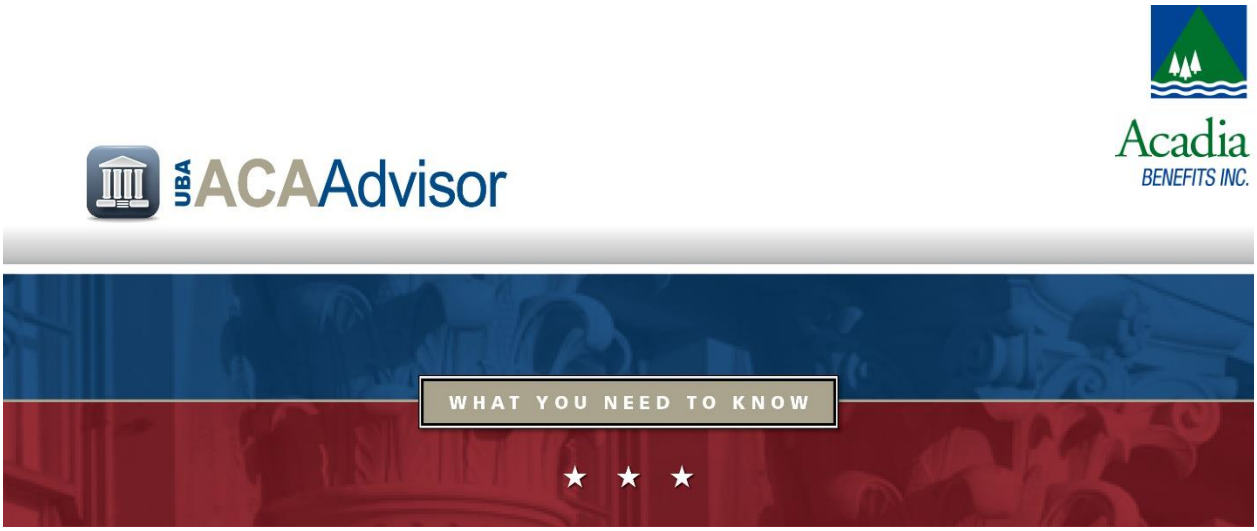

FAQs on Tobacco Cessation Coverage and Mental Health / Substance Use Disorder Parity

On October 27, 2016, the Department of the Treasury, Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Departments) issued FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation.

The Departments' FAQs cover two primary topics: tobacco cessation coverage and mental health / substance use disorder parity.

Tobacco Cessation Coverage

The Departments seek public comment by January 3, 2017, on tobacco cessation coverage. The Departments intend to clarify the items and services that must be provided without cost sharing to comply with the United States Preventive Services Task Force's updated tobacco cessation interventions recommendation applicable to plan years or policy years beginning on or after September 22, 2016.

Mental Health / Substance Use Disorder Parity

Generally, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that the financial requirements and treatment limitations imposed on mental health and substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits.

A financial requirement (such as a copayment or coinsurance) or quantitative treatment limitation (such as a day or visit limit) is considered to apply to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification.

If it does not apply to at least two-thirds of medical/surgical benefits, it cannot be applied to MH/SUD benefits in that classification.

If it does apply to at least two-thirds of medical/surgical benefits, the level (such as 80 percent or 70 percent coinsurance) of the quantitative limit that may be applied to MH/SUD benefits in a classification may not be more restrictive than the predominant level that applies to medical/surgical benefits (defined as the level that applies to more than one-half of medical/surgical benefits subject to the limitation in the classification).

In performing these calculations, the determination of the portion of medical/surgical benefits subject to the quantitative limit is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. The MHPAEA regulations provide that "any reasonable method" may be used to determine the dollar amount of all plan payments for the substantially all and predominant analyses.

MHPAEA's provisions and its regulations expressly provide that a plan or issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request and the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to the participant or beneficiary.

However, the Departments recognize that additional information regarding medical/surgical benefits is necessary to perform the required MHPAEA analyses. According to the FAQs, the Department have continued to receive questions regarding disclosures related to the processes, strategies, evidentiary standards, and other factors used to apply a nonquantitative treatment limitation (NQTL) with respect to medical/surgical benefits and MH/SUD benefits under a plan. Also, the Departments have received requests to explore ways to encourage uniformity among state reviews of issuers' compliance with the NQTL standards, including the use of model forms to report NQTL information.

To address these issues, the Departments seek public comment by January 3, 2017, on potential model forms that could be used by participants and their representatives to request information on various NQTLs. The Departments also seek public comment on the disclosure process for MH/SUD benefits and on steps that could improve state market conduct examinations or federal oversight of compliance by plans and issuers, or both.

The remaining FAQs addressed more specific questions related to MH/SUD parity. Here is a summary of the Departments' answers:

- Participants may receive help in obtaining documents and interpreting documents related to MH/SUD benefit denial. Participants may use the Parity Consumer Web Portal to connect to an agency for help.

- If the plan is a non-grandfathered individual or group health plan and a participant's claim for benefits has been denied for a reason that involves medical judgment (including a challenge to the plan's or issuer's compliance with respect to parity in the application of its medical management techniques), a participant can seek external review after exhausting internal appeals.

- Under MHPAEA, group health plans and issuers must use a "reasonable method" for the MHPAEA's substantially all and predominant analyses, which includes using reasonable data to produce reasonable projections. Group health plans and issuers should not use claims data from an issuer's or third party administrator's entire book of business in an unreasonable manner to calculate the amount of a particular group health plan's or issuer's payments under MHPAEA.

- For large group market and self-insured group health plans, a group health plan or issuer must consider group health plan-level claims data to perform the substantially all and predominant analyses and must rely on such data if it is credible to perform the required projections.

- MHPAEA regulations do not permit a plan or issuer to apply stricter NQTLs to all benefits for mental health conditions in a classification than those applied to all medical/surgical benefits in the same classification.

  Example: A plan cannot require in-person prior authorization for inpatient, in-network mental health benefits, when it does not require in-person prior authorization for inpatient, in-network medical/surgical benefits.

- The Departments' regulations require that a plan or insurance issuer may not impose an NQTL with respect to MH/SUD benefits in a benefit classification unless, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable and applied no more stringently with respect to MH/SUD benefits than with respect to medical/surgical benefits in the same classification.

  Example: A plan cannot require prior authorization or apply a fail-first requirement for coverage of a substance use disorder, when it does not require prior authorization or apply a fail-first requirement to medical/surgical benefits.

- MHPAEA prohibits separate treatment limitations in a plan or coverage that are applicable only with respect to MH/SUD benefits.

  Example: A plan cannot exclude court-ordered treatment for substance use disorders if the plan does not exclude court-ordered treatment for medical/surgical conditions.

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