The law doesn't require coverage of mental health or substance abuse disorders. However, if an employer group offers even limited mental health or substance abuse disorder treatment benefits, they cannot treat those benefits differently from other medical/surgical services. Beyond that, MHPAEA applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care plans, the State Children's Health Insurance Program, and state and local government plans that do not opt-out.

In 2010, after the passage of the Patient Protection and Affordable Care Act (ACA), all fully-insured individual and small employer group health plans are required to cover 10 essential health benefits (EHBs), including mental health and substance abuse disorder treatment, by January 1, 2014. When the Department of Health and Human Services (HHS) adopted final EHB regulations, they said that mental health and substance use disorder coverage offered in these markets had to follow all of the MHPAEA rules. This effectively extended the mental health parity rules into the small group fully insured market.

WK: Are any group health plans exempt from the federal mental health parity requirements?

Waltman: Almost every group health insurance plan has to think about compliance with mental health parity rules. Of course, there are always a few exceptions. Employers with fewer than 50 employees that self-fund their group health plans, including those small businesses with level-funded coverage, are exempt from the federal MHPAEA and ACA parity requirements. State parity laws do not apply to them either. Also, self-funded non-federal governmental health plans may opt-out of the MHPAEA. So, state and local government plans that make that determination are not required to provide equivalent mental health and substance use disorder coverage.

WK: What are the most frequently litigated issues involving the MHPAEA, and how can plans avoid these compliance issues?

Waltman: The most complicated part of MHPAEA compliance is ensuring equality in what are termed non-quantitative treatment limits (NTQLs). NTQLs are all the ways

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that plans provide coverage without directly using numbers and math. Examples include pre-authorization requirements, coverage of different types of providers, formulary design, and what standards the plan uses to determine medical necessity. Plans can not apply NTQLs to mental health conditions more stringently than they do to medical/surgical benefits in the same classification.

Since NTQLs can seem subjective, many group plans struggle with this part of mental health parity compliance. Unsurprisingly, most MHPAEA litigation against health insurance issuers and employer group plan sponsors involves NTQL determinations, such as pre-authorization requirements and other medical cost management techniques. For example, if a plan doesn't require a care plan before approving an inpatient hospital stay for a hip replacement, there could be a lawsuit if they require a care plan before allowing an inpatient psychiatric stay. Medical necessity criteria, which is what a plan uses to make individual coverage determinations, also is often a target. Parity litigation occurs regarding all types of care, but inpatient treatment coverage and coverage of autism spectrum disorders are two of the most common.

To guard against a parity related lawsuit, employers should make sure they know which parity laws may apply to them and that they understand their responsibilities according to each one. It's also an excellent idea to evaluate plan offerings each year when it comes to both quantitative and non-numerical treatment limits. Even if an employer offers fully-insured benefits, ultimately, every business that sponsors the group plan needs to check and make sure their coverage is compliant. All mental health benefit information needs to be part of every employer group's ERISA plan documents.

WK: Currently, every state has enacted mental health parity legislation. How do state laws interact with the federal mental health parity requirements?

Waltman: State mental health parity laws (like all state mandated benefit requirements) apply to fully-insured health insurance policies and health insurance carriers. In some cases, state mental health coverage are broad-based supplements to the MHPAEA, and in others, they are coverage mandates specific to particular disorders and kinds of treatment. Any business that offers fully-insured group coverage needs to make sure that their carrier's coverage complies with both state and federal laws. Groups that offer self-funded or level-funded coverage only need to worry about the federal MHPAEA requirements. As explained earlier, smaller self-funded plans and local and state government plans that opt out of the MHPAEA do not have to worry about either kind of requirement.

WK: Recently, California passed a controversial mental health parity law. What are the arguments for and against the new law?

Waltman: The new law expands the number of mental health conditions that all fully-insured plans sold in the state must cover. It requires all carriers that offer fully-insured group or individual health plans to cover all mental health conditions and substance use disorders listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Health Disorders*. Before, California only required plans to cover certain conditions listed specifically in the old law and conditions in an outdated version of the DSM. In addition, the new law gives insurance carriers specific standards to meet when designing medical necessity criteria concerning mental health and substance use disorder treatment coverage.

Advocates for the new law like how it broadens access to mental health benefits for many state residents. They also note that medical necessity standards are one of those NQTLs that make MHPAEA compliance so tricky. By giving health plans specific standards to follow, they hope to improve parity compliance across the board. Those who opposed the new law think that its restrictive nature could limit medical necessity decisions and that it would add to overall administrative costs. In addition, many thought the new law missed the main problem many beneficiaries face—finding providers that will accept health insurance coverage. Instead, some people would have preferred an investment in a bigger mental health workforce.

WK: What are the advantages and disadvantages of offering mental health benefits?

Waltman: There are many advantages to offering employees access to mental health care benefits. Helping to reduce office stress, improving productivity, reducing absenteeism, and increasing overall health of the workforce are just some of them. By providing and emphasizing strong mental health benefits, employers have the opportunity to help destigmatize mental health care. Strong mental health benefits, like all health care benefits, also are a great tool for attracting and retaining excellent employees. Particularly this year, employees really need and value enhanced access to mental health services at work.

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Editors
Lauren Bikoff, MLS
Tulay Turan, JD

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A disadvantage of offering any type of medical benefit, mental health included, is increased costs. Health insurance premium pricing directly relates to the cost of medical care. Some types of mental health and substance use disorder care, like other forms of medical care, can be expensive. However, there are tangible costs and costs that are far less tangible. When people do not have access to mental health care and treatment for substance use disorders, their work performance and overall health suffers. Some mental health problems are associated with poor employment experience, so businesses who limit mental health coverage can face costs from lost productivity, absenteeism, and morale problems down the road. In addition, people with untreated mental health and substance use disorders face higher rates of non-mental health-related illnesses, such as hypertension and diabetes. Employees with what could be preventable chronic medical conditions increase costs long-term. So, many employers believe that an upfront investment in their employee's mental health, as well as their physical health, is a very worthwhile one.

WK: What strategies can employers use to control mental health care costs?

Waltman: There are lots of ways that employers can control health care costs, including through upfront investment in their workforce's mental well-being. COVID-19 has really expanded the use of telehealth for mental health care services, which can be an affordable and more convenient option than in-person visits, particularly now! An employee assistance program (EAP) can also offer people access to initial mental health and substance use disorder services.

WK: Do you have anything else to add?

Waltman: Administering a group health insurance plan is not easy. Mental health and substance abuse issues are also tough stuff. Putting it all together in a legal and compliant way is trickier. MZQ Consulting is always available to help employer group plans and health insurance brokers with parity compliance questions, compliance audits, and plan document preparation. ■

TELECOMMUTING

Companies now three times more willing to hire remote workers from anywhere, survey finds

With remote work becoming the new normal for many, more companies are now willing to not only hire remote workers, but to hire them from anywhere. More than one third say they are willing to hire 100 percent remote workers anywhere in the U.S. or internationally, according to a recent survey by The Conference Board. The new findings also reveal that, after six months of adapting to the pandemic, many organizations continue to expect taking cost-reduction actions including layoffs and restructurings. On the upside, many companies have been able to fully or partially reverse some of the cost-cutting measures taken at the beginning of the pandemic, specifically around reducing salaries and wages.

LATEST INTEREST RATES

IRS
December AFRs
Period for Compounding

	Annual	Semiannual	Quarterly	Monthly
Short-term				
AFR	0.15%	0.15%	0.15%	0.15%
110% AFR	0.17%	0.17%	0.17%	0.17%
120% AFR	0.18%	0.18%	0.18%	0.18%
130% AFR	0.20%	0.20%	0.20%	0.20%
Mid-term				
AFR	0.48%	0.48%	0.48%	0.48%
110% AFR	0.53%	0.53%	0.53%	0.53%
120% AFR	0.58%	0.58%	0.58%	0.58%
130% AFR	0.62%	0.62%	0.62%	0.62%
150% AFR	0.72%	0.72%	0.72%	0.72%
175% AFR	0.84%	0.84%	0.84%	0.84%
Long-term				
AFR	1.31%	1.31%	1.31%	1.31%
110% AFR	1.45%	1.44%	1.44%	1.44%
120% AFR	1.58%	1.57%	1.57%	1.56%
130% AFR	1.71%	1.70%	1.70%	1.69%

30-year Treasury Securities Rate

Month	*Yield Rate*
October 2020	1.57%

Yield Curve and Segment Rates

Spot Rates	*First Segment*	*Second Segment*	*Third Segment*
October 2020	0.54%	2.38%	3.28%

