Proposed FAQs About Mental Health and Substance Use Disorder Parity

The U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Departments") released proposed FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX.

The Departments respond to FAQs as part of implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures Act).

Generally, the MHPAEA requires that the financial requirements (for example, coinsurance and copays) and treatment limitations (for example, visit limits) imposed on mental health or substance abuse disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a class.

Similarly, a group health plan or issuer cannot impose a nonquantitative treatment limitation (NQTL) regarding MH/SUD benefits in a class, unless, under the plan's written terms and in its operation, the standards and factors used in applying the NQTL to MH/SUD benefits are comparable to and are applied no more stringently than the standards and factors used in applying the limitation to medical/surgical benefits in the same class.

The MHPAEA regulations include express disclosure requirements. For example, if a participant requests the criteria for medical necessity determinations regarding MH/SUD benefits, then the plan administrator must make the information available to the participant.

To assist plan sponsors with disclosure requests, DOL released a revised draft Mental Health and Substance Use Disorder Parity Disclosure Request that plan sponsors may provide to individuals who request information from an employer-sponsored health plan regarding treatment limitations.

To assist plan sponsors in determining whether a group health plan complies with MHPAEA, the DOL released its Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act.

All public comments to the proposed FAQs and revised draft disclosure request form are due by June 22, 2018.

Here is a summary of the Departments' answers to FAQs:

- A group health plan does not comply with the MHPAEA if it applies an NQTL (of excluding experimental or investigative treatment) more stringently to applied behavioral analysis (ABA) therapy to treat children with Autism Spectrum Disorder than to medical/surgical benefits in the same class.

  In this FAQ, the written plan stated that it excluded experimental or investigative treatment for both MH/SUD and medical/surgical benefits using the same standards. However, in practice, the plan imposed this exclusion more stringently on MH/SUD benefits because it denied all claims for ABA therapy, despite professionally recognized treatment guidelines and randomized controlled trials supporting the use of ABA therapy.

- A group health plan does not comply with the MHPAEA if it applies an NQTL (of defining experimental or investigative treatments as those with a rating below "B" in the Hayes Medical Technology Directory) more stringently to MH/SUD benefits than for medical/surgical benefits.

  In this FAQ, the written plan stated that it uses a rating below "B" for defining experimental. However, the plan applied this standard differently for MH/SUD benefits than for medical/surgical benefits. The plan applied unconditional exclusion of treatments with a "C" rating for MH/SUD benefits while it applied conditional exclusion of treatments with a "C" rating for medical/surgical benefits.

- A health plan does not comply with MHPAEA when it sets prescription medication dosage limits lower than professionally-recognized treatment guidelines for MH/SUD benefits than for medical/surgical benefits.

  In this FAQ, the plan stated that it follows the dosage recommendations in professionally-recognized treatment guidelines to set dosage limits for prescription drugs in its formulary. However, in practice, it set dosage limits to treat opioid use disorder at less than what professionally-recognized treatment guidelines recommend.

- A large group health plan may exclude all benefits for a particular condition or disorder without violating MHPAEA. However, if the plan is insured, then state law would determine whether the exclusion is permitted. In this FAQ, a large group health plan or large insurance coverage provides benefits for prescription drugs to treat both medical/surgical and MH/SUD conditions, but contains an exclusion for items and services to treat bipolar disorder, including prescription drugs. An exclusion of all benefits for a particular condition is not a treatment limitation under the MHPAEA regulations.

- A health plan probably does not comply with MHPAEA if it requires a participant to have two unsuccessful attempts at outpatient treatment before being eligible for inpatient in-network SUD benefits while only requiring one unsuccessful attempt at outpatient treatment to be eligible for inpatient in-network medical/surgical benefits.

- A health plan does not comply with MHPAEA if it reduces reimbursement rates for non-physician practitioners providing MH/SUD services while it does not use a comparable process of reimbursement of non-physician providers of medical/surgical services.

- A health plan does not comply with MHPAEA if, in developing its medical/surgical provider network, it attempts to ensure that participants can schedule an appointment within 15 days for non-urgent care while the plan doesn't use an appointment availability standard in developing its MH/SUD provider network.

- A health plan does not comply with MHPAEA if it excludes all inpatient, out-of-network treatment outside of a hospital setting for eating disorders, while it covers inpatient, out-of-network treatment outside of a hospital setting for medical/surgical conditions if the prescribing physician obtains plan authorization and the treatment is medically appropriate.

- If a participant with an MH/SUD receives benefits for emergency care for a particular acute condition, then the facts of the case would determine whether the acute condition is defined as a medical condition or an MH/SUD condition.

- If an ERISA-covered plan utilizes a network, its summary plan description (SPD) must provide a general description of the provider network. The list of providers in that SPD must be up-to-date, accurate, and complete (using reasonable efforts). The list may be provided as a separate document that accompanies the plan's SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect.

  An ERISA-covered plan must disclose a summary of material modifications or changes in the information required to be included in the SPD not later than 210 calendar days after the close of the plan year in which the modification or change was adopted.

- ERISA-covered plans that use provider networks may use a hyperlink or URL address for an MH/SUD provider directory in enrollment and plan summary materials, as long as the DOL's electronic disclosure safe harbor requirements are met.

5/1/2018