

****Set out below is PROPOSED guidance regarding nonquantitative treatment limitations and disclosure requirements in connection with the Mental Health Parity and Addiction Equity Act (MHPAEA). This guidance was developed consistent with section 13001(b) of the 21st Century Cures Act. Public comments are invited and should be submitted by June 22, 2018 to E-OHPSCA-FAQ39@dol.gov. All comments will be shared among the Departments.****

[PROPOSED] FAQs ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART XX

[Date will be inserted upon finalization]

Below are responses to additional frequently asked questions (FAQs) regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, the 21st Century Cures Act (Cures Act), and the Employee Retirement Income Security Act (ERISA). These FAQs have been prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, “the Departments”). As with previously issued FAQs (available at www.dol.gov/ebsa/healthreform/index.html and www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html), these FAQs are designed to help people understand and benefit from the law, as intended.

Mental Health Parity and Addiction Equity Act of 2008 and the 21st Century Cures Act

In general, MHPAEA requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

With regard to any nonquantitative treatment limitation (NQTL), the MHPAEA final regulations provide that a group health plan or health insurance issuer may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same

classification. MHPAEA also imposes certain disclosure requirements on group health plans and health insurance issuers.

Q1: What are the Departments doing to promote understanding of and compliance with MHPAEA as required under the 21st Century Cures Act?

The Departments work with plans, issuers, and service providers to help them understand and comply with MHPAEA, and ensure that individuals receive the benefits to which they are entitled. The Departments also coordinate with State regulators (both individually and through the National Association of Insurance Commissioners (NAIC)) to issue guidance to address frequently asked questions from stakeholders in an effort to increase understanding and compliance. Compliance assistance is a high priority and, thus, the Departments emphasize assisting plans and issuers that are working to comply with the law's requirements.

The Cures Act, enacted December 13, 2016, requires the Departments to, among other requirements, solicit feedback and issue guidance regarding the disclosure and NQTL requirements of MHPAEA. Section 13001(b) of the Cures Act requires that the Departments issue clarifying information and illustrative examples of methods that a plan or issuer offering group or individual health insurance coverage can use to disclose information in compliance with MHPAEA. Section 13001(b) also directs the Departments to issue clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that plans and issuers may use regarding the development and application of NQTLs such as:

1. Medical management standards based on medical necessity or appropriateness, or whether a treatment is experimental or investigative;
2. Limitations with respect to prescription drug formulary design, and use of “step therapy” protocols or “fail-first” policies;
3. Network admission standards (such as credentialing);
4. Factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as such factors apply to network adequacy; and
5. Examples of sources of information that may serve as evidentiary standards for the purposes of making determinations regarding the development and application of NQTLs.

Accordingly, on June 16, 2017, the Departments issued additional MHPAEA compliance assistance guidance regarding benefits for eating disorder treatment, and solicited feedback from stakeholders as to whether additional clarification was needed regarding how the requirements of MHPAEA apply to treatment for eating disorders.¹ The Departments also released a draft model

¹ See FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Part-38.pdf>.

disclosure request form for comment and solicited feedback as to how disclosure processes may be improved.² Comments were due by September 13, 2017 and are available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38>. Based on the feedback received through that solicitation, the Departments have revised the draft model form. A copy of the revised draft model form can be found at https://www.reginfo.gov/public/do/PRAICList?ref_nbr=201706-1210-001.

The Departments have submitted the revised form to the Office of Management and Budget (OMB) as required by the Paperwork Reduction Act. OMB is requesting comments on the revised form. Comments are requested on any aspect of the draft model form, including ways to reduce burden on individuals, families, health care providers, States, group health plans, health insurance issuers, and other stakeholders.

Please send comments on these disclosure issues to: Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for DOL-EBSA, Office of Management and Budget, Room 10235, 725 17th Street, N.W., Washington, DC 20503; by Fax: 202-395-5806 (this is not a toll-free number); or by email: OIRA_submission@omb.eop.gov. Commenters are encouraged, but not required, to send a courtesy copy of any comments by mail or courier to the U.S. Department of Labor-OASAM, Office of the Chief Information Officer, Attn: Departmental Information Compliance Management Program, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; or by email: DOL_PRA_PUBLIC@dol.gov. [Commenters should submit their views by June 22, 2018](#) to ensure consideration. Comments should reference control number 1210-0138.