24-Month Average without adjustment by 25-year segment rates

November 2020	1.99%	3.21%	3.80%

Adjusted 24-Month Average

November 2020	3.64%	5.21%	5.94%

Minimum Present Value Segment Rates

	First Segment	*Second Segment*	*Third Segment*
October 2020	0.54%	2.38%	3.28%

PBGC

Rates for valuing benefits of terminating single-employer and multiemployer plans
For plans with a valuation date on or after
December 1, 2020 1.62%

Rates for valuing lump sums for PBGC payments
For plans with a valuation date on or after
December 1, 2020 0.00%

Rates for valuing lump sums for private sector payments
For plans with a valuation date on or after
December 1, 2020 0.00%

Variable rate premium for single-employer plans
For premium payment years beginning in

	First Segment	*Second Segment*	*Third Segment*
November 2020	0.54%	2.38%	3.28%

The survey found that 36 percent of companies say they are willing to hire 100 percent remote workers anywhere in the US or internationally. Just 12 percent were receptive to that approach before COVID-19. Compared to before the pandemic, companies are now far more willing to hire remote workers (52 percent willing before COVID-19 vs. 88 percent now). However, half still prefer that employees live within commuting distance to the office location.

The future of remote work. More than one third of respondents expect that 40 percent or more of their employees will work remotely (at least three days per week) 12 months post-pandemic. That is up from five percent prior to the pandemic.

Back to the office. A plurality of companies is planning to return to the workplace by March, but significant uncertainty remains. About 60 percent of companies have either already returned or are currently planning to return to the workplace by March 2021. However, this date could change based on the severity of the second COVID-19 surge. A quarter of respondents are more uncertain, either awaiting a vaccine or noting other determining factors, such as trends in COVID-19 cases in the geographic area. Only 19 percent of companies had remained open or returned to the workplace by the end of September 2020. ■

SOURCE: *www.conference-board.org*

HRA

Employers express interest in individual coverage HRA

Individual coverage health reimbursement arrangements (ICHRAs), a new employer-sponsored health care benefit program for active employees that became available this year, are drawing the attention of U.S. employers, particularly wholesale and retail employers and those in education and the public sector. This is according to new research by Willis Towers Watson.

An IRS rule issued in 2019 opened the door for employers to begin offering ICHRAs this year. With an ICHRA, employees choose where their medical benefit dollars are spent by purchasing individual insurance coverage and then receiving a reimbursement through an employer-sponsored HRA. The survey found growing interest in this new benefit as a way for employers to keep their costs fixed by giving employees the opportunity to manage their own health care benefit choices and spend.

According to the *2020 Health Care Delivery Survey,* 15 percent of employers are planning to offer or considering offering ICHRAs to at least some portion of its employees in 2022 or later. The survey results showed similar levels of interest regardless of employer size, with 20 percent of large employers planning to offer or considering offering ICHRAs to at least some portion of their active employees. In a further sign of support for ICHRAs, a forthcoming Willis Towers Watson survey of chief financial officers found one-third are considering ICHRAs for some portion of their active employees.

The survey found nearly one in three (29 percent) public sector and education employers and almost a quarter (22 percent) of wholesale and retail employers are planning to offer or considering offering ICHRAs in 2022 or later. ■

SOURCE: *www.willistowerswatson.com*

FSA

IRS increases flexible spending account carryover amount

Q *Your cafeteria plan and health flexible spending account (FSA) has allowed a $500 carryover in the past, but you heard there has been a change to the rules. What was the change?*

A Since 2013, the IRS has allowed health FSAs to offer a $500 carryover in which participants can carry over unused amounts remaining at the end of a plan year in a health FSA (up to $500) to pay or reimburse a participant for medical care expenses incurred during the following plan year.

Under Notice 2020-33, the IRS increased the $500 carryover amount for 2020 or later years to an amount equal to 20 percent of the maximum health FSA salary reduction contribution for that plan year. Therefore, for plan years beginning on or after 2020, the carryover amount is $550 (20 percent of $2,750).

Employers that want to offer the indexed increase in the health FSA carryover amount must adopt a plan amendment to the Sec. 125 cafeteria plan on or before the last day of the plan year from which amounts may be carried over. Therefore, for 2020, employers sponsoring a calendar-year plan must adopt the amendment allowing the indexed carryover limit no later than December 31, 2020.

SOURCE: *IRS Notice 2020-33, I.R.B. 2020-22, May 26, 2020.*

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