

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VII) AND MENTAL HEALTH PARITY IMPLEMENTATION

November 17, 2011

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the market reform provisions of the Affordable Care Act, as well as FAQs regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). These FAQs have been prepared jointly by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/>), these FAQs answer questions from stakeholders to help people understand the new law and benefit from it, as intended.

The Departments anticipate issuing further responses to questions and issuing other guidance in the future. We hope these publications will provide additional clarity and assistance.

SUMMARY OF BENEFITS AND COVERAGE

Q1: On August 22, 2011, the Departments issued proposed regulations and proposed templates in connection with implementation of the Summary of Benefits and Coverage and Uniform Glossary requirements of PHS Act § 2715. An applicability date “beginning March 23, 2012” was proposed. At the same time, the Departments invited comments generally, as well as on a range of discrete issues, including the timing of the application of the SBC requirement.

My plan anticipates that preparation of the summary of benefits and coverage will take several months and require significant resources. In light of the March 23, 2012 proposed applicability date, we are considering moving forward with implementation of the Summary of Benefits and Coverage requirements, using the proposed rules and templates, but are concerned that the final rules and templates will differ from the proposed rules and templates, which would prompt additional implementation costs. What is the timeline for the issuance of future guidance on the summary of benefits and coverage? What actions should my plan be taking now, if any?

The Departments received many comments on the proposed regulations and templates and intend to issue, as soon as possible, final regulations that take into account these comments and other stakeholder feedback.

PHS Act section 2715 provides that group health plans and health insurance issuers shall provide the Summary of Benefits and Coverage and Uniform Glossary pursuant to standards developed by the Departments. Accordingly, until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act section 2715.

It is anticipated that the Departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.

THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplemented the Mental Health Parity Act of 1996 (MHPA). Generally, MHPAEA specifies that the financial requirements and treatment limitations imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits.¹ MHPAEA also prohibits separate financial requirements or treatment limitations that are applicable only to mental health or substance use disorder benefits. On February 2, 2010, the Departments published interim final rules implementing MHPAEA.² Previously-issued FAQ guidance was jointly prepared by the Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) and published on June 30, 2010 (<http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>) and December 22, 2010 (<http://www.dol.gov/ebsa/faqs/faq-aca5.html>).

Under MHPAEA and the Departments' interim final rules, a group health plan or group health insurance issuer generally cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits in any of 6 classifications³ that is more restrictive than the financial requirements or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits in the same classification. Thus, if a plan generally applies a \$25 copayment to at least 2/3 of outpatient, in-network, medical/surgical benefits, a higher copayment could not be imposed on outpatient, in-network mental health or substance use disorder benefits.

In addition to financial requirements and quantitative treatment limitations, plans and issuers often impose nonquantitative treatment limitations, such as:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods used to determine usual, customary, and reasonable fee 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); and
- Exclusions based on failure to complete a course of treatment.

The parity standard for nonquantitative treatment limitations does not require applying a simple arithmetic test to compare the treatment of mental health or substance use disorder benefits to the treatment of medical/surgical benefits. The Departments' interim final rules provide that,

¹ MHPAEA does not require plans to cover mental health and substance use disorder benefits. It applies only if a plan chooses to provide those benefits.

² 75 FR 5410.

³ The six classifications of benefits defined in the interim final rules are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.

The following FAQs answer questions from stakeholders regarding nonquantitative treatment limitations, and one other common question, to help people understand the law and benefit from it, as intended. In addition to publishing these clarifying FAQs, the Departments will continue to investigate complaints by providers, consumers, and others and will take enforcement action for violations to ensure compliance with current law.

Q2: For all mental health and substance use disorder benefits, my group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary, but the plan does not require such prior authorization for any medical/surgical benefits. Is this permissible?

No. The plan is applying a nonquantitative treatment limitation to mental health and substance use disorder benefits that is not applied to medical/surgical benefits. This violates MHPAEA's prohibition on separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

Q3: My group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given for only one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. Is this permissible?

No. The plan is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits. While some differences in prior authorization practices with respect to individual conditions or treatments might be permissible based on recognized clinically appropriate standards of care, the interim final regulations do not permit a plan to apply stricter nonquantitative treatment limitations to all benefits for mental health or substance use disorders than those applied to all medical/surgical benefits. The application of nonquantitative treatment limitations -- both with respect to the plan's benefits and its care management practices -- must comply with the nonquantitative treatment limitation rules.

Q4: My group health plan considers a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others.

For example, under my plan, prior authorization is required for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented.

Has my plan complied with the nonquantitative treatment limitation rules?

Yes. It appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.

Q5: I am an employer considering several health insurance policy options. One health insurance policy requires prior authorization for all outpatient mental health benefits but only a few types of outpatient medical/surgical benefits (outpatient surgery; speech, occupational and physical therapy; and skilled home nursing visits.) Is this permissible?

While some differences in plan requirements for prior authorization might be permissible based on recognized clinically appropriate standards of care, it is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior authorization would also result in all outpatient mental health and substance use disorder outpatient benefits needing prior authorization.

Q6: A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorder conditions, but only 30 percent of medical/surgical conditions. Is this permissible?

Yes. The evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.

Q7: Is my group health plan always limited in the amount that it can charge for all mental health/substance use disorder providers to the same rate as medical/surgical generalists?

No. The standard for determining the maximum copayment that can be applied to mental health/substance use disorder benefits is determined by the predominant copayment that applies to substantially all medical/surgical benefits within a classification. If the copayment that meets this standard is the one charged for a medical/surgical specialist, that copayment can be charged for all mental health/substance use disorder benefits within that classification. On the other hand, if the copayment that meets this standard is the one charged for a medical/surgical generalist, then that is the copayment that can be charged to all mental health/substance use disorder benefits within that classification.