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 and Washington, D.C. law firm. Ashley Gillihan, 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.

Avoiding Common Practices That Violate The Mental Health Parity And Addiction Equity Act [1]

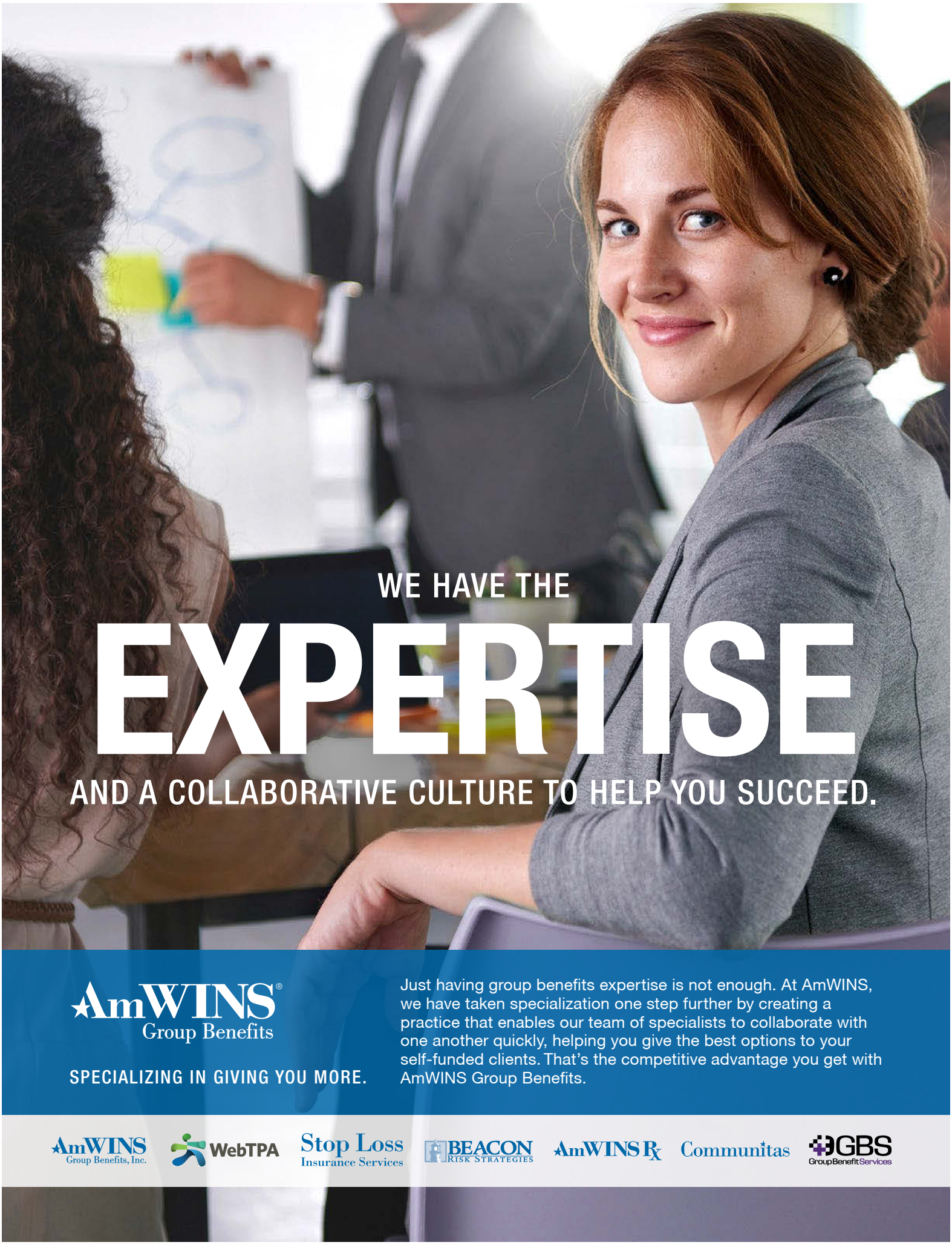
The Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")[2] is designed to require true benefit parity between medical benefits for physical conditions and mental health and substance abuse benefits. If a plan provides medical/surgical benefits and mental health or substance abuse benefits, the plan must provide parity with respect to (i) financial requirements (e.g., deductibles, copayments, coinsurance and out-of-pocket maximums), (ii) quantitative treatment limitations (e.g., number of visits or treatments or days of coverage) and (iii) nonquantitative treatment limitations ("NQTLs")(e.g., medical management standards).

