Segal Consulting

update

Compliance News for Multiemployer Plans

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Mental Health Parity and Addiction Equity Act Enforcement Is a Priority for Federal Agencies

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires parity between medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits. The Departments of Labor and Health and Human Services (the "Departments") have recently issued guidance warning plan sponsors about certain plan provisions that could signal non-compliance with the law. The warning comes at a time when many plan sponsors are facing greater challenges, most notably a significant increase in claims for costly out-of-network care in residential treatment centers and intensive outpatient settings, and may be considering new ways to manage those costs. This *Update* discusses the "warning signs" document and other recent guidance on the MHPAEA.

Health Compliance News Highlights:

- The federal government is stepping up its enforcement of the MHPAEA.
- Plan sponsors should review medical-management techniques for mental health and/or substance use disorder (MH/SUD) services.
- The MHPAEA regulations require plan sponsors to follow a complex evidence-based process to support the application of certain medical-management tools to MH/SUD care.
- Evidence and documentation supporting the application of these tools must be provided to participants and their health care providers.

Background on MHPAEA Compliance

The MHPAEA requires that health plans provide parity in two categories:[1]

- ***Numerical or "Quantitative" Financial Requirements or Treatment Limits*** The MHPAEA requires that the financial requirements and treatment limitations imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to all or substantially all medical and surgical benefits. Compliance with this category, which generally covers cost-sharing requirements and day or visit limits, is relatively straightforward when the plan's cost-sharing provisions are consistent across different classes of benefits. However, where plan cost-sharing provisions vary (*e.g.*, various levels of coinsurance for in-network outpatient services), the analysis can be more complicated, and a plan sponsor may have to analyze actual claims data in order to determine the level of cost sharing that achieves parity.[2] Special rules apply to deductibles and out-of-pocket limits.[3]

- ***"Non-Quantitative" Treatment Limits*** The "warning signs" guidance puts the spotlight on this second category, which requires parity with respect to any technique or tool that a plan may use to manage or limit the scope or duration of MH/SUD treatment.

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

[2] On April 20, 2016, the Departments released answers to frequently asked questions (FAQs) that address compliance with the MHPAEA. See Question 8 in the answers to FAQs released on April 20, 2016.

[3] For example, if a plan sponsor applies a deductible to MH/SUD care, it must apply a single cumulative deductible to medical/surgical care and MH/SUD care. If the plan has an out-of-pocket limit, expenses incurred for MH/SUD care and medical/surgical care must count toward a single limit.

Warning Signs

In the new “warning signs” document, the Departments highlight plan provisions that, on their face, appear to apply certain requirements only to MH/SUD or differently to MH/SUD. Examples of questionable practices include:

- Blanket prior authorization required for all MH/SUD services;
- Pre-service notification or immediate post-service notification for non-scheduled MH/SUD admissions with a benefit reduction when notice is not provided;
- Prior authorization or concurrent care review every 10 days for MH/SUD care, but not for medical/surgical;
- Medical necessity determinations delegated to physicians for medical/surgical services, but the plan conducts MH/SUD determinations;
- Plan requires prior authorization every three months for pain medications prescribed in connection with MH/SUD conditions;
- For coverage of intensive outpatient treatment for MH/SUD, plan requires that patient has not achieved progress with non-intensive outpatient treatment;
- For residential treatment for MH/SUD, plan requires a likelihood that inpatient care will result in improvement;
- Written treatment plan required for MH/SUD benefits;
- Coverage for MH/SUD denied when a patient fails to follow treatment plan or ends treatment against the advice of his or her provider;
- Exclusion of residential level of treatment for SUD; and
- Requirement that MH/SUD facilities (but not medical/surgical facilities) be licensed by a state.

In an enforcement action, plans with some of these “red-flag” provisions will have to be able to provide detailed evidence to substantiate compliance, as noted in the next section.

Applying Non-Quantitative Treatment Limits to MH/SUD Care

To support the application of certain medical-management tools (*e.g.*, prior authorization), especially to outpatient MH/SUD care, plan sponsors must follow an evidence-based process. The plan sponsor must first consider neutral factors. Examples include the cost of treatment, high-cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis or type or length of treatment, clinical efficacy of treatments, licensing and accreditation of providers, and claims types with a high percentage of fraud. Then, the plan sponsor must apply the selected factors comparably to medical/surgical care and to MH/SUD care and determine which services meet the criteria for application of the medical-management tool.

