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Mental Health Parity Update

The White House Mental Health and Substance Use Disorder Parity Task Force recently released its final report recommending that agencies' future budgets include funding to expand MHPAEA compliance audit capacity. It also identified a need for more guidance on what group health plans and issuers are required to disclose regarding their mental health and substance use disorder benefits. Simultaneously, the departments issued guidance on medication assisted treatment for opioid use disorder and a potpourri of other mental health parity issues.

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits group health plans from applying any financial requirement or quantitative treatment limitation to mental health and substance use disorder (MH/SUD) benefits in a classification that is more restrictive than the predominant (more than one-half) financial requirement or treatment limitation of that type applied to substantially all (at least two-thirds of) medical/surgical (M/S) benefits in the same classification. It also prohibits a group health plan from imposing any nonquantitative treatment limitation on MH/SUD benefits unless comparable limitations are applied no less stringently to M/S benefits.

The final MHPAEA regulations state that, in assessing whether a financial requirement or quantitative treatment limitation satisfies the "predominant" or "substantially all" standards, the determination of the portion of M/S benefits subject to the requirement or limitation is based on the dollar amount of all plan payments for M/S benefits in the classification expected to be paid for the plan year. Plans may use any reasonable method for determining such dollar amount. (See our January 14, 2014 *For Your Information*.) April 2016 guidance from the Departments of Labor (DOL), Health & Human Services (HHS), and the Treasury (departments) stated that it would not be reasonable for an issuer of a fully insured group health plan to

Types of Financial Requirements and Treatment Limitations

- **Financial requirements** affect the amount of benefits paid, such as deductibles, co-payments, coinsurance, and out-of-pocket maximums.
- **Quantitative treatment limitations** are expressed numerically and affect the scope or duration of benefits for treatment, such as day or visit limits.
- **Nonquantitative treatment limitations** (NQTLs) are not expressed numerically but otherwise affect the scope or duration of benefits for treatment. They include medical management techniques such as preauthorization, formulary design, and step therapy or fail-first requirements.

determine dollar amounts based on its entire book of business because it should generally have group health plan-specific data to make projections; if it does not, it can use data from other group health plans similar in structure and demographics. The guidance directed self-insured group health plans to use plan-specific data, to the extent available. (See our May 19, 2016 *For Your Information*.)

On March 29, 2016, President Obama created the White House Mental Health and Substance Use Disorder Parity Task Force (Task Force) to develop "tools, guidelines, and mechanisms" that will help enforce parity in coverage for mental health and substance use disorder services. The Task Force, led by the White House Domestic Policy Council, includes representatives from DOL, HHS, and Treasury, along with the Departments of Defense, Justice, and Veterans' Affairs, and the Offices of Personnel Management and National Drug Control Policy.

Federal Parity Task Force Report

On October 27, 2016, after listening sessions, meetings, and comments involving a range of stakeholders, the Task Force released its final report, a consumer guide to disclosure rights in conjunction with the final report, a fact sheet, and a blog post. The final report recommends:

Ramping up agency enforcement capacity and strengthening noncompliance penalties. Agencies' future budgets should include funding to expand capacity to conduct random audits in addition to responding to MHPAEA complaints. Congress should provide DOL with authority to assess civil monetary penalties. DOL and HHS should release annual investigation, results and violation data.

Enhancing compliance information. In May 2016, DOL and HHS released a Warning Signs document identifying NQTLs that require additional review to determine if they comply with parity — for example, blanket preauthorization requirements applying to all MH/SUD services. The final report recommends developing "Warning Signs 2.0" to address additional potentially problematic NQTLs and appropriate application of comparable NQTLs, and in particular to address network adequacy issues.

The final report also called for FAQs on parity and opioid use disorder services (see below), establishing two policy implementation conferences in 2017, and providing a Compliance Assistance Materials Index.

Enhancing consumer protections.

- Consumer web portal. Designed as an entry point for consumers seeking information and resources on their coverage questions and issues, including complaints, appeals and other actions, the Task Force released a beta version of the portal.
- Simplified disclosure tools for consumers, plans and issuers. The Task Force identified a need for more guidance on what plans and issuers are required to disclose regarding their MH/SUD benefits, and requested comments (see below) on improving and streamlining disclosure requests — including the possibility of model disclosure request forms.
- Consumer Guide to Disclosure Rights. The guide is designed to improve consumer awareness of parity protections.

Extending parity rules, compliance and implementation. Non-ERISA plans should have to disclose processes, strategies, evidentiary standards and other factors applied to M/S limitations to the same extent as ERISA plans. Self-funded, non-federal governmental plans should not be able to use the HIPAA opt-out process for parity

compliance. CMS has added MHPAEA compliance to its review of plans subject to essential health benefit requirements.

The final report also recommends improving parity implementation in state Medicaid, the Children's Health Insurance Program (CHIP), Medicare, and TRICARE, as well as reviewing SUD benefits in the Federal Employees Health Benefits Program.

The Centers for Medicare & Medicaid Services (CMS) is awarding $9.3 million in grants to help state insurance regulators ensure compliance.

