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Departments finalize mental health parity compliance guidance

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The Departments of Labor, Treasury, and Health & Human Services (departments) recently finalized guidance on how MHPAEA's nonquantitative treatment limitation rules apply to experimental or investigative treatment exclusions, step therapy requirements, and provider networks. The departments also issued a final disclosure template to help participants and beneficiaries request information on limitations that may affect their mental health and substance use disorder benefits. With MHPAEA enforcement still a priority, now is a good time to work with advisors to evaluate parity compliance.

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally prohibits group health plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable conditions or more stringent limits on those benefits than they do on the same classification of medical and surgical benefits. The law requires parity in financial requirements (e.g., deductibles or copayments) and quantitative treatment limitations (e.g., number of covered visits). It also requires parity in nonquantitative treatment limitations (NQTLs) — which are non-numerical limits on the scope or duration of benefits, such as a pre-authorization requirement or a medical management technique. Although MHPAEA does not require a plan to cover any specific MH/SUD conditions, it mandates that if the plan covers an MH/SUD condition, it must do so in parity with medical/surgical benefits.

MHPAEA enforcement

The DOL has **reported** that, during its 2018 fiscal year, it reviewed 115 ERISA plans for MHPAEA compliance and identified 21 MHPAEA violations, 55% of which involved NQTLs. Additionally, it answered over 127 MHPAEA public inquiries in 2018.

Although there are currently no civil monetary penalties for parity violations, the DOL and plan participants may bring actions under ERISA to enforce MHPAEA. In addition, an employer may also face an excise tax of $100 per individual, per day, if its group health plan fails to comply with MHPAEA.

Regulations issued in 2013 set out the rules for determining parity. (See our January 14, 2014 *FYI*.) Since then, the Departments of Labor, Treasury, and Health & Human Services (departments) have issued additional guidance on how the MHPAEA applies to group health plans. (See our July 5, 2017, December 2, 2016, and May 19, 2016 issues of *FYI*.)

In April 2018, the departments issued proposed FAQs that set out examples of various types of NQTLs that may violate MHPAEA parity requirements. They also proposed a model form that individuals could use to request information about: (1) a plan's limitations on coverage of MH/SUD benefits in general, or of specific treatments or, (2) the basis for a plan's denial of a claim for MH/SUD benefits. (See our May 14, 2018 *FYI*.)

Final FAQs on NQTLs

The final FAQs generally restate the content of the proposed FAQs with some minor editing — they do not provide any additional interpretations of how MHPAEA applies to NQTLs. The updates include the following:

Exclusions of experimental or investigative treatments

These FAQs are substantially unchanged. They reiterate that to comply with MHPAEA, a plan that excludes experimental or investigative treatments must ensure that any processes, strategies, evidentiary standards, and other factors used to impose the exclusion are applied comparably to all medical/surgical and MH/SUD benefits in the relevant classification. This includes not only how the plan defines "experimental or investigative" and applies that definition to both medical/surgical and MH/SUD treatments, but also how the plan applies any exceptions to its general standards. The FAQ states that if a plan that determines a treatment should be excluded as experimental or investigative after properly applying its relevant standard, it should document the factors relied upon to exclude the treatment on this basis. Similarly, if the plan provides for exceptions from its general standards, it should document not only the availability and requirements of the exceptions process, but also the factors relied upon in determining how the exception applies to both MH/SUD and medical/surgical benefits.

Exclusions of specific MH/SUD condition

MHPAEA does not require plans to cover items and services to treat *any* specific MH/SUD condition. The proposed FAQ had referred specifically to a plan's exclusion of treatment for bipolar disorder — stating that excluding all items and services for that condition would be permissible under MHPAEA. The final FAQs remove the reference to treatment of bipolar disorder to clarify that MHPAEA rules are not limited to that condition.

"Step therapy" protocols and "fail-first" policies

A plan must be able to demonstrate that any step therapy or fail-first policies it imposes on MH/SUD benefits are based on evidentiary standards or other factors comparable to those applied to medical/surgical benefits. The final FAQ notes that it is generally unlikely that a plan's analysis would support application of different step therapy requirements to MH/SUD benefits but that if the plan can make that demonstration, it should document the factors relied upon to support the different protocols.

Provider reimbursement rates

The FAQ notes that to comply with MHPAEA, a plan must be able to demonstrate that it follows a comparable process in determining payment rates for non-physician practitioners for both medical/surgical and MH/SUD benefits. A plan cannot use a different methodology for developing and applying reimbursement rates for nonphysician practitioners providing medical/surgical benefit than it uses for non-physician practitioners providing MH/SUD benefits.

Network adequacy

The FAQ notes that although MHPAEA does not require a plan to ensure that the number of in-network MH/SUD providers and in-network medical/surgical providers are comparable, the plan must utilize a comparable process and apply comparable strategies and evidentiary standards when developing and insuring an adequate network. For example, if a plan uses waiting times for appointments as a factor in assessing network adequacy, and, where appropriate, increases reimbursement rates to accelerate network participation, it must do so comparably for both MH/SUD providers and medical/surgical providers. The FAQ states that as long as the plan takes comparable steps to ensure an adequate number of in-network MH/SUD providers, the plan will not violate MHPAEA, even if there are a disparate number of MH/SUD and medical/surgical providers in the plan's network.

Restrictions on coverage based on type of facility

Coverage restrictions based on facility type are NQTLs. Accordingly, in evaluating an exclusion or other limitation on MH/SUD benefits based on the type of facility, a plan must be able to demonstrate that the exclusion or limitation is based on comparable factors and applied no more stringently than those applied to medical/surgical conditions and justify the disparate treatment to comply with MHPAEA. The FAQ notes that a plan may rely on a mix of statistical, clinical or other factors, such as high incidence of fraud with respect to services in a particular classification, and that the plan should document any factors relied upon in developing and applying this NQTL.

"Step therapy" and "fail-first" step therapy

These protocols are medical management techniques in which a plan will not cover a higher-cost treatment until it is shown that lower-cost treatment is not effective.

Disclosures regarding MH/SUD benefits

The final FAQs include an additional question regarding the model form that ERISA plan participants, or their authorized representatives, may use to request general information regarding MH/SUD benefits and treatment limitations, or to obtain documentation after an adverse benefit determination involving MH/SUD benefits to support an appeal. Use of the specific form is optional. The model form is set out at the end of the FAQs.

Note the quick turnaround!

Plans must respond to disclosure requests within 30 days of receipt of the request. Failure to comply with a disclosure request within this timeframe may result in a penalty of $110 per day.

In closing

The finalization of the FAQs provides another reminder to plan sponsors that they need to evaluate whether their NQTLs comply with MHPAEA and document the basis for any disparities in how they apply to MH/SUD benefits. They should also ensure that processes are in place to respond in short order to participant or provider disclosure requests.

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