KINNEY&LARSON LLP

Frequently Asked Questions Part 31 - New Insight for the Mental Health Parity and Addiction Equity Act and Other Group Health Plan Mandates.

By Phil Larson - April 2016

On April 20th, 2016, agency guidance from the Department of Labor, Health and Human Services, and Treasury provided what many may consider new information on several compliance obligations for health plans and other related entities. The guidance is meant to be clarifications on previously issued rules, not necessarily new law, but some aspects of the guidance will likely require new changes for entities.

This memo will attempt to shed light on several compliance obligations found in the new Q&As. The Q&As primarily covered several issues with the Mental Health Parity and Addiction Equity Act (MHPAEA), then focused on several other aspects of health plan compliance tied to market reforms under the Affordable Care Act (ACA) and other plan obligations.

Mental Health Parity and Addiction Equity Act Provisions:

On March 29th, 2016, the White House also published a memorandum creating a task force on mental health and substance abuse parity to ensure compliance.

PLAN LEVEL TESTING METHODOLOGY: MHPAEA has several testing requirements tied to it to verify limits provided for under mental health or substance abuse can pass certain mathematical thresholds. This is to show that these limits are on par with other plan benefits. The testing is already complicated and some vendors were testing MHPAEA against the data for their book of business. A Q&A seems to require the testing for plans at the specific plan level, not compared to the entire book of business. This requirement seems to apply to all forms of testing, whether for the "substantially all" or the "predominant" testing methodology. If an issuer does not have sufficient data to calculate the substantially all and predominant tests at the plan level, it can use data at the product level (provided certain requirements are met).

ALL PARTS OF THE PLAN NEED COMPLIANCE: In order to ensure compliance, each sub-vendor of the plan will also need to comply. If any plan differences apply for a mental health sub-vendor for example, then those differences must go through testing as described above. This could mean that any limits (including process limits) provided for by sub-vendors of the plan may need to be tested with specific plan data to ensure their processes are in compliance. The included example was for Managed Behavioral Health Organizations (MBHO) or similar entities that administer mental health or substance abuse benefits under the plan. MHBOs can be independent organizations, part of a health plan, or can be supported by health care providers.

STRONG ACCESS RIGHTS TO DOCUMENTS: The MHPAEA provides for very strong access rights of not only plan participants but providers to show compliance. This can include but not be limited to:

- A Summary Plan Description (SPD) from an ERISA plan, or similar summary information that may be provided by non-ERISA plans;
- The specific plan language regarding the imposition of limits (such as a preauthorization requirement);
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining that the limit will apply;
- Information regarding the application of the limits to any medical/surgical benefits within the benefit classification at issue;
- The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which the limits will apply to any medical/surgical benefits within the benefit classification at issue; and
- *Any analyses performed by the plan as to how the limit complies with MHPAEA*.

MEDICAL NECESSITY DETERMINATION FOR ALL: Part of the MHPAEA analysis may include a determination that the provision meets medical necessity. The recent Q&As also point out that medical necessity determinations tied to MHPAEA compliance can be requested from participants, *potential participants* or contracting provider upon request.

MEDICATION ASSISTED TREATMENT (MAT): Finally, the recent Q&As provide that FDA approved medication for detoxification or maintenance treatment tied to behavior health services may fall under the MHPAEA rules. The Departments' final regulations implementing MHPAEA define "substance use disorder benefits" under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law which must be consistent with generally recognized medical standards. In addition, the special rule for multi-tiered prescription drug benefits also applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as needed.

Other Market Reform Requirement Provisions:

In January 2016, the Department of Labor provided a 300-page summary of MHPAEA to congress outlining enforcement and compliance.

DISCLOSURE REQUIREMENTS. The Q&As confirm that any data or documentation used to calculate payment standards for benefits (including usual and customary reimbursements or UCR) are instruments under which the plan is established or operated and subject to disclosure laws. This may be required under ERISA disclosure provisions, the DOL claims procedures, as well as internal and external review requirements tied to the ACA.

CLINICAL TRIALS. The Q&As confirm that the requirement to provide coverage relating to clinical trials is subject to the current plan coverage (if any) but cannot deny coverage for complications or adverse events (side effects) tied to clinical trials. For example, if chemotherapy is allowed for cancer, it may be required for some clinical trials (e.g. chemotherapy provided under clinical trial for anti-nausea medication).

RESCISSIONS. The Q&As remind plans that only in limited cases can plan coverage terminate retroactively (e.g. fraud or failure to pay as permissible examples).

REFERENCED BASED PRICING OR FIXED FEES. Some health plans outside of the marketplace, the individual and small group markets are not subject to the Essential Health Benefit package requirements, found in §1302(a) of the ACA. These plans, if not subject to grandfather must still meet limitations on cost sharing under §2707(b) of the PHS Act. For 2016, the maximum out of pocket amounts are $6,850 per individual and $13,700 for family. A recent Q&A points out one danger of reference based prices or fixed fee amounts (including similar network designs) *if the plan does not ensure that the participants have adequate access to quality providers*. Specifically, this can impact the in-network maximum out-of-pocket calculations by including these out-of-pocket expenses toward the maximums under §2707(b). This reinforces earlier FAQs on this point from October 2014 (Part 21).

PREVENTIVE CARE**.** The guidance offers a reminder that the required preparation for a preventive screening is still part of the requirements to provide preventive care. For example, prescribed bowel preparation medications *are an integral part* of the preventive screening colonoscopy. Just like the colonoscopy, these medications must also be covered without cost sharing, subject to reasonable medical management.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)**.** The Q&As reminds plans that required coverage under the WHCRA includes all stages of reconstruction of the breast on which the mastectomy was performed. This is not only for the surgery and reconstruction of the other breast, but also coverage to produce a symmetrical appearance, prostheses, physical complications of the mastectomy (e.g. Lymphedema), coverage for nipple and areola reconstruction and re-pigmentation.

These rules are complicated and entities should be careful about many of these details. If you need assistance understanding any of these rules, MHPAEA compliance or the ACA generally, please contact Kinney & Larson LLP.

Phil Larson Phil.Larson@kinneyandlarson.com (952) 405-8641

KINNEY&LARSON LLP

Mark Kinney Mark.Kinney@kinneyandlarson.com (952) 892-7022