In addition, based on the comments and other information received, including written and oral comments received in connection with the HHS-sponsored listening session on mental health parity that occurred on July 27, 2017,³ the Departments understand that additional compliance information is needed. Some of that information is contained in these FAQs. Other information will be issued by the Departments on a rolling basis, including revised compliance program documents and updated enforcement data. In addition, the Departments are aware that increased public awareness of MHPAEA and commitment to its successful implementation has led to the creation of partnerships among different advocacy groups that focus on developing accreditation programs that seek to advance understanding of and compliance with the law. The Departments

² A copy of that draft model form, as well as instructions, can be found at <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html> or <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

³ See 82 FR 30876 (July 3, 2017), available at <https://www.gpo.gov/fdsys/pkg/FR-2017-07-03/pdf/2017-13959.pdf>. See also Achieving Parity in Health Insurance Coverage: 21st Century Cures Act Parity Listening Session; available at <https://www.hhs.gov/programs/topic-sites/mental-health-parity/achieving-parity/cures-act-parity-listening-session/index.html>. The Departments also reviewed DOL compliance reviews, consumer complaints and feedback from States and other stakeholders during the Substance Abuse and Mental Health Administration policy forums, among other information. See Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), available at <https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

are considering how such accreditation programs can be utilized as a best practice to help increase compliance with MHPAEA. For the most current information on MHPAEA and the Cures Act implementation, see <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity> and <https://www.hhs.gov/mental-health-and-addiction-insurance-help/index.html>.

Q2. My health plan document states that it excludes treatment that is experimental or investigative for both medical/surgical benefits and for MH/SUD services. For both medical/surgical benefits and MH/SUD services, the plan generally follows current medical evidence and professionally recognized treatment guidelines on the efficacy of treatment. With respect to both medical/surgical benefits and MH/SUD services, the plan's documents state that the plan denies a treatment as experimental for a given condition when no professionally recognized treatment guidelines define clinically appropriate standards of care for the condition, and fewer than two randomized controlled trials are available to support the treatment's use with respect to the condition.

The plan defines Autism Spectrum Disorder as a mental health condition. More than one professionally recognized treatment guideline and more than two controlled randomized trials support the use of Applied Behavioral Analysis (ABA) therapy to treat certain children with Autism Spectrum Disorder. For the most recent plan year, the plan denied all claims for ABA therapy to treat children with Autism Spectrum Disorder under the rationale that the treatment is experimental or investigative. With respect to medical/surgical conditions, the plan approved treatment when supported by one or more professionally recognized treatment guidelines and two or more controlled randomized trials. Is this permissible?

No. A medical management standard limiting or excluding benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA.⁴ A group health plan may impose an NQTL if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing the NQTL are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to medical/surgical benefits in the same classification. Although the plan as written purports to exclude experimental or investigative treatment for both MH/SUD and medical/surgical benefits using the same standards, in practice, it imposes this exclusion more stringently on MH/SUD benefits, as the plan denies all claims for ABA therapy, despite the fact that professionally recognized treatment guidelines and the requisite number of randomized controlled trials support the use of ABA therapy to treat children with Autism Spectrum Disorder. Accordingly, because the plan applies

⁴ MHPAEA regulations at 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); and 45 CFR 146.136(c)(4)(ii) contain an illustrative list of NQTLs that includes, among other things, medical management standards limiting or excluding benefits based on medical necessity; formulary design for prescription drugs; network tier design; and plan methods for determining usual, customary, and reasonable charges.

the NQTL more stringently to mental health benefits than to medical/surgical benefits, the plan's exclusion of ABA therapy as experimental does not comply with MHPAEA.

