ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan, Steven Mindy, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

DOL issues comprehensive compliance guidance for Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act (MHPAEA) amended ERISA, the Internal Revenue Code, and the Public Health Service Act to require most group health plans to satisfy certain requirements with respect to financial and treatment limitations. These requirements are generally designed to ensure parity between medical/surgical and mental health and substance use disorder benefits—and in some cases, to ensure better treatment for mental health and substance use benefits. Since the enactment of the MHPAEA, the DOL has issued final regulations and numerous FAQs to assist stakeholders with MHPAEA compliance. Then, in 2016, Congress passed the 21st Century CURES Act, which—among other things- amplified certain notice and disclosure requirements in the MHPAEA, clarified that eating disorders are mental health conditions, and required the Department of Labor to solicit feedback and provide compliance tools for stakeholders.

Now, the DOL has issued three additional; items designed to assist stakeholders with compliance:

- An MPHAEA Enforcement Overview;
- A proposed FAQ (comments are due by June 22); and
- An MHPAEA self-compliance tool

These three very helpful items couldn't come at a better time as DOL audit activity continues at a high level (as evidenced by the enforcement overview) and the litigation trend seems to be increasing. The rules are very complicated and stakeholders continue to struggle to make sense of it all despite all of the guidance. This article addresses the key points of the most recent guidance identified above but we encourage stakeholders to become familiar with all of the guidance to help mitigate the ever increasing risk associated with the MHPAEA.

Enforcement Overview[1]

The enforcement overview provides stunning statistics regarding DOL activity with respect to the MHPAEA that underscore the need to become intimately familiar with the MHPAEA rules. The DOL notes that it closed 347 investigations in 2017 and out of those, 187 involved plans subject to MHPAEA—each of which was reviewed for MHPAEA compliance. Of those 187 MHPAEA compliance reviews, the DOL found 92 violations. The message—if your plan is subject to the MHPAEA and if you are audited, the DOL will review for MHPAEA compliance and there is good chance that a violation will be cited.

The enforcement overview also proclaims the work the DOL is doing to pursue voluntary compliance. The DOL employs over 100 benefit advisors who provide education and compliance assistance and those benefit advisors answered 127 public inquiries in 2017 related to MHPAEA. The goal of the benefit advisor is to obtain compliance without referring such matters for investigation.

FAQs[2]

The proposed FAQs focus on two very important aspects of the MHPAEA: non-quantitative treatment limitations and disclosure.

Non-quantitative treatment limitations

The non-quantitative treatment limitation ("NQTL") requirements of the MHPAEA have proven to be one of the most challenging aspects of MHPAEA compliance because they are not based on objective mathematical formulas like the financial and quantitative treatment limitation requirements. The MHPAEA final regulations indicate that a group health plan (and a health insurance issuer) may not impose a NQTL with respect to mental health/substance use disorder benefits in any classification unless, under the terms of the plan--*as written and in operation*--any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health/substance use disorder

benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification. It has been quite the challenge to identify, first and foremost, what constitutes a NQTL. This FAQ and the prior FAQs issued by the DOL have gone a long way to help address that challenge. In addition, it has also been a challenge to determine whether the plan uses comparable standards and strategies and whether they are applied more stringently to mental health/substance use benefits. This proposed FAQ helps to clarify those issues to some extent.

Highlights include:

- The FAQ clarifies that an exclusion of <u>all</u> benefits for a particular condition or disorder is not a NQTL for purposes of the MPHEA rules. For example, a general exclusion under a plan for items and services to treat bipolar disorder, including prescription drugs, is not an NQTL even though the plan provides prescription drug benefits for medical /surgical benefits.

- When a plan covered services or treatments for eating disorders but excluded coverage for eating disorder services provided in an inpatient, out-of-network setting outside of a hospital (e.g, a residential treatment center), the plan violated the NQTL rules when the plan covered such treatments for medical/surgical conditions when there is physician authorization and determination that the treatment is medically appropriate based on clinical standards of care.

- A plan's terms indicate that claims for medical/surgical and mental health/substance use disorder benefits are denied as "experimental and investigative" when no professionally recognized treatment guidelines define clinically appropriate care for a condition and fewer than two randomized controlled trials are available to support the treatment's use for that condition. For example, autism satisfies the plan's definition of mental health conditions. In the past year the plan denies all autism related ABA therapy claims as experimental and investigative even though more than one professional recognized guideline existed and more than two randomized trials exist to support the use of ABA therapy to treat autism but approves any medical/surgical claim for benefits that meets the same criteria. The plan violates the NQTL rules.

- The plan violates the NQTL rules when it sets dosage limits for buprenorphine, an opioid addiction treatment drug, that are less than the professionally-recognized treatment guidelines but sets dosage limits for all medical /surgical drugs at or above the professionally recognized guidelines.

- Where a plan requires a participant to have two unsuccessful attempts at outpatient substance use disorder treatment to be eligible for inpatient benefits but only requires one unsuccessful attempt at outpatient medical/surgical benefits, the plan violates the NQTL rules *unless the plan can demonstrate that evidentiary standards or other factors were utilized comparably to develop and apply the differing step therapy requirements.*


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- A plan violated the NQTL rules where it paid the same reimbursement rates for approved physician and non-physician providers of medical/surgical benefits but paid a lower rate for non-physician providers of mental health/substance use disorder services than it paid physician providers of the same services.
- A plan violated the NQTL rules where it ensured that participants could schedule an appointment with a network provider within 15 days for non-urgent medical/surgical care but did not ensure the same with respect to network providers of mental health/substance use disorder care.

Disclosure

The MHPAEA final regulations require plan administrators to disclose the criteria for medical necessity determinations with respect to mental health/substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request. In accordance with ERISA Section 104(b), these documents must be provided within 30 days to avoid a penalty. This FAQ reminds stakeholders that "instruments" governing the plan required to be disclosed under Section 104(b) of ERISA would include any information on medical necessity criteria for medical/surgical benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

This FAQ also provides a cite to a revised disclosure model form, which was required by the Cures Act, and indicates that OMB is requesting comments on the Form, which are due June 22, 2018. You can find the revised form at https://www.reginfo.gov/public/do/PRAICList?ref_nbr=201706-1210-001.

Self-Compliance Tool[3]

The DOL has also issued an updated self-compliance tool for MHPAEA compliance. The tool asks a series of questions designed to help stakeholders determine whether the plan complies with the MHPAEA. Below is a summary of helpful reminders and tips included in the tool:

- Medically Assisted Treatment for opioid disorder and treatments for eating disorders are subject to the MHPAEA;
- Plans may divide the outpatient classifications into two sub-classifications—office visits and other. Sub-classifications for specialist office visits and general physician office visits are not permitted;
- A plan may divide benefits furnished on an in-network basis into sub-classifications that reflect network tiers (such as preferred provider and participating provider).
- The 2/3 substantially all test is based on payments expected to be paid for the plan year and that running that test across a "book of business" is permitted only when the plan has insufficient data to do a reasonable projection of future claims.
- Plans should clearly define which benefits are treated as medical/surgical and which are mental health/substance use.
- Factors that may be included in any NQTL design include but are not limited to:
    - Excessive utilization
    - Recent medical escalation
    - Provider discretion in determining diagnosis;
    - Lack of clinical efficiency of treatment or service
    - High variability in cost per episode per care;
    - Claim types with a high percentage of fraud.

All stakeholders should take the time to carefully review this self-compliance tool and apply it to the plans they sponsor or administer. ■

References

1 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf

2 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-proposed.pdf

3 https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf