SUTHERLAND

LEGAL ALERT

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Agencies Delay Summary of Benefits and Coverage Requirements, Issue FAQs on Mental Health Parity

On November 17, the tri-agency task force[1] released new FAQs on the implementation of the Patient Protection and Affordable Care Act (PPACA) and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The FAQs are Part VII in a series of informal guidance issued by the task force since March 2010. The latest round of guidance includes several items of interest for employers: (1) a delay of the applicability date for the Summary of Benefits and Coverage (SBC) requirements under PPACA; (2) clarifications regarding the nonquantitative treatment limitations and copayment variations prohibited for mental health/substance use disorder benefits under MHPAEA,[2] and (3) information on permissible copayment variations for mental health/substance use disorder benefits.

SBC Applicability Date

The FAQs confirm that group health plans and health insurance issuers will not be required to comply with the SBC requirements until final regulations are issued by the task force and become applicable.

As background, section 2715 of the Public Health Services Act (PHSA), as added by PPACA, directs the agencies to work with a National Association of Insurance Commissioners (NAIC) working group to develop standards for compiling a summary of benefits and coverage for enrollees in group and individual health plans within one year following PPACA's enactment date. The statute requires that the summary must be no longer than four pages long and include a font no smaller than 12 point; also, it must be presented in a culturally and linguistically appropriate manner that utilizes terminology understandable by the average enrollee. The statute includes specific content standards for the summary, including uniform definitions of insurance and medical terms; detailed cost-sharing information; a description of the plan's exceptions, reductions and limitations on coverage; a coverage "facts label" that includes examples to illustrate common benefits scenarios; and information on whether the plan provides minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code). In addition, the statute requires that the summary be provided to participants no later than 24 months after the enactment of PPACA, which would be March 23, 2012.

The agencies and the NAIC working group were unable to meet the statute's one-year deadline for developing SBC standards. On August 22, 2011, the tri-agency task force issued a proposed template for, and proposed regulations regarding, the SBC, with an applicability date of March 23, 2012, consistent with the statute. However, the task force requested comments on a number of issues regarding the proposed rules, including the feasibility of the applicability date. In response, the task force received hundreds of comments on the proposed rule, many of which requested a delay in the applicability date given the complexity of the new requirements and the acknowledgment that the proposed rules and template were specifically designed for insurance products and might not work well for self-insured plans.

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[1] The tri-agency task force consists of the Departments of Health and Human Services (HHS), Labor (DOL) and Treasury and the Internal Revenue Service (IRS).

[2] Group health plans of private employers with 50 or fewer employees are exempt from the MHPAEA requirements.

The FAQs issued on November 17 acknowledge the public comments and, as noted above, make clear that group health plans and health insurance issuers will not be required to comply with the SBC requirements until final regulations are issued by the task force and become applicable. Furthermore, the FAQs state that the task force anticipates an applicability date that "gives group health plans and health insurance issuers sufficient time to comply," suggesting that the final regulations will include a delayed effective date.

Mental Health Parity: Nonquantitative Treatment Prohibitions

The MHPAEA interim final rules (IFR), which were issued on February 2, 2010, require group health plans and group health insurance issuers to apply the same or similar cost-sharing and financial requirements to mental health/substance use disorder benefits that apply to medical/surgical benefits in the same classification. For comparative purposes, the IFR includes six "classifications" of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. Under an enforcement safe harbor issued last June, within these six classifications, plans and issuers may subclassify benefits on the basis of office visits and all other outpatient items and services for purposes of the parity rule. Within these classifications, a plan or issuer may not impose a financial requirement or a qualitative treatment limitation (for instance, on the number of covered visits) on mental health/substance use disorder benefits that is more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits in the same classification.

The IFR also requires parity for nonquantitative treatment limitations. Specifically, both as written in the plan or policy and as applied in operation, such limits must be no more stringent than the limits applied to medical/surgical benefits in the same category, except as required under recognized clinically appropriate standards of care (such as medical necessity) or with regard to experimental treatments. However, the IFR applies an amorphous standard for the "in practice" criterion, making compliance with the rule difficult for employers with group health plans.

The latest round of FAQs clarifies that the following types of nonquantitative limits on availability of mental health/substance abuse benefits are prohibited under MHPAEA unless they are applied equally to medical/surgical benefits:

- requiring prior authorizations regarding medical necessity;
- compressed approval windows or additional authorization requirements for medical necessity; and
- substantively broader application of prior authorization requirements.

However, at least two of the FAQs address situations in which nonquantitative limits are permissible, including where a uniform rule simply results in differences in the number of situations in which concurrent review of care is required and where prior authorization is permissibly applied to a broad array of benefits.

Mental Health Parity: Copayment Variations

Finally, the FAQs address copayment variations for mental health/substance use disorder providers. The maximum copayment that a plan can request for mental health and addiction benefits is determined by the predominant copayment that applies to medical/surgical benefits in the same classification. Accordingly, if the predominant copayment is a higher copayment that is applied to medical/surgical specialists, rather than the copayment for medial/surgical generalists, the higher payment can be charged for all mental health/substance use disorder benefits within that classification.

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