Q3: My health plan generally excludes treatment that is experimental or investigative for both medical/surgical benefits and for MH/SUD services. The plan defines experimental or investigative treatments as those with a rating below "B" in the Hayes Medical Technology Directory. However, the plan reviews and covers certain treatments for medical/surgical conditions that have a rating of "C" on a treatment-by-treatment basis, while denying all benefits for MH/SUD treatment that have a rating of "C" or below, without reviewing the treatments to determine whether exceptions are appropriate. Is this permissible under MHPAEA?

No. A medical management standard that limits or excludes benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA.⁵ A plan may impose an NQTL on MH/SUD benefits if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its exclusion with respect to MH/SUD benefits are comparable to and applied no more stringently than, those used in applying the NQTL requirement with respect to medical/surgical benefits in the same classification. Here, although the text of the plan sets forth the same evidentiary standard for defining experimental as the Hayes Medical Directory ratings below "B," the plan applies a different evidentiary standard, which is more stringent for MH/SUD benefits than for medical surgical benefits because the unconditional exclusion of treatments with a "C" rating for MH/SUD benefits is not comparable to the conditional exclusion of those treatments with a "C" rating for medical/surgical benefits. Because of the discrepant application of the evidentiary standard used by the plan, the fact that the plan ultimately denies some medical/surgical benefits that have a rating of "C" does not justify the total exclusion of treatments with a "C" rating for MH/SUD. Accordingly, the plan does not comply with MHPAEA.

Q4: My health plan documents state that the plan follows professionally-recognized treatment guidelines when setting dosage limits for prescription medications, but the dosage limit set by my plan for buprenorphine to treat opioid use disorder is less than what professionally-recognized treatment guidelines generally recommend. The dosage limits set by my plan with respect to medical/surgical benefits are not less than the limits such treatment guidelines recommend. Is this permissible under MHPAEA?

No. Medical management standards that limit or exclude benefits based on medical necessity, medical appropriateness, or other factors are NQTLs.⁶ Plans and issuers may impose dosage

⁵ 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii).

⁶ See 26 CFR 54.9812-1(c)(4)(ii)(A); 29 CFR 2590.712(c)(4)(ii)(A); 45 CFR 146.136(c)(4)(ii)(A).

limits as a medical management technique with respect to prescription drug coverage under the plan. Even though these medical management techniques may result in numerically expressed limitations (such as dosage limits), the techniques are nevertheless NQTLs. The Departments' regulations require that the processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD prescription drug benefits (in this case, a dosage limit on buprenorphine to treat opioid use disorder) must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying dosage limits to prescription drugs to treat medical/surgical conditions. If the plan follows the dosage recommendations in professionally-recognized treatment guidelines to set dosage limits for prescription drugs in its formulary to treat medical/surgical conditions, it must also follow comparable treatment guidelines, and apply them no more stringently, in setting dosage limits for prescription drugs, including buprenorphine, to treat MH/SUD conditions.

The Departments are aware that as an alternative to following professionally-recognized treatment guidelines, many plans and issuers use Pharmacy and Therapeutics (P&T) committees to decide how to cover prescription drugs and evaluate whether to follow or deviate from professionally-recognized treatment guidelines for setting dosage limits. Although the use of P&T committees to inform dosage limits for prescription drugs in this manner does not *per se* violate MHPAEA, these processes must comply with MHPAEA's NQTL standard in practice. For example, if the plan deviates from nationally-recognized treatment guidelines for buprenorphine/naloxone to treat opioid use disorder based on P&T committee reports, but does not deviate from such guidelines with respect to covering prescription drugs to treat medical/surgical benefits based on the recommendations of the P&T committee, then this deviation should be evaluated for compliance with MHPAEA's NQTL requirements (for instance, by determining (1) whether the expertise of the members of the P&T committee in MH/SUD conditions is comparable to their expertise in medical/surgical conditions, and (2) by determining whether the committees' evaluation of nationally-recognized treatment guidelines in setting dosage limits for medications for both MH/SUD and medical/surgical conditions is comparable).

