MARSH & McLENNAN AGENCY
Known locally as McGraw Wentworth

REFORM UPDATE

Issue One Hundred Twenty-Six **November 2016**

November 29, 2016

FREQUENTLY ASKED QUESTIONS (FAQS) PART 34 FINAL REGULATIONS – EXCEPTED BENEFITS, LIFETIME/ANNUAL LIMITS, SHORT TERM MEDICAL POLICIES

The government recently released guidance on the following:

- FAQs on Preventive Care and Mental Health Parity and Addiction Equity Act (MHPAEA) implementation
- Final rules on excepted benefits, lifetime/annual limits, short-term medical policies

This *Reform Update* explains the guidance.

FAQS PART 34

The question on preventive services under the ACA is actually a request for comments on coverage for tobacco cessation services. On September 22, 2015, the United States Preventive Services Task Force (USPSTF) updated its tobacco cessation recommendations. It reclassified tobacco cessation efforts as an "A" recommendation. Clinicians should be asking all adults whether they smoke and advise smokers to quit. They should also offer behavioral interventions and FDA-approved drugs to help.

This broad recommendation did not offer details on the covered preventive services that do not require cost sharing under the ACA. The Departments in a subsequent FAQ provided a safe harbor for health plans to cover tobacco cessation attempts. The safe harbor would be met if the plan covered without cost sharing:

1. Screening for tobacco use
2. Coverage for at least two attempts to quit smoking each year

Tobacco cessation attempts include coverage for:

1. Four counseling sessions of at least ten minutes each (including telephone, group and individual counseling sessions) without prior authorization.

2. All FDA-approved tobacco cessation drugs (including both prescription and over the counter) for a 90-day treatment regimen without prior authorization.

Since the recommendation was updated, stakeholders have asked the Departments to clarify the specific covered items and services that don't require cost sharing. The Departments are seeking comments on:

- Must all seven categories of FDA-approved drugs be covered without cost sharing or may plans use reasonable medical management techniques to determine which specific drug categories will be covered without cost sharing?
- Can plans use reasonable medical management techniques to:
  - Limit the number of quit attempts each year or the duration of the interventions prescribed?
  - Manage the categories of FDA-approved drug interventions that may be covered without cost sharing when used in combination?
  - Limit the types of covered behavioral interventions that do not require cost sharing?

The Departments are requesting comments be sent to marketreform@cms.hhs.gov by January 3, 2017.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The MHPAEA requires that group health plans offering mental health or substance use benefits cannot impose financial requirements or quantitative and non-quantitative treatment limitations (NQTLs) that are more restrictive than the predominant financial requirements and treatment limitations for medical and surgical benefits. For more details on the MHPAEA, please review our *Benefit Advisor* at http://www.mcgrawwentworth.com/Benefit_Advisor/2014/BA_Issue_1.pdf.

MHPAEA requires a number of disclosures on how mental health benefits are treated in comparison to medical/surgical benefits. Many of these disclosures are required when a claim is denied. Some must be provided in response to a member's request. Stakeholders remain confused about required disclosures.

The Departments have requested specific comments on the following:

- Should the Departments create model forms for participants to request information on various NQTLs? If so, what should the forms include? For example, should a participant be able to request a specific list of documents?
- Should different types of NQTLs require different model forms? For example, should there be separate model forms for specific information about medically necessity criteria, fail-first policies, formulary design, or the plan's method for determining usual, customary, or reasonable charges? Should there be a separate model form for plan participants and others to request the plan's analysis of its MHPAEA compliance?

- What other steps can the Departments take to improve the scope and quality of disclosures? What other steps can be taken to simplify or improve processes for requesting disclosures under existing law in regard to Mental Health and Substance Use Disorder (MH/SUD) benefits?

Plans can send comments to e-ohpsca-mhpaea-disclosure@dol.gov. Comments are requested by January 3, 2017.

Hopefully, comments will shape future guidance and help employers comply with the MHPAEA.

The FAQs also included the following questions on MHPAEA compliance:

- **An individual had a mental health claim denied and had requested documents to demonstrate that mental health benefits were being treated differently from medical/surgical benefits. The individual was not sure how to interpret the documents. Does the government offer resources to help?**

  More than one state or federal agency may be able to help get documents or interpret information. The government has created a webpage listing appropriate resources on mental health parity. The site is called the *Parity Consumer Web Portal*. It can be found at www.hhs.gov/mental-health-and-addiction-insurance-help.

  Appeal rights are available if a group health plan provides the coverage, including external review. General information on MHPAEA's requirements is also available on the web at https://www.dol.gov/ebsa/mentalhealthparity/index.html and https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.

- **The MHPAEA rules cover how plans apply financial requirements such as deductibles, copays and so on. What should a group health plan do if it does not have sufficient claim data to do a "substantially all" or "predominant" analysis?**

  Group health plans can use their own claim data to make projections if the data is credible. Smaller plans should analyze plan level, not product level, data. If plan level data is not credible (as certified by an actuary), the plan can use any reasonable method to do the "substantially all" or "predominant" analysis. As part of using a reasonable method to make projections, plans need to document the assumptions used in choosing the data set and making projections. This analysis need not be done annually. It needs to be done only if there is a change in benefits that may affect a financial requirement or treatment limitation.

- **Before authorizing an admission to an in-network, inpatient mental health facility, a group health plan requires a plan representative to determine whether inpatient care is medically necessary. However, for medical or surgical inpatient admissions the plan requires only prior telephone authorization. Is the requirement for an in-person visit permitted if the same requirement does not apply to medical or surgical treatment?**

  No, the plan is applying a non-quantitative treatment limitation to inpatient mental health treatment that is not applied to inpatient medical/surgical treatment.