“Plan sponsors must follow an evidence-based process.”

An example in a recent answer to an FAQ involved a prior-authorization requirement after a patient’s ninth visit for treatment of depression.[4] To support the prior-authorization requirement, a plan sponsor would have to demonstrate and document that it did the following:

- Identified a neutral factor (in this case, situations where the length of treatment exceeded the national average by 10 percent or more);
- Applied the neutral factor to outpatient medical/surgical and MH/SUD care; and

[4] See Question 9 in the answers to FAQs released April 20, 2016.

- Documented (using studies, schedules and similar data) that the national average length of outpatient treatment for depression is eight visits.

New Guidance on Documentation and Disclosure Requirements for Non-Quantitative Treatment Limits

Recent answers to FAQs have also confirmed that plan sponsors must provide, upon request, the following documentation to participants and their health care providers acting as authorized representatives:[5]

- The summary plan description or other plan document;
- The specific plan language setting out the medical-management tool applied to the MH/SUD care at issue;
- The processes, strategies, evidence and other factors considered by the plan (including factors that were relied upon and were rejected) in determining that this management tool would apply to the MH/SUD care at issue;
- Information regarding the application of the same tool to medical/surgical care;
- The processes, strategies, evidence and other factors considered by the plan (including factors that were relied upon and were rejected) in determining the extent to which this management tool would apply medical/surgical care; and
- Any analyses performed by the plan as to how the treatment limit complies with the MHPAEA.

In addition, criteria for medical necessity determinations must also be provided upon request.[6] All of this documentation would also need to be available in any enforcement action initiated by the federal government.

> "Plan sponsors must provide,… upon request,… documentation to participants and their health care providers."

Implications for Plan Sponsors

In light of the extensive process required to justify the application of certain medical-management tools to MH/SUD care, plan sponsors that apply such tools to MH/SUD care need to review those tools (as written and in operation) and determine whether their application is consistent with the MHPAEA. If the plan sponsor has not gone through the evidence-based process outlined in this *Update* to support the application of medical-management tools to MH/SUD care, this effort should be undertaken right away. This process can be more difficult when one entity administers medical/surgical benefits and a separate one administers MH/SUD benefits, because coordination between the two may be lacking.

As part of this process, it would be important to also review the plan's cost-sharing requirements and other quantitative limits to make sure they continue to comply with the MHPAEA. This is especially important if the plan's design has changed in recent years and it has been a while since an initial MHPAEA analysis was performed.

Heightened scrutiny of medical-management tools may make it harder for plan sponsors to control the significant increase in claims for costly out-of-network care in residential treatment centers and intensive outpatient settings that many plans are experiencing. However, there are strategies that can be implemented that are permitted by the MHPAEA.

> "Plan sponsors that apply [medical-management] tools to MH/SUD care need to review those tools (as written and in operation) and determine whether their application is consistent with the MHPAEA."

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[5] See Question 9 in the answers to FAQs released April 20, 2016.

[6] For additional information, see Segal's December 16, 2016 *Update*, "New Guidance on the Mental Health Parity and Addiction Equity Act."

Some types of non-quantitative treatment limits are not highlighted in the "warning signs" document, but nonetheless must be applied comparably to medical/surgical care and MH/SUD. These include formulary design, network tier design, standards for provider admission to the network (including reimbursement rates) and plan methods for determining allowed charges for out-of-network care.

If enforcement issues arise, fund counsel must be involved in addressing them.

How Segal Can Help

Segal works with trustees and their fund counsel on compliance issues. We can help plan sponsors and their service providers identify medical-management tools being used and obtain the evidence and documentation needed to support their application to MH/SUD care. Related services we provide include analysis of whether cost-sharing requirements and other treatment limits are consistent with the MHPAEA and designing cost-control strategies that are permitted under the MHPAEA, including for addressing any spike in out-of-network utilization.

Questions?

For more information about how these new rules may affect your plan, please contact your Segal consultant or the Segal office nearest you.

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