Departments Issue FAQs Providing Implementation Guidance on the Mental Health Parity and Addiction Equity Act of 2008 and the 21st Century Cures Act

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On September 5, 2019, the Departments of Labor, Health and Human Services, and Treasury ("Departments") released guidance (the "FAQs") with examples of applications of Nonquantitative Treatment Limitations ("NQTL") that could violate the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The FAQs clarify that a health plan's administration of the plan rules may violate MHPAEA even if the plan language on its face provides that the NQTL applies to both medical/surgical and mental health/substance use disorder ("MH/SUD") benefits. This signifies that a plan's actions are as important as its terms. In addition, the FAQs reiterate the plan's obligations under law to provide participants, upon request, with documentation related to the development and application of a NQTL, and provide a model disclosure form for this purpose for participants to use. The FAQs also contain guidance on network provider disclosure requirements.

As background, the MHPAEA allows a NQTL to be imposed on an MH/SUD benefit only if, under the terms of the plan and as applied, the processes, strategies, evidentiary standards and other factors used by the plan in applying a NQTL to an MH/SUD benefit are comparable to, and applied no more stringently than, those same standards used in applying a NQTL to medical/surgical benefits in the same classification. (Classifications include in-network, out-of-network, in-patient, out-patient, etc.) The FAQs provide a number of examples where a plan applied a NQTL more stringently for MH/SUD benefits generally, or just certain MH/SUD benefits, than for medical/surgical benefits, even though the plan terms stated that the NQTL applied to both types of benefits.

For example, one FAQ describes a plan that excluded experimental or investigational treatments, defined as those treatments with a rating below "B" in the Hayes Medical Technology Directory, with an exception for treatments with a "C" rating only where determined to be medically appropriate. However, in practice, the plan approved certain medical/surgical benefits with a "C" rating under the medically appropriate exception but denied all treatments for MH/SUD benefits with a "C" rating because it never reviewed whether such treatments are medically appropriate. The FAQ states that this violates the MHPAEA because it is not using comparable procedures for both types of benefits.

The FAQs provide further examples of how other types of NQTLs, such as step therapy requirements, dosage requirements, in-network provider reimbursement rates, and network admission standards, could violate MHPAEA as applied. The FAQs reiterate that participants can request documents from the plan to demonstrate that an NQTL is being applied consistently with the law and can request any and all factors used to develop such an NQTL. Plans are obligated by law to provide such documents and are potentially subject to penalties of $110 per day under ERISA if the documents are not provided within 30 days of the participants'

request. For example, in order to satisfy its disclosure obligations to participants under law in the example described above, the FAQ says that the plan should document in writing the availability and requirements of its exception process, as well as the factors relied upon in determining how the exception process applies to both medical/surgical and MH/SUD benefits.

To assist participants in making such requests, the FAQs include a final version of a model disclosure form for participants to use. The form is set up so that participants can easily request the following: (1) the factors used in the development of the NQTL; (2) the sources used to evaluate the factors (e.g., evidentiary standards); and (3) evidence or documentation that the NQTL complies with the above rules, as applied. The form also explicitly states that the plan must respond within 30 days from the date of receipt. Typically, plans rely on service providers (e.g., PPO network providers, PBMs) to assist in developing these criteria and to apply it consistently for claims administration and processing purposes. Because of the short deadline, the potential penalties linked with noncompliance, and the possibility that plans may receive these form requests more frequently in the future, plans may want to consider putting their providers on notice that if such a request is made, immediate responses will be needed so that the plan can respond timely. Plans also may want to consider contractual amendments with providers to address these reporting issues and to ensure a timely response.

The FAQs also clarify that plans can provide a list of network providers via an internet address or a hyperlink and that this address should be part of any SBC. This will satisfy the obligation to provide information regarding provider networks in the DOL's SPD disclosure rules.

Please contact Slevin & Hart for more information about these FAQs and how they could affect your plan's compliance with MHPAEA.

Attorneys

Paul Esposito

Hillary Webb