SEYFARTH SHAW

Health Care Reform Management Alert Series

Departments Issue FAQs on the Mental Health Parity and Addiction Equity Act and Request Comments on Tobacco Cessation Products

Issue 104

By Benjamin Conley, Joy Sellstrom and Kelly Pointer

This is the one hundred and fourth issue in our series of alerts for employers on selected topics on health care reform. (Click here to access our general Summary of Health Care Reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

On October 26, 2016, the Departments of Health and Human Services, Labor and Treasury (the Departments) published issue 34 of their series of FAQs on the Affordable Care Act, found here. The FAQs discuss the Mental Health Parity and Addiction Equity Act and seek input for future guidance on tobacco cessation coverage as part of preventive care services.

I. Preventive Care: Request for Comments on Tobacco Cessation Coverage

Background: The Departments have issued several pieces of guidance on the Affordable Care Act's requirement to cover preventive care. See our alerts here, here, and here. Non-grandfathered plans must cover tobacco use counseling and intervention as preventive care.

Safe Harbor: What is my plan required to cover in terms of tobacco cessation? In prior FAQs, the Departments said that a plan would be in compliance with this requirement if, for example, the plan covers without cost sharing or prior authorization: (1) screening for tobacco use; and (2) for those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for: (i) four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling); and (ii) all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider. Later the United States Preventive Services Task Force stated that pharmacotherapy and behavioral interventions both are effective and recommended; combinations of interventions are most effective, and all should be offered.

FAQs: Before providing additional guidance on what items and services must be provided without cost sharing, the Departments seek comments on whether the plan may use medical management techniques to determine which categories

of FDA-approved pharmacotherapy interventions must be covered without cost sharing, and whether plans can use medical management techniques to, for example, limit the number of quit attempts per year or limit the types of behavioral interventions that are covered without cost sharing.

II. Mental Health Parity and Addiction Equity Act

Background: As discussed in our February 6, 2014 Management Alert (found here) on the Mental Health Parity and Addiction Equity Act (MHPAEA), a group health plan or policy that includes medical and surgical benefits and mental health and substance use disorder ("mental health") benefits cannot impose financial requirements (e.g., deductibles and co-payments) or quantitative treatment limitations (e.g., number of visits or days of coverage) on mental health benefits that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits (this is referred to as the "substantially all/predominant test"). Additionally, the standards for nonquantitative treatment limitation (NQTL) for mental health benefits in any classification must be comparable to, and no more stringent than, the standards used in applying the limitation for medical and surgical benefits in the same classification.

FAQs: The Departments seek comments on issuing model forms that could be used by participants to request information on NQTLs and introduce a Parity Consumer Web Portal that individuals can use to connect to the appropriate agency for help in obtaining documents or information: www.hhs.gov/mental-health-and-addiction-insurnace-help.

A. Financial Requirements and Quantitative Treatment Limitations: Use of the Plan's Claims Data in Performing the Substantially All/Predominant Test

Background: The substantially all/predominant test is a quantitative analysis and is run using the dollar amount of all plan payments for medical and surgical benefits in the classification expected to be paid under the plan for the plan year.

The MHPAEA regulations established six classifications of benefits:

- *in-patient/in-network,*
- *in-patient/out-of-network,*
- *out-patient/in-network,*
- *out-patient/out-of-network,*
- *emergency care, and*
- *pharmacy benefits.*

Additionally, plans can subdivide outpatient benefits into office visits, and all other outpatient items and services.

FAQs: The FAQs clarify that a plan generally should use its own claims data to perform the analysis. However, the Departments also acknowledge there could be circumstances where the plan's data would not give a fair estimation of the payments to be made. For example, using the plan's data could be unreasonable if there is insufficient data, the plan significantly changed its benefit package, the plan experienced a significant workforce change that would impact claims costs, or the plan design is new. In that case, the plan should use other claims data to make a reasonable projection to conduct actuarially-appropriate analyses. For example, the plan could use data from similarly-structured plans with similar demographics. The assumptions used in choosing a data set and making projections should be documented and, to the extent possible, the claims data should be customized to reflect the plan's characteristics. Any determination that the plan's

claims data is unreasonable should be made by an actuary who is subject to (and meets) the qualification standards for the issuance of a statement of actuarial opinion in regard to health plans in the United States, and who has the necessary education and experience to provide the actuarial opinion.