Q5: My large group health plan or large group insurance coverage provides benefits for prescription drugs to treat both medical/surgical and MH/SUD conditions but contains a general exclusion for items and services to treat bipolar disorder, including prescription drugs. Is this permissible under MHPAEA?

Yes, although if the plan is insured, it would depend on whether State law permits such an exclusion for large group insurance coverage. Generally, MHPAEA requires that treatment limitations imposed on MH/SUD benefits cannot be more restrictive than treatment limitations that apply to medical and surgical benefits. An exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of the definition of "treatment limitations" in the MHPAEA regulations. Small employer group health insurance coverage and individual health insurance coverage are subject to the requirement to provide essential health

benefits, and the determination of whether certain benefits must be covered under the requirements for essential health benefits depends on the benefits in the applicable State's EHB benchmark plan.

Q6: My health plan requires step therapy for both medical/surgical and MH/SUD inpatient, in-network benefits. The plan requires a participant to have two unsuccessful attempts at outpatient treatment in the past 12 months to be eligible for certain inpatient in-network SUD benefits. However, the plan only requires one unsuccessful attempt at outpatient treatment in the past 12 months to be eligible for inpatient, in-network medical/surgical benefits. Is this permissible under MHPAEA?

Probably not. Refusing to pay for a higher-cost therapy until it is shown that a lower-cost therapy is not effective (commonly known as “step therapy protocols” or “fail-first policies”) is an NQTL.⁷ The Departments’ regulations require that the processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to treat medical/surgical conditions. Although the same NQTL – step therapy – is applied to both MH/SUD benefits and medical/surgical benefits for eligibility for inpatient, in-network services, the requirement for two attempts at outpatient treatment to be eligible for inpatient, in-network SUD benefits is a more stringent application of the NQTL than the requirement for one attempt at outpatient treatment to be eligible for inpatient, in-network medical/surgical benefits. Unless the plan can demonstrate that evidentiary standards or other factors were utilized comparably to develop and apply the differing step therapy requirements for these MH/SUD and medical/surgical benefits, this NQTL does not comply with MHPAEA.

Q7. My health plan documents state that in-network provider reimbursement rates are determined based on the providers’ required training, licensure, and expertise. However, medical/surgical benefits, reimbursement rates are generally the same for physicians and non-physician practitioners. For MH/SUD benefits, the plan pays reduced reimbursement rates for non-physician practitioners. Is this permissible under MHPAEA?

No. While a plan is not required to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers, a plan’s standards for admitting a provider to participate in a network (including the plan’s reimbursement rates for providers) is an NQTL. A plan may impose an NQTL if under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its NQTL with respect to MH/SUD services are comparable to and applied no more stringently than those used in applying the NQTL with respect to medical/surgical benefits in the same classification. Here, the plan reduces reimbursement rates for non-physician

⁷ See 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii).

practitioners providing MH/SUD services. However, the plan does not use a comparable process with respect to reimbursement of non-physician providers of medical/surgical services. Accordingly, the plan's use of this NQTL does not comply with MHPAEA.

Q8: My health plan meets applicable State and Federal network adequacy standards for MH/SUD services. With respect to medical/surgical providers, the plan exceeds State and Federal network adequacy standards by attempting to ensure that participants and beneficiaries can schedule an appointment with a network provider within 15 days for non-urgent care when the individual has symptoms of a condition. The plan does not utilize a standard relating to availability of appointments in creating its provider network for MH/SUD services. Is this permissible under MHPAEA?

No. As explained in the preamble to the Departments' final rules implementing MHPAEA, plan standards such as network adequacy (although not specifically enumerated in the illustrative list of NQTLs), must be applied in a manner that complies with the regulations.⁸ The Departments' regulations require that the processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to treat medical/surgical conditions. Therefore, although a plan may use factors such as distance standards and waiting times for participants and beneficiaries for appointments for services to measure network adequacy, if these factors are used for these purposes they must be applied to medical/surgical and MH/SUD benefits in a comparably manner. Here, while the plan meets applicable State and Federal network adequacy standards, the plan does not consider how long participants and beneficiaries may have to wait for appointments for services as a factor in developing its network of MH/SUD providers, even though the plan considered it in developing the network for medical/surgical providers. Accordingly, the plan does not comply with MHPAEA.

