Do Your Mental Health and Substance Abuse Benefits Meet New Standards?

In response to the growing heroin and prescription drug abuse epidemic, the Obama administration announced in March 2016 the formation of a Mental Health and Substance Use Disorder ("MHSUD") Parity Task Force to make sure Americans receive the care they need to treat mental health and substance use disorders – care to which they are entitled under Federal law.

The Task Force issued its report to the President in October 2016. The following recommendations are some of the most important ones group health plan sponsors should pay attention to:

- Increase federal agencies' capacity to audit health plans for parity compliance
- Allow the Department of Labor ("DOL") to assess civil monetary penalties
- Release data annually on closed Federal parity investigations, results and violations

Now is the time to review the mental health and substance use disorder benefits covered under your group health plans. Do they comply with Federal and state laws, such as the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* ("MHPAEA") and the *Affordable Care Act* ("ACA") *of 2010*?

A Brief History of the Mental Health and Substance Use Disorder Federal Laws

The Mental Health Parity Act of 1996 generally required fully insured and self-funded group health plans with 50 or more employees to apply the same annual and lifetime dollar limits to mental health benefits as medical/surgical benefits. Plans could still apply different deductibles, copayments and coinsurance, as well as incorporate different visit and day limits for mental health services compared to medical/surgical benefits. As a consequence, mental health benefits could continue to be more costly to employees and provide less coverage than comparable medical/surgical benefits. Substance use disorder benefits were not considered in this legislation.

MHPAEA addressed many of the initial law's shortcomings. This bill requires full parity with a plan's medical/surgical benefits for mental health as well as substance use disorder benefits. MHPAEA generally applies to fully insured and self-funded plans with 50 or more employees.

MHPAEA **prohibits group health plans from imposing more restrictive treatment and financial limitations** on mental health and substance use disorder benefits than are applied to the medical/surgical benefits. **Treatment limitations** include the frequency of treatment, number of visits, days of coverage and scope or duration of the coverage. **Financial limitations**, such as deductibles, copayments, coinsurance and out-of-pocket expenses, cannot be more onerous than the plan's medical/surgical benefits. The plan must provide out-of-network MHSUD benefits if the plan offers out-of-network benefits for medical/surgical care.

In addition, **non-quantitative treatment limitations** can be no more restrictive than the plan's medical/surgical benefit limitations, some of which include:

- 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
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers)
- 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
- 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

Under updates made to the ACA in 2014, preventive screenings for depression and alcohol abuse must be made available at no cost to covered members (non-grandfathered plans). MHSUD benefits are considered essential health benefits ("EHB"), which must be covered under individual and insured small group health plans that incorporate the provisions and protections of the MHPAEA. The ACA also eliminates the imposition of annual and lifetime dollar limits for in-network EHBs, including MHSUD benefits, and requires all in-network out-of-pocket costs for EHBs track to a single annual out-of-pocket maximum limitation. (The only exception to this dollar limit rule are grandfathered group health plans that aren't subject to the ACA annual out-of-pocket limitation restrictions.)

Large group health plans, self-funded group health plans and grandfathered group health plans while not required to cover MHSUD benefits must offer MHSUD benefits on par with medical/surgical benefits without any annual and lifetime dollar limits when made available under the plan.

The President's MHSUD Task Force

The President charged the MHSUD task force to review parity implementation and provide recommendations to:

- Increase awareness of parity protections
- Improve understanding of the parity requirements and protections under the law for consumers, employers, insurers and state regulators
- Increase transparency of the compliance process and of the support, tools and resources available to ensure compliance with parity
- Improve the monitoring and enforcement process

First – the good news. The task force concluded that "employers and health plans have made progress in complying with MHPAEA, particularly in identifying and eliminating inequities in financial and quantitative treatment limitations (like different copays or visit limits)."

However, DOL investigations uncovered a variety of impermissible MHSUD non-quantitative treatment limitations under group health plans. These non-quantitative treatment limitations can be more subjective in nature and sometimes difficult to analyze, as the MHPAEA law and implementing regulations are quite complex. Four common types of non-quantitative treatment limits that may raise concerns (and how to evaluate them) are:

- **Prior authorization**: Review the processes and procedures a participant must take to get approval from the plan or issuer before a MHSUD service or medication is covered compared to the medical/surgical procedures
- **Utilization review**: Determine whether the review process to assess a course of treatment for MHSUD benefits is imposed more frequently or stringently than it is for medical/surgical benefits.
- **Fail-first or step therapy**: Consider whether fail-first policies, such as requiring a certain treatment regimen before admission to an inpatient facility is granted, are being applied more stringently to MHSUD benefits than medical/surgical benefits
- **Provider reimbursement rates**: Check to see if behavioral health and substance use disorder providers are reimbursed at lower levels, since concerns have been raised that reimbursing providers at lower levels may limit the scope of the network for MHSUD benefits

Many comments provided to the task force suggested that additional guidance on the parity requirements for non-quantitative treatment limits would be helpful. State regulators would like to see additional checklists and tools on how to review insurance plan parity provisions for insured plans offered in their states. In the meantime, plan sponsors should review MHSUD parity compliance with insurers and/or third-party administrators to uncover any potential trouble spots.

What Was Accomplished

The task force presented its findings along with initial steps to implement its recommendations, including:

- **Supporting consumers and expanding education**: The Department of Health and Human Services ("HHS") created a consumer web portal to help plan participants better understand their parity rights (currently in Beta format and seeking public input). In addition, a Consumer Guide to Disclosure Rights brochure is available to explain what information the plan and/or issuer must provide to covered participants. Covered employees will have access to this information, which could potentially lead to more requests for information and additional mental health and substance use disorder appeals when claims are denied or approval procedures appear onerous.
- **Improving parity implementation and compliance**: Earlier this year, regulators issued a Warning Signs document to help plan sponsors identify non-quantitative treatment limits that may warrant more scrutiny. In conjunction with the task force, the Department of the Treasury ("Treasury"), DOL and HHS created a Compliance Assistance Materials Index to place all MHSUD parity-related guidance in one place. These departments also released in October 2016 FAQs about Affordable Care Act Implementation Part 34, which provides examples of non-quantitative treatment limitations (many of which address opioid addiction) that do not comply with parity laws, since similar limitations are not imposed on the plan's medical/surgical benefits.

The information provided in the task force report sheds light on the continuing importance regulators are placing on raising awareness of consumer rights and protections for mental health and substance use disorder benefits. The report also confirms regulators' commitment to ensure that these services are provided as robustly as medical/surgical benefits. We can expect more tools and guidance to help plan sponsors properly design and implement mental health and substance use disorder benefits in the future.

Get more information about mental health and substance use disorder parity at the DOL's website.