- **A plan requires intensive outpatient substance abuse treatment before it will approve inpatient substance abuse treatment. The plan has a similar requirement for medical/surgical treatment. Can a plan deny inpatient coverage if no intensive outpatient programs exist in the area?**

  No, this arrangement is considered a "fail first" or "step therapy" requirement. If a fail first requirement that applies to mental health and substance abuse benefits includes a requirement that an individual can't reasonably satisfy, it is viewed as treating mental health and substance abuse benefits more stringently. If there is no access to an intensive outpatient program, an individual can't reasonably satisfy that requirement.

- **A plan requires prior authorization for buprenorphine when it is medically necessary to treat an opioid abuse disorder. The plan states the prior authorization is required due to the safety risks associated with the drug. However, the plan does cover other drugs that have similar safety risks without prior authorization. Is this permissible?**

  No, in this case, the prior authorization is being applied more stringently to a substance abuse treatment than to medical treatment. The issue is the plan has added prior authorization due to safety concerns but has not added prior authorization for medical treatments that may also generate safety concerns.

- **A plan requires a member to meet specific non-pharmacological fail-first requirements (such as counseling) before it will cover buprenorphine to treat an opioid addiction. Evidence shows that similar fail-first requirements could be imposed on other medical treatments, yet they are not. Is this permissible?**

  No, here again, the fail-first requirements are being applied more stringently to substance abuse treatment than to medical treatments.

- **A group health plan follows nationally recognized treatment guidelines when it sets prior authorization requirements for various prescription medications. Yet it requires prior authorization for each 30-day refill of a buprenorphine/naloxone prescription to treat an opioid use disorder. This is not consistent with nationally recognized standards. Is this permissible?**

  No. A plan can follow nationally recognized treatment guidelines; however, rules should be consistent. Typically, authorization for prescription treatments is often appropriate at 6 or 12 months. Requiring a prior authorization every 30 days is a red flag that the plan is not complying with the MHPAEA.

- **Can a plan exclude court-ordered treatment for substance-abuse disorders if it does not exclude court-ordered treatment for medical/surgical conditions?**

  No, if the exclusion for court-ordered treatment only applies to substance-abuse disorders. A plan could apply medically necessary criteria to medical/surgical and mental health/substance abuse treatment. In that case, the plan may decline court-ordered substance abuse disorder treatment if the plan determines it is not medically necessary.

These FAQs continue to help employers understand their plan's obligations in order to comply with the MHPAEA.

FINAL RULES ON EXCEPTED BENEFITS, LIFETIME/ANNUAL LIMITS, SHORT-TERM MEDICAL POLICIES

The Departments of Labor (DOL) and Health and Human Services (DHHS) recently released final regulations on excepted benefits, lifetime/annual limits and short-term medical policies. The proposed rules were discussed in our *Reform Update* at http://mcgrawwentworth.com/wp-content/uploads/Reform-Update-122.pdf. The Departments will finalize expatriate plan regulations at a later date.

The final rules adopt the proposed rules without changes. Following is a summary of the final rules.

Excepted Benefits

These aspects of the excepted benefit rules are now final:

- If supplemental coverage provides benefits for services not covered by the primary coverage, it can be an excepted benefit if **none** of the benefits are an essential health benefit (EHB) in the state where the policy is issued. If any of the additional benefits are considered EHBs, then the coverage is not a supplemental, excepted benefit.
- If the supplemental health policy fills gaps in cost sharing (such as deductibles or coinsurance) and covers additional categories of benefits that are not EHBs, it is viewed as a supplemental, excepted benefit (assuming all other requirements are satisfied).
- Travel insurance may fall within the category of an excepted benefit. Travel insurance is coverage for a planned trip of less than six months. To be considered excepted, the travel insurance must provide non-medical benefits, such as coverage for trip interruption and lost baggage. The health benefits cannot be offered as a stand-alone option.

These final rules did not change fixed dollar or cancer policies. More information on excepted benefits can be found in our *Reform Update* at http://mcgrawwentworth.com/wp-content/uploads/Reform_Update_100.pdf.

Lifetime/Annual Dollar Limits

These rules finalized a minor change to previous essential health benefits (EHBs) regulations. The ACA does not allow annual or lifetime limits on EHBs. Self-funded plans of any employer size and insured plans of large employers (50 or more employees) are not required to cover EHBs. Even though some plans are not required to cover EHBs, they cannot apply annual or lifetime dollar limits to those benefits.

Previous guidance allowed these plans to determine EHBs by using any state's benchmark EHB plan or one of the three largest plans by enrollment as options under the Federal Employee Health Benefit Plan (FEHBP). However, sometimes the benchmark plan does not cover all the services the ACA requires. These plans often have associated supplemental coverage to pay for services that are required but not included in the benchmark plans.

This new guidance simply requires these employers to pick a state EHB benchmark plan or an eligible FEHBP option and include any supplemental coverage associated with that plan as part of that EHB plan. Annual or lifetime dollar limits cannot be applied to supplemental benefits associated with the EHB benchmark plan that an employer chooses.

Short-Term Medical Policies

The final regulations limit the length of time short-duration medical policies can be in effect. Short-term, limited-duration insurance is excepted coverage only if it is in effect for less than three months. This includes any time period during which the individual can renew the policy. The contract has to specify an expiration date. The three-month limit was chosen because it equates to the "short term coverage gap" allowed under the individual mandate. No penalty applies if the gap in coverage during the year is less than three months.

The final rules also require a written notice. Short-term medical plans must display notices using the following wording, in at least a 14-point font, in application materials:

> THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Employers do not usually offer short-duration policies. These plans can provide coverage for a maximum of three months.

The final regulations apply to plan and policy years beginning on or after January 1, 2017.