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BENEFIT NEWS BRIEFS

New ACA FAQs On Preventive Services Affecting Non-Grandfathered Plans, and the MHPAEA

The Department of Labor recently issued *FAQs About Affordable Care Act Implementation Part 34 And Mental Health And Substance Use Disorder Parity Implementation.* The nine FAQs are broken down into three main topics:

- FAQ 1 - tobacco cessation for nonpregnant adults (applicable to non-grandfathered plans).
- FAQs 2-8 - The *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*
- FAQ 9 - exclusion of court-ordered treatment for substance use disorders under *MHPAEA*.

Tobacco Cessation For Nonpregnant Adults in Non-Grandfathered Plans

FAQ 1 discussed the US Preventive Services Task Force (USPSTF) updated Recommendation for tobacco cessation interventions issued on September 22, 2015. Preventive Service Recommendations by the USPSTF with an "A" or "B" rating must be adopted by non-grandfathered plans by the first plan year that begins one year after the date of the recommendation. Here, the Recommendation was made on September 22, 2015 and is applicable to plan years beginning on or after September 22, 2016. For calendar year plans, that is January 1, 2017.

The Recommendation for tobacco cessation was broadened from being just for pregnant women to also include all nonpregnant adults. The Recommendation states that "*clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide both behavioral interventions and FDA-approved pharmacotherapy for cessation to adults who use tobacco*." The Recommendation also states that "*[b]oth intervention types (pharmacotherapy and behavioral interventions) are effective and recommended; combinations of interventions are most effective, and all should be offered*."

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The Recommendation provides additional detail on individual, group and telephone behavioral interventions and also describes the seven FDA-approved over-the-counter (OTC) and prescription medications for treating tobacco dependence that are now available. These include (a) three types of OTC nicotine replacement products (transdermal nicotine patches, nicotine lozenges, and nicotine gum), (b) two prescription-only nicotine replacement products (nicotine inhaler or nasal spray (Nicotrol®)); and (c) prescription-only bupropion hydrochloride sustained release (Zyban® or generic) and varenicline tartrate (Chantix®), which do not contain nicotine.

While the DOL is requesting comments for future guidance on such coverage, the FAQ stated that even without such guidance the **affected non-grandfathered plan must offer coverage consistent with the specific recommendation made by the USPSTF.**

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

How to obtain plan documents showing how the plan is MHPAEA Compliant

FAQ 2 counsels an individual whose requests to the plan for documents to show whether the plan is treating MH/SUD benefits differently than medical/surgical benefits have gone unanswered. The FAQ explains that there may be more than one government agency, including both Federal and State agencies that can help such individuals to obtain documents or understand the information they receive. Individuals can use www.hhs.gov/mental-health-and-addiction-insurance-help to identify an agency that can assist them.

Methodology behind doing the "substantially all" or "predominant analyses"

FAQ 3 answers a technical data analysis question on the methodology behind doing the "substantially all" or "predominant analyses" under the *MHPAEA* (not discussed herein).

In-Person exam for medical authorization for mental health conditions only

FAQ 4 addresses a situation where prior to authorizing admission to an inpatient, in-network facility for a mental health condition, a group health plan requires that a plan representative examine the individual in person to determine whether inpatient care is medically necessary. For all medical and surgical inpatient, in-network admissions, the plan also requires prior authorization but it is conducted over the phone without an in-person examination.

The FAQ asks whether this in-person prior authorization requirement for mental health inpatient admissions permissible? The answer is NO. In this case, the plan is imposing a prior authorization Non-Quantitative Treatment Limit (NQTL) more stringently with respect to inpatient mental health benefits than to inpatient medical/surgical benefits.

Lack of qualified facility in geographic area of a plan participant

FAQ 5 concerns a plan that requires an individual first enroll in an intensive outpatient program before the plan authorizes coverage for inpatient treatment for a substance use disorder. The plan applies similar requirements to medical/surgical benefits. However, unlike medical/surgical benefits for which the requirements can be satisfied by programs offered in the person's geographic area, no intensive outpatient programs are available to treat the individual's substance use disorder in the person's geographic area. Upon informing the plan of this problem, the person was told there are no exception to the rule.