Q9: My health plan generally covers medically appropriate treatments. The plan covers inpatient, out-of-network treatment outside of a hospital setting for medical/surgical conditions if the prescribing physician obtains authorization from the plan and the treatment is medically appropriate for the individual, based on clinically appropriate standards of care. The plan provides benefits for the treatment of eating disorders but excludes all inpatient, out-of-network treatment outside of a hospital setting for eating disorders, including residential treatment (which it regards as an inpatient benefit). Is this permissible under MHPAEA?

No. The Departments' regulations implementing MHPAEA define "mental health benefits" as benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law.

⁸ 78 FR 68239, 68246 (Nov. 13, 2013).

Section 13007 of the 21st Century Cures Act clarified that if a group health plan or health insurance issuer provides coverage for eating disorder benefits, including residential treatment those benefits must be offered consistent with the requirements of MHPAEA. Accordingly, the Departments have clarified that eating disorders are mental health conditions and, therefore, treatment of an eating disorder is a “mental health benefit” within the meaning of that term as defined by MHPAEA.⁹

Plan or coverage restrictions based on facility type are NQTLs under MHPAEA.¹⁰ A plan may impose an NQTL if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its exclusion with respect to MH/SUD benefits are comparable to and applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification. In evaluating an exclusion of an intermediate level of care, including residential treatment, it must be initially determined if the intermediate level of care is assigned to the six benefit classifications in the same way for both medical/surgical and MH/SUD benefits. If so, then the basis for the exclusion (in this case, residential treatment) in the classification must be reviewed to determine if the processes, strategies, evidentiary standards and other factors that are the basis for the exclusion of MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used in applying the NQTL to medical/surgical benefits in the same classification.

Following this analysis, if a plan can articulate factors that are comparable to and applied no more stringently than to support excluding residential treatment in certain circumstances, the plan may be able to demonstrate that the exclusion is consistent with parity standards will meet its obligation with respect to this limitation under MHPAEA. However, in this example, the plan provides inpatient, out-of-network treatment outside of a hospital for medical/surgical conditions so long as a prescribing physician obtains prior authorization from the plan and the treatment is medically appropriate for the individual, while the plan unequivocally excludes all inpatient, out-of-network treatment outside of a hospital (in this case, residential treatment) for eating disorders. This restriction on residential treatment for eating disorders is not comparable to this plan’s coverage restrictions for inpatient treatment outside of a hospital for medical/surgical conditions, which are less stringent. This exclusion does not comply with MHPAEA.

Q10: My health plan provides benefits for emergency room care. If emergency room care is provided for an acute condition affecting my physical health that arises as a complication of a mental health condition or substance use disorder, are benefits for that care considered MH/SUD benefits for the purposes of MHPAEA?

⁹ See Frequently Asked Questions about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-andFAQs/aca_implementation_faqs38.html

¹⁰ 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii).

It depends. The Departments' regulations implementing MHPAEA define "medical/surgical benefits" as benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but not including mental health or substance use disorder benefits. Similarly, "mental health benefits" and "substance use disorder benefits" are defined as benefits with respect to items or services for mental health conditions or substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Mental health conditions must be defined to be consistent with generally recognized independent standards of current medical practice.

Despite any underlying MH/SUD condition, if, under the terms of the plan or coverage (and in accordance with applicable Federal and State law, the particular acute condition affecting an individual's physical health is defined as a medical condition, then benefits for emergency room care provided for the diagnosis, cure, mitigation, treatment, or prevention of the acute condition are medical/surgical benefits for purposes of MHPAEA. For example, assuming that a plan treats all lacerations as a medical condition, if a participant with a mental health condition or substance use disorder seeks emergency treatment for lacerations, the emergency treatment for the lacerations would be medical/surgical benefits for purposes of MHPAEA.