Our focus will be on NQTLs, and in particular those practices that have been identified in recent regulations or subregulatory guidance as violating the MHPAEA. These practices include plan terms that violate the MHPAEA on their face, as well as administrative and procedural practices that are impermissible. In this regard, the Department of Labor (DOL) maintains a website to help plans comply with the MHPAEA.[3] Among other things, the DOL has a posted a list of "warning signs" that require further consideration under the MHPAEA and a self-compliance tool that includes MHPAEA provisions.[4]

Before diving into the prohibited terms and practices, let's take a minute to review what aspects of a plan's design and/or administration constitute NQTLs. The regulations provide the following non-exhaustive illustrative list of NQTLs that should be analyzed.

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment;
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage;
- Limitations on inpatient services in situations where the participant is a threat to self or others;
- Court-ordered or involuntary treatment; and
- Services provided by clinical social workers.

Now that we know what to look at, let's see what we should look for. Here is a list of plan terms and operations/procedural practices that have been identified by DOL as being impermissible NQTLs. Of course, this is not an exhaustive list.



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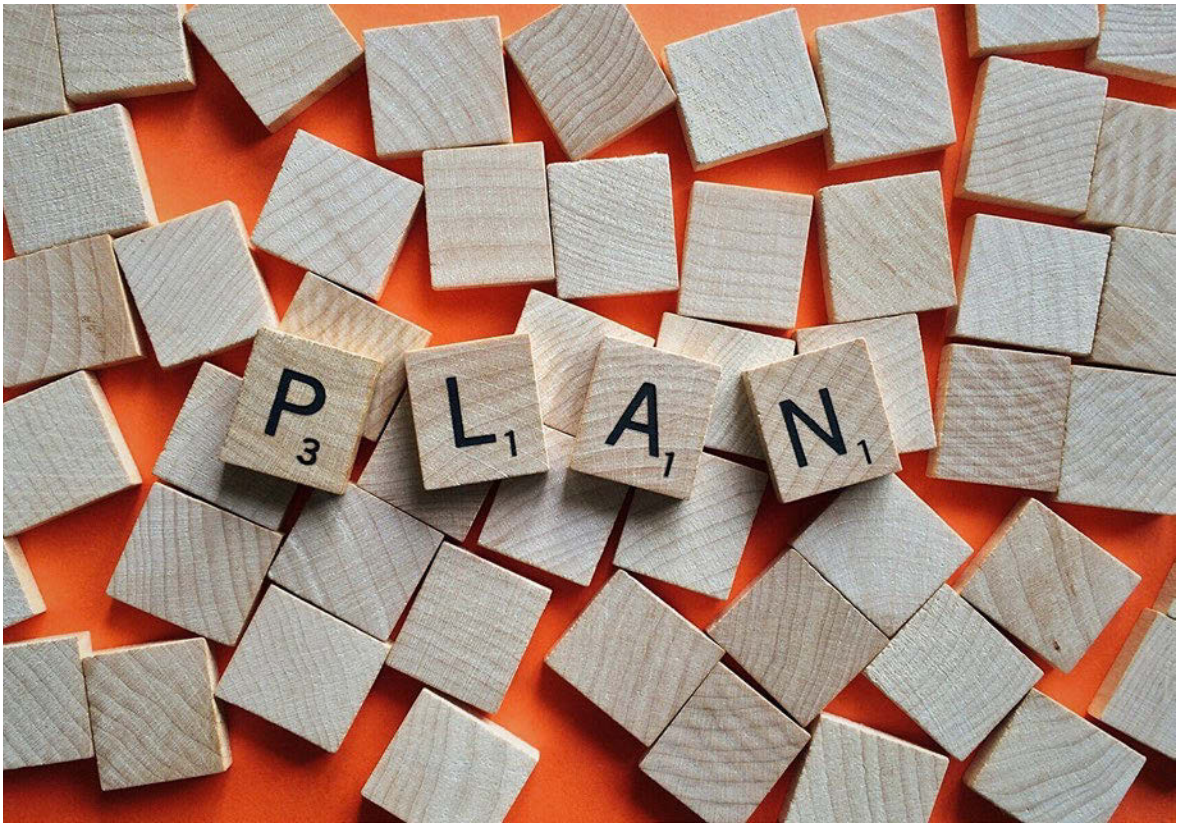
Issues with Plan Terms

- A plan applies the same prior approval requirement and evidentiary criteria to medical/surgical ("Med/Surg") benefits and mental health/substance use disorder ("MH/SUD") benefits, but the penalty for not obtaining prior approval differs. For MH/SUD claims without prior approval, no benefits are paid. For Med/Surg claims there is a 25% reduction in the benefits the plan would otherwise pay. Since the penalties for failing to obtain prior approval are greater for MH/SUD benefits than they are for Med/Surg benefits, the plan violates MHPAEA.