What happens to the final report under the Trump administration?

The Task Force issued the final report just days before the 2016 presidential election. It remains to be seen if and how President-elect Trump will use this report to promote administrative directives and/or support congressional action. In the past, providing mental health care has been an issue that has garnered support from both Democrats and Republicans. (See our *Legislate* from **September 6, 2016**.)

FAQs on Mental Health and Substance Use Disorder Parity Implementation

In conjunction with the final report, the departments issued another round of guidance on the application of MHPAEA. This set of FAQs appears to further preclude employers from providing MH/SUD benefits under terms less favorable than M/S benefits.

Medication Assisted Treatment for Opioid Use Disorder

As the final report recommends, several FAQs address medication assisted treatment for opioid use disorder. They provide that a plan cannot:

- Require prior authorization for FDA-approved medications for the treatment of opioid use disorder — even due to stated safety concerns — unless it requires prior authorization for prescription drugs to treat M/S conditions that have similar safety risks
- Impose a "fail-first requirement" on coverage of FDA-approved medications for the treatment of opioid use disorder unless, under plan terms and in practice, it applies equally stringent processes, strategies, evidentiary standards and other factors to fail-first requirements for M/S benefits in the relevant prescription drug classification
- State that it follows nationally recognized guidelines but then deviate from those guidelines only with regard to MH/SUD benefits

The FDA has approved three drugs for the treatment of opioid use disorder:

- Methadone
- Buprenorphine
- Naltrexone

> **Comment.** The departments note in particular that a plan's use of a pharmacy and therapeutics committee to decide how to cover prescription drugs and determine whether to deviate from nationally recognized treatment guidelines for opioid use disorder treatments should be evaluated for compliance with NQTL requirements. For example, plans should consider if the committee includes MH/SUD experts in addition to M/S experts.

Financial Requirements and Quantitative Treatment Limitations

The guidance clarifies that the requirement to use plan-specific data when examining financial and quantitative parity applies only where sufficient claims data exist. If a qualified actuary determines there is not enough data at

the plan level for a reasonable projection of future claims costs, the plan can use other data for this purpose — including data from "other similarly-structured plans with similar demographics," if actuarially appropriate. The guidance also reiterates that a plan does not have to perform the parity analysis each year unless there is a change in benefit design, cost-sharing structure or utilization that would affect a financial requirement or treatment limitation within a classification or subclassification.

Comment. Plan sponsors using other data should be sure to document their assumptions.

Nonquantitative Treatment Limitations

Medical management standards are a type of NQTL. The guidance notes that the analysis of whether a particular medical management standard satisfies parity rules should not focus on the final result but on whether there has been parity in application of the underlying processes and strategies — there cannot be arbitrary or discriminatory differences in how they are applied to MH/SUD benefits as compared to M/S benefits. For example, a plan cannot impose an in-person examination prior to admission to an inpatient, in-network facility for MH/SUD where it requires prior authorization over the phone (rather than in person) for M/S benefits. Additionally, beginning with plan years on or after March 1, 2017, a plan may not apply an NQTL to an MH/SUD benefit that the participant "cannot reasonably satisfy" — for example, requiring enrollment in an intensive outpatient program before authorizing an inpatient treatment program where there is no such program to treat an individual's SUD in that individual's geographic area.

As the final report recommends, the guidance requests comments on the utility and content of model forms that participants and their representatives could use to request information on NQTLs. Responding to stakeholder views that model forms could help facilitate uniform implementation and enforcement of MHPAEA, the departments ask if there should be a specific list of documents relating to specific NQTLs and whether different types of NQTLs require different model forms.

Court-Ordered Treatments

The guidance states that the exclusion of court-ordered treatment for SUDs is not permissible if the plan covers court-ordered treatment for M/S conditions. However, if the plan applies medical necessity criteria to all treatment requests, it may do so in the case of court-ordered SUDs.

One Q&A on Coverage of Preventive Services

The ACA requires that non-grandfathered group health plans cover certain preventive care items and services without cost-sharing consistently – including those with a rating of "A" or "B" in the current recommendations of the US Preventive Services Task Force, such as tobacco cessation interventions. (See our **May 28, 2015** *For Your Information*.) The guidance asks for comments on the types of FDA-approved pharmacotherapy interventions for tobacco cessation that plans must cover without cost-sharing and the circumstances under which plans can use reasonable medical management techniques.

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In Closing

It is not clear how the Trump administration will react to the final report's actions and recommendations. Comments on the FAQs are due January 3, 2017. Unless the Trump administration pulls back on enforcement of MHPAEA, employers seeking to avoid risk should provide MH/SUD benefits that are as generous as, and no more restrictive than, those applied to comparable M/S benefits.

Does Your Plan Comply with Mental Health Parity Rules?

Since 2010, DOL has conducted over 1,500 investigations concerning MHPAEA and found **over 170 violations** for noncompliance with mental health parity rules. Given the complexity of these rules, group health plans should consider a compliance review focused on mental health parity issues.

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