If, however, under the terms of the plan or health insurance coverage (and in accordance with applicable Federal and State law, if an insured plan), the particular acute condition affecting an individual's physical health is defined as a mental health or substance use disorder condition then benefits for emergency room care provided for the diagnosis, cure, mitigation, treatment, or prevention of the acute condition are MH/SUD benefits for the purposes of MHPAEA.

ERISA Disclosure for MH/SUD Benefits

The MHPAEA final regulations provide express disclosure requirements. Specifically, the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request.¹¹ In addition, under MHPAEA, the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available to participants and beneficiaries.¹² The Departments also explained in the preamble to the final regulations that, in addition to these specific disclosure obligations under MHPAEA, ERISA's general disclosure obligation in section 104(b) and the accompanying disclosure regulation at 29 CFR 2520.104b-1 provide that, for plans subject to ERISA, instruments under which the plan is established or operated must generally be furnished to plan participants within 30 days of request. Instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary

¹¹ 26 CFR 54.9812-1(d)(1), 29 CFR 2590.712(d)(1), 45 CFR 146.136(d)(1) and 147.160.

¹² 26 CFR 54.9812-1(d)(2), 29 CFR 2590.712(d)(2), 45 CFR 146.136(d)(2) and 147.160.

standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan. In addition, 29 CFR 2560.503-1, 29 CFR 2590.715-2719 and 45 CFR 147.136 set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. This includes documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

Contemporaneous with the issuance of the MHPAEA final regulations, the Departments published FAQs about Affordable Care Act Implementation Part XVII and Mental Health Parity Implementation¹³ addressing a group health plan's disclosure obligations under MHPAEA and ERISA generally, as well as the specific information a participant is entitled to receive when a claim for MH/SUD benefits has been denied. In addition to reiterating that "instruments under which the plan is established or operated" under ERISA section 104 includes documents with information on medical necessity criteria for both medical/surgical and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, this guidance noted that other provisions of Federal law require such disclosures. The following FAQs provide examples of how other provisions of Federal law may require disclosures relevant to MH/SUD benefits.

Q11: My ERISA-covered group health plan utilizes a provider network and provides a provider directory with its summary plan description (SPD). My former psychiatrist retired three years ago and is therefore no longer participating in the network. However, the provider directory furnished by the plan lists her as still participating in the network. When I began making calls to find a replacement provider, it became clear that the entire directory is out of date and inaccurate. Is this permissible?

No. Under 26 CFR 2520.102-3 of the Department of Labor's regulations, if an ERISA-covered plan utilizes a network, its SPD must provide a general description of the provider network. The list of providers in that SPD must be up-to-date, accurate, and complete (using reasonable efforts). The list may be provided as a separate document that accompanies the plan's SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect. Moreover, an ERISA-covered plan must disclose a summary of material modifications or changes in the information required to be included in the summary plan description not later than

¹³ See FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq_aca17.html and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs17.html.

210 calendar days after the close of the plan year in which the modification or change was adopted. *See* 29 CFR 2520.104b-3(a).

Qualified Health Plan (QHP) issuers are obligated to comply with 45 CFR 156.230(b)(2) that requires the issuer to publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, and the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Health Insurance Marketplace, HHS, and the Office of Personnel Management (OPM).

Q12: Are ERISA-covered plans and issuers that utilize provider networks permitted to provide a hyperlink or URL address in enrollment and plan summary materials for a provider directory where information related to MH/SUD providers can be found?

Yes. While ERISA-covered plans must provide an SPD that describes provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services under ERISA section 102 and the Department of Labor's implementing regulations, such information could be provided electronically, for instance in a hyperlink or URL address, provided the Department of Labor's electronic disclosure safe harbor requirements at 29 CFR 2520.104b-1(c) are met.

Furthermore, under PHS Act section 2715 and its implementing regulations, group health plans and health insurance issuers offering group or individual health insurance coverage must provide a Summary of Benefits and Coverage that includes an Internet address (or other contact information) for obtaining a list of in-network network providers.

Finally, QHP issuers currently must make their provider directories available online. For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date provider directory, including information on which providers are accepting new patients, as well as each provider's contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM.