Final FAQs, Model Disclosure Form, and Enforcement Fact Sheet Regarding 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 final FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39. 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).

The Departments provide a model disclosure form that employees can use to request information from their group health plan or individual market plan regarding treatment limitations that may affect access to mental health or substance use disorder (MH/SUD) benefits. The form can be used for general information requests regarding MH/SUD benefits and can also be used to obtain documentation after an adverse benefit determination to support an appeal. Use of the form is optional and plans and issuers may use their own disclosure forms.

The DOL also released an enforcement fact sheet summarizing the DOL's closed investigations and public inquiries regarding mental health and substance use disorder during the 2018 fiscal year. An appendix to the fact sheet was released that references the MHPAEA Final and Interim Final Rules and the guidance the Departments have issued for each category of violation cited in the fact sheet. The DOL also released an introduction to the fact sheet that provides an overview of its MHPAEA fiscal year 2018 enforcement strategy.

Generally, the MHPAEA requires that the financial requirements (for example, coinsurance and copays) and treatment limitations (for example, visit limits) imposed on 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.

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The Departments intend to provide additional MHPAEA implementation information on a rolling basis. The most current information can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity and https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html#Mental%20Health%20Parity.

Here is a summary of the Departments' answers to the 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.

  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.

  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 reviewed claims for medical/surgical treatments with a "C" rating to determine whether an exception was medically appropriate while claims for MH/SUD treatments with a "C" rating were denied without review.

- 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.

  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.

  The Departments note that plans and issuers may use Pharmacy and Therapeutics (P&T) committees as an alternative to following professionally-recognized treatment guidelines to decide how to cover prescription drugs and evaluate whether to follow or deviate from professionally recognized treatment guidelines for setting dosage limits. However, use of P&T committees to inform dosage limits must comply with the MHPAEA's NQTL standard in practice. The expertise of the P&T committee in MH/SUD conditions must be comparable to their expertise in medical/surgical conditions. The committee's evaluation of nationally-recognized treatment guidelines in setting dosage limits for medications for MH/SUD conditions and medical/surgical conditions must be comparable.

- A large group health plan may exclude all benefits for a particular condition or disorder without violating MHPAEA.

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- 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 for 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 a comparable 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 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.
- 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.

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