White House Parity Task Force Provides Guidance on Mental Health and Substance Use Disorder Parity Law
On October 27, 2016, The White House Mental Health and Substance Use Disorder Parity Task Force (the “Task Force”) released actions and recommendations for improving implementation of the federal parity law.

The recommendations are based on feedback the Task Force received through a series of listening sessions held from March through October with consumers, providers, employers, health plans, and state regulators. Additionally, the Task Force received more than 1,100 public comments from individuals with mental health (MH) and substance use disorders (SUDs), families, and advocates.

Please note that with a new President and Congress taking control in 2017, the law and therefore these recommendations may be revisited.

THE FINAL REPORT’S MAIN TAKEAWAYS

The report (the “Final Report”) summarizes several overarching themes from these sessions and written comments regarding compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA). Specifically, the report addresses parity awareness and education, quantitative treatment limitations (QTLs), non-quantitative treatment limitations (NQTLs), appeals and disclosure, and enforcement.

In brief, the report recognized the complexities of MHPAEA analyses. It focused on four common forms of NQTLs: prior authorization, utilization review, “fail first” or step therapy, and reimbursement rates. Regarding how parity compliance should be disclosed to consumers, the report recognized that information must be understandable to consumers and not overly burdensome on payers. There was also recognition that documents to be disclosed can be immense.

Because of that complexity, the regulators announced a new portal that consumers can use to seek help in obtaining requested documents or help in reviewing documents related to mental health parity. This portal will provide consumers with a one-stop place for parity complaints and, as such, payers may see an uptick in complaints.

Finally, the regulators acknowledged for the first time that health plan disclosure requirements of medical and surgical benefits exist only for ERISA plans. The Task Force recommended that Congress extend this requirement to non-ERISA plans as well.

It is important to note that health plans recently received legislative support to help stakeholders better understand compliance requirements. Congress recently passed a revised “21st Century Cures Act,” whose updated provisions on mental health parity require the departments of HHS, Labor and Treasury to release compliance program guidance. Specifically, they are to provide illustrative examples of past findings of compliance.
and noncompliance with existing mental health parity requirements, including disclosure requirements and non-quantitative treatment limitations. The bill also requires them to issue new guidance documents to help health plans with parity compliance.

**THE FINAL REPORT’S RECOMMENDED NEXT STEPS**

To address these overarching themes, the Final Report posited both short-term action items as well longer-term recommendations, as described below.

Short-term actions set forth in the report include:

» The release of a Compliance Assistance Materials Index, from the departments of Labor (DOL), Health and Human Services (HHS), and the Treasury to place all parity-related FAQs and guidance in one place

» $9.3 million in grants to CA, CO, DC, HI, IL, IN, MA, MD, MI, MN, MS, NC, NE, NH, NM, NY, OR, PA, RI, and UT to support parity implementation and oversight. California, New York, Massachusetts, Oregon, and Rhode Island were cited as models of promising enforcement efforts.

» The release of a “Consumer Guide to Disclosure Rights,” from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the DOL, describing the various federal disclosure laws

» The announcement of two “State Policy Academies on Parity Implementation for State Officials” hosted by SAMHSA, focusing on parity compliance in the commercial market and parity in Medicaid and the Children’s Health Insurance Program (CHIP)

» The release of annual data from the DOL on closed federal parity investigations. Beacon will seek to ensure that the information provided will not identify organization names in order to protect against misappropriations of findings.

» The addition of MHPAEA compliance to CMS’ review of plans subject to Essential Health Benefits (EHB) requirements under the ACA

Longer-term recommendations include:

» Increasing the federal agencies’ capacity to audit health plans for parity compliance

» Developing additional examples of parity compliance best practices and “Warning Signs” documents
Promoting legislative changes to allow the DOL to assess civil monetary penalties for parity violations

Promoting legislative changes to clarify that health plan disclosure requirements include medical and surgical benefits

Promoting legislative changes to eliminate the HIPAA opt-out process for self-funded non-federal governmental plans

Providing technical assistance to state Medicaid and CHIP agencies as they implement parity in their programs. Specifically, CMS will issue a parity analysis toolkit to help states assess Medicaid managed care organizations’ and CHIP programs’ compliance with the final parity rules. The toolkit will review key considerations for defining and classifying mental health and substance use disorder benefits (including intermediate and long-term supports and services); conducting claims-based analyses for quantitative treatment limits; identifying and analyzing non-quantitative treatment limits; as well as considerations for Alternative Benefit Plans and CHIP. This announcement is good news given stakeholders’ lack of understanding regarding how parity will work in the Medicaid space.

Reviewing the mental health and substance use disorder benefits provided by Medicare Advantage plans and strengthening parity in Medicare Part A benefits

Expanding access to mental health and substance use disorder services in TRICARE

The following are links to the report, a White House press release, and a blog post from the Director of the Domestic Policy Council, Cecilia Muñoz and the Secretary of Labor, Thomas E. Perez.

THE BALANCE BETWEEN CONSUMER ACCESS TO INFORMATION AND CLARITY

The DOL, HHS, and the Treasury also issued ACA FAQ Part 34. Specifically, the FAQs request feedback on how streamlined the documents need to be for a group health plan to demonstrate parity compliance. One FAQ asks questions as to how best to ensure consumers’ rights to access all appropriate information and documentation while at the same time not overly burden plan administrators. Beacon will refine our thoughts on the best approach and provide comments, which are due Jan. 4, 2017. Specifically, the agencies are requesting comments on whether a model form for parity disclosure should be adopted, and if so, what content should be included in such a form. Takeaways from the other FAQs include the following information:

For inpatient admissions, a plan cannot require an in-person examination for MH/SUD benefits during the prior authorization process but allow for a phone examination on the medical/surgical side during prior authorizations.
A plan cannot implement fail-first requirements if they cannot be reasonably satisfied. For example, a plan cannot require a member to be treated in an intensive outpatient program (IOP) before being admitted to a higher level of care if there are no such programs available. This fail-first prohibition will go into effect March 1, 2017.

A prior authorization requirement for buprenorphine due to safety concerns is not permissible when prescription drugs treating medical/surgical conditions with similar safety risks do not require prior authorization.

Fail-first requirements for buprenorphine prescriptions (i.e., requirement of counseling) will generally not be allowed if comparable medical/surgical prescriptions do not require fail-first protocols.

Prior authorizations for refills of buprenorphine prescriptions every 30 days will generally not be allowed if medical/surgical prescriptions do not require the same protocols.

An exclusion or disallowance of court-ordered treatment for substance use disorders is not permissible under MHPAEA if a health plan does not exclude court-ordered treatment for medical/surgical conditions. However, plans are allowed to apply medical necessity criteria in the case of court-ordered treatment for substance use disorders if they do so for all benefits and not singled-out SUD cases.

Many stakeholders issued statements upon the release of the report and other materials praising the goal of achieving both the spirit and the letter of the parity law. Although release of the report did fine-tune some aspects of MHPAEA interpretation and compliance, much work remains for the incoming administration if it chooses to engage on parity-related issues.

If you have any questions or comments, feel free to email Bradley Lerner, Associate General Counsel for Beacon Health Options, at bradley.lerner@beaconhealthoptions.com.