The FAQ explains that this is NOT permissible. However, the FAQ also notes that because the prior guidance did not address the application of fail-first requirements in situations involving lack of access and may have reasonably been interpreted in an alternative manner, the Departments will apply this clarifying guidance for plan years beginning on or after March 1, 2017.

Prior authorization prescription drug requirement for only opioid use disorder medications

FAQ 6 addresses the situation where a plan requires prior authorization from the plan's utilization reviewer that buprenorphine is medically necessary for the treatment of opioid use disorder. The plan says the prior authorization requirement is imposed due to safety risks associated with buprenorphine. Although there are prescription drugs to treat medical/surgical conditions that have similar safety risks, the plan does not impose similar prior authorization requirements on those drugs. The FAQ asks is this prior authorization requirement permissible?

The answer in this fact pattern is NO. However, the FAQ notes a plan may impose an NQTL, including a prior authorization requirement for buprenorphine, 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 prior authorization requirement with respect to buprenorphine to treat an opioid use disorder are comparable to, and applied no more stringently than, those used in applying its prior authorization requirement with respect to medical/surgical benefits in the prescription drug classification under *MHPAEA.*

First fail requirements on substance use drugs but not on medical/surgical drugs

FAQ 7 states that a plan requires that a covered person meet specific non-pharmacological fail-first requirements (for example, that the person has tried counseling alone, failed at recovery, and resumed substance use) before it will authorize coverage for buprenorphine to treat the individual's opioid use disorder. While comparable evidentiary standards and other factors indicate that similar fail-first requirements could be imposed on certain prescription drugs covered by the plan for medical/surgical conditions, the plan does not impose fail-first requirements in these instances. Is this fail-first requirement permissible?

The FAQ explains that in this instance, the first-fail requirement is NOT allowed. A fail-first requirement is an NQTL that must comply with the requirements of *MHPAEA*.

Plan refill limitation is allegedly based on national guidelines

FAQ 8 concerns a group health plan that indicates it follows nationally-recognized treatment guidelines for setting prior authorization requirements for prescription drugs, but requires prior authorization for buprenorphine/naloxone combination at each refill (every 30 days) for opioid use disorder, which is not consistent with nationally-recognized treatment guidelines.

The FAQ asks whether this refill limitation is permissible. The FAQ explains that this refill limitation is not permissible and notes that the "30 days" rule does not follow nationally recognized guidelines which are listed in footnotes.

Exclusions for court-ordered treatment for substance use disorders

The introduction to FAQ 9 notes that group health plans may sometimes exclude coverage of court-ordered treatment. The FAQ notes that questions have been asked about whether exclusions for court-ordered treatment are subject to *MHPAEA*, and how the MHPAEA analysis would apply.

FAQ 9 asks if an exclusion of court-ordered treatment for substance use disorders permissible under *MHPAEA* for a plan that does not exclude court-ordered treatment for medical/surgical conditions? The FAQ explains that if the exclusion applies only to court-ordered treatment for substance use disorders but not to court-ordered treatment for medical/surgical conditions, then the exclusion is NOT allowed under MHPAEA, which prohibits separate treatment limitations in a plan that are applicable only with respect to MH/SUD benefits. Thus, a plan that wishes to keep an exclusion for court-ordered treatment for substance use disorders would need an exclusion for court-ordered treatment for medical/surgical conditions to maintain parity and make the exclusions allowable. One is hard-pressed to think of a court-ordered treatment for medical/surgical conditions that would be impacted by adding such an exclusion.

The FAQ also explains that plans often apply medical necessity criteria to all treatment requests, and may do so in the case of court-ordered treatment for substance use disorders, if that is consistent with *MHPAEA's* parity requirements for NQTLs. If the plan determines that court-ordered treatment is not medically necessary and denies a claim for benefits, then an individual would be informed of his or her right to appeal and request external medical necessity review, consistent with the Departments' regulations for claims, appeals and external review.

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