- An employee must exhaust his/her EAP counselling sessions before accessing MH/SUD benefits, while there is no similar requirement for Med/Surg benefits. Since the EAP exhaustion requirements only apply MH/SUD benefits, the provision violates MHPAEA.

- The plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center). For inpatient treatment outside of a hospital for other conditions, including Med/Surg benefits and MH/SUD benefits other than substance use disorder, the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual, based on clinically appropriate standards of care. The plan violates MHPAEA because of the differing treatment of substance use disorders as to residential treatment centers.



- A plan excludes coverage for inpatient, out-of-network treatment of chemical dependency when obtained outside of the State where the policy is written. There is no similar exclusion for inpatient/out-of-network Med/Surg coverage. The plan violates MHPAEA because of the geographic limitations on treatment for chemical dependency but not on other benefits.

- A plan requires prior authorization for all outpatient MH/SUD services after the ninth visit and will only approve up to five additional visits per authorization. With respect to outpatient Med/Surg benefits, the plan allows an initial visit without prior authorization. After the initial visit, the plan pre-approves benefits based on the individual treatment plan recommended by the attending provider based on that individual's specific medical condition. There is no explicit, predetermined cap on the amount of additional visits approved per authorization. While the plan is more generous with respect to the number of visits initially provided without preauthorization, the plan still violates MHPAEA because of the cap of five additional visits for MH/SUD benefits with no cap on Med/Surg benefits.

- A plan excludes treatment of chronic behavior disorders (any condition lasting more than six months) but does not impose any limits on chronic Med/Surg benefits.

- A plan requires participants to obtain prior authorization for substance use disorder treatment and non-emergency admissions to MH/SUD treatment facilities while not requiring pre-authorization for Med/Surg benefits.

- A plan excludes coverage for residential level of treatment for substance use disorders in a substance use disorder treatment center but provides benefits for extended care expenses for Med/Surg benefits in similar settings such as a skilled nursing facility and hospice through home health care services.

- A plan imposes the following requirements for MH/SUD benefits with no comparable requirement for Med/Surg benefits: (1) a written treatment plan prescribed and supervised by a behavioral health provider, (2) follow-up treatment, and (3) a restriction that the written plan be for a condition that can favorably be changed (presumably with treatment).

Operational or Procedural Issues

- A plan has identical preauthorization requirements for both Med/Surg and MH/SUD benefits. In practice, however, Med/Surg benefits are routinely approved for seven days after which a treatment plan must be submitted by the patient's attending provider and approved by the plan while for MH/SUD benefits routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. Although the plan's terms are identical with respect to MH/SUD benefits and Med/Surg benefits, the differing application of the Plan's preauthorization requirement violates MHPAEA.

- A plan will not cover "black box" warning drugs (i.e., certain prescriptions drugs labelled regarding serious or life-threatening reactions) for antidepressants but will cover black box warning drugs for other MH/SUD conditions as well as Med/Surg conditions if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care. Even though black box warning drugs are provided for other MH/SUD conditions, the singling out of antidepressants for exclusion while black box warning drugs are available for all Med/Surg benefits violates MHPAEA.

Conclusion

Employers may be responsible for penalties under the MHPAEA, whether they sponsor self-funded or fully-insured plans. Accordingly, a careful review of plan terms and administrative practices should be undertaken to insure compliance. The examples in this article should provide a good starting point for that review, but these are only illustrative of the types of provisions that can be problematic. Employers will likely need to engage legal counsel and the plan's insurer/claims administrator to get a more thorough evaluation. ■

References:

1 Steven Mindy, a senior associate in Alston & Bird's Washington DC office assisted with this article.

2 The MHPAEA amended Section 712 of ERISA, Section 2705 of the Public Health Services Act and Section 9812 of the Internal Revenue Code.

3 https://www.dol.gov/ebsa/mentalhealthparity/ (last visited August 4, 2017).

4 https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf; https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/cagappa.pdf (last visited August 4, 2017).