Sibson Consulting

update

Compliance News for Plan Sponsors

December 16, 2015

New Guidance on the Mental Health Parity and Addiction Equity Act

The Departments of Labor, Treasury, and Health and Human Services recently released guidance on certain aspects of the Mental Health Parity and Addiction Equity Act (MHPAEA). This guidance includes answers to Frequently Asked Questions (FAQs) addressing disclosure requirements under the MHPAEA,[1] as well as final regulations on how external review requirements under the Affordable Care Act[2] affect the MHPAEA.[3] This *Update* provides background information on the MHPAEA and summarizes the new guidance.

Background

The MHPAEA requires parity between medical/surgical benefits and mental health/substance use disorder benefits. Compliance with the MHPAEA requires that health plans provide parity in both numerical or "quantitative" financial requirements or treatment limits (*e.g.*, cost-sharing and day or visit limits) and "nonquantitative" treatment limits (*e.g.*, tools to manage the mental health or substance use disorder benefit).[4] Importantly, prior authorization requirements, determinations that a treatment is experimental, methods for reimbursing providers, step-therapy programs, and restrictions based on geographic location or facility type must meet the parity requirements.

The MHPAEA regulations include two disclosure requirements applicable to plan administrators (or to the plan's health insurer, if the coverage is insured). Plan administrators must:

- Provide detailed criteria for medical necessity determinations relating to mental health or substance use disorder benefits to any current or potential participant, beneficiary or contracting provider who requests this information; and
- Provide the reason for any denial of benefits or payment to the affected participant or beneficiary.

With respect to the second requirement, the reason for the denial must be provided in a manner that is consistent with the claims and appeals rules under the Employee Retirement Income Security Act (ERISA).

Health Compliance News Highlights:

- A plan administrator or health insurer cannot refuse to provide the plan's medical necessity criteria on the basis that the information is proprietary or has commercial value.
- A plan administrator or health insurer may provide an understandable summary of the plan's medical necessity criteria, but this not a substitute for providing the actual criteria when requested.
- Some determinations made by non-grandfathered plans are subject to external review.

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[1] The answers to these FAQs are available on the Department of Labor's website.

[2] The Affordable Care Act is the shorthand name for the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-152.

[3] These final regulations are discussed in Sibson Consulting's December 16, 2015 *Update*, "Departments Release Series of Final Rules Under the Affordable Care Act."

[4] For background information on the final MHPAEA regulations, see Sibson's January 22, 2014 *Capital Checkup*, "Final Rule on the Mental Health Parity and Addiction Equity Act."

Answers to FAQs on MHPAEA Disclosure Requirements

Plan administrators (or the plan's health insurer, if the coverage is insured) must provide a copy of the plan's medical necessity criteria when requested. A request for the plan's or insurer's medical necessity criteria and supporting information cannot be denied on the basis that the information is proprietary or has commercial value. Plan administrators and insurers may provide a summary of the medical necessity criteria, intended to be read by a layperson, but providing such a summary is not a substitute for providing the actual underlying medical necessity criteria when that information is requested.

Final Rules on External Review

The Affordable Care Act requires that non-grandfathered plans offer external review of adverse benefit determinations that involve medical judgment, if requested by the participant. Most plans will meet this requirement by contracting with three Independent Review Organizations (IROs). Final MHPAEA rules state that a determination of whether a plan or insurer is complying with the nonquantitative treatment limitation provisions of the MHPAEA is a medical judgment subject to external review. For example, a determination that inpatient treatment for a mental health condition is not medically necessary is based on a medical judgment and would be subject to external review.

Implications for Plan Sponsors

Plan sponsors that develop their own medical necessity criteria must be able to provide copies of this information when requested. They also need to ensure that these criteria are developed and applied in a manner that is consistent with the MHPAEA.

Plan sponsors that rely on outside mental health or substance use disorder service providers or managed care organizations need to ensure that these organizations have developed these criteria and are applying them in a manner consistent with the MHPAEA. Plan sponsors should ask their service providers for assurance that they are complying in all respects with the MHPAEA. When one organization administers medical/surgical benefits and a separate one administers mental health or substance use disorder benefits, it can be more difficult to ensure that benefits are administered consistently with the MHPAEA.

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If you would like additional information about this news, please contact your Sibson consultant or the Sibson office nearest you. Sibson can be retained to work with plan sponsors and their legal counsel on compliance issues.

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