How often does our plan have to perform the substantially all/predominant test? It depends on the facts and circumstances. We do know the plan is not required to perform the test each year unless there is a change in plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or treatment limitation within a classification (or sub-classification).

B. Nonquantitative Treatment Limitations (NQTLs): Plan Designs that Could Raise Red Flags

Background: A plan may not impose an NQTL with respect to mental health benefits in any classification unless, under the terms of the plan as written and in operation, the NQTL is comparable to and not applied more stringently than NQTLs for medical and surgical benefits in the same classification.

What are some examples of NQTLs?

- *Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;*
- *Formulary design for prescription drugs;*
- *For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;*
- *Standards for provider admission to participate in a network, including reimbursement rates;*
- *Plan methods for determining usual, customary, and reasonable charges;*
- *Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);*
- *Exclusions based on failure to complete a course of treatment; and*
- *Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.*

FAQs: The FAQs provide a number of examples of NQTLs applied inconsistently between mental health and medical and surgical conditions that would violate the MHPAEA, including the following:

- A process for obtaining authorization for inpatient, in-network facilities requiring the participant to obtain an in-person exam for coverage of a mental health condition but allowing a telephone authorization for medical and surgical benefits.
- A requirement that the participant first enroll in an intensive outpatient program before authorizing coverage for inpatient treatment for a substance use disorder where no such program is available in the participant's geographic area. Under the facts provided, a similar requirement exists for medical and surgical benefits. However, the FAQs state that if (i) a fail-first requirement that applies to mental health benefits includes a condition that an individual cannot reasonably satisfy (in this case, first attempting an intensive outpatient program where there are no such programs available), and (ii) the lack of access to programs necessary to satisfy the requirement exists only with respect to mental health benefits,

then the fail-first requirement is operationally applied more stringently with respect to mental health than medical and surgical benefits. This guidance on situations involving lack of access applies for plan years beginning on or after March 1, 2017.

- A requirement that the participant obtain authorization from the plan that buprenorphine is medically necessary for the treatment of his or her opioid use disorder due to safety risks. Under the facts provided, similar safety risks exist for prescription drugs to treat medical and surgical conditions but the plan does not require prior authorization on those drugs.
- A requirement that the participant meet a non-pharmacological fail-first requirement (for example, trying counseling alone) before the plan will authorize coverage for buprenorphine to treat an opioid use disorder. Under the facts provided, similar fail-first requirements could be imposed on prescription drugs covered by the plan for medical and surgical conditions, but are not.
- Stating that the plan follows nationally-recognized treatment guidelines for setting prior authorization requirements for prescription drugs, but deviates from such guidelines for drugs use for an opioid use disorder. The FAQs note that plans can use Pharmacy and Therapeutics (P&T) committees in deciding how to cover prescription drugs and evaluating whether to follow or deviate from nationally-recognized treatment guidelines for setting the prior authorization requirements but these processes must comply with MHPAEA's NQTL standard in operation.
- An exclusion of court-ordered treatment for substance use disorders when the plan does not exclude court-ordered treatment for medical and surgical conditions.

Conclusion

Issue 34 of the Departments' FAQs provides a helpful summary of the requirement to provide tobacco cessation as part of plan's preventive care offerings and practical examples of plan designs and operations that could be red flags as to an MHPAEA violation. In light of the report of the White House Mental Health and Substance Use Disorder Parity Task Force (issued simultaneous with the FAQs) recommending an expansion of MHPAEA compliance audits, and the passage of the 21st Century Cures Act which clarifies the Departments' authority to audit a health plan that has been found to have violated existing mental health parity laws five times (see our Alert here), employers should ensure that benefits provided for mental health and substance use disorder are at least as generous as medical and surgical benefits.

Benjamin Conley, Joy Sellstrom, and Kelly Pointer are members of Seyfarth Shaw's Employee Benefits and Executive Compensation Department. If you would like further information, please contact your Seyfarth Shaw LLP attorney, Benjamin Conley at bconley@seyfarth.com, Joy Sellstrom at jsellstrom@seyfarth.com or Kelly Pointer at kpointer@seyfarth.com, or any member of the Employee Benefits and Executive Compensation Department.