Overview

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to ensure "parity" or fairness between mental health and/or substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a health plan. Enacted in 2008, MHPAEA does not require a plan to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, The Departments of Treasury, Labor and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. On Friday November 8, 2013, the Departments issued a Final Rule (FR) implementing the law.

A simple example of a parity requirement would be the frequency of office visits. Under MHPAEA, a plan may not allow a patient to have an unlimited number of medically necessary appointments with a dermatologist, but limit patients to only 5 appointments with a psychiatrist.

However, while the premise of the law seems simple, the regulations related to the law are quite complicated, and therefore, implementation of the law has been complicated. This brief summary of the law is intended to help consumers and family members, providers and other stakeholders understand the law and the rights it affords them.

Links to key materials:

- Final regulation, available at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf
- Interim Final Regulation, available at http://www.dol.gov/ebsa/mentalhealthparity/
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html
- U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf
- News release, available at http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html
- CMS January 16, 2013 letter to State Health Officials and Medicaid Directors, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

Effective Date

In general, the Final Rule is effective for plan years beginning on or after July 1, 2014. In practice, most plan years begin on January 1, so the effective date for a majority of plans covered by MHPAEA will be January 1, 2015. With respect to new guidance in the Final Rule, plans and issuers must continue to comply with the February 2010 IFR.

Key Definitions – Both the IFR and the Final Rule provide**:**

- "Mental health benefits" and "substance use disorder benefits" are defined as benefits for items and services as defined "under the terms of the plan" and in accordance with applicable Federal and State law.

- Non-Quantitative Treatment Limitations (NQTLs) are defined as treatment limits "which otherwise limit the scope or duration of benefits for treatment" and are not expressed numerically. An example of NQTLs include medical management techniques like prior authorization.

- "Scope of service" is referred to as "the types of treatment and treatment settings that are covered by a group health plan or health insurance coverage."

Covered Plans (ACA Extends Parity Coverage Beyond the MHPAEA Final Rule)

The provisions in the Final Rule apply to:

- Grandfathered and non-grandfathered large employer plans[1]
- Grandfathered and non-grandfathered individual plans
- Non-grandfathered small group plans
- Plans offered through the health insurance marketplace

The Affordable Care Act (ACA) extended MHPAEA to the individual market and qualified health plans. Additionally, the final regulations implementing the ACA's essential health benefits (EHB) requirement mandates issuers offering non-grandfathered small group and individual plans in and outside of the health insurance marketplace to comply with MHPAEA.

The Final Rule confirms that self-funded, non-federal state and local government plans may continue to opt out of compliance with MHPAEA. A list of plans that have applied for an opt-out is available here.

Financial Requirements/Quantitative Treatment Limitations

The Final Rule reiterates the standard in the IFR, which prohibits plans and issuers from imposing a financial requirement or quantitative treatment limitation on MH/SUD benefits that is more restrictive than the "predominant" financial requirement or quantitative treatment limit that applies to "substantially all" medical/surgical benefits in the same classification.

Under the IFR, "substantially all" is defined as meaning two-thirds and "predominant" is defined as meaning more than one-half of medical/surgical benefits in the same classification.

The IFR also prohibited plans and issuers from having cumulative requirements (such as deductibles or out-of-pocket maximums) or cumulative quantitative treatment limits (such as annual or lifetime day or

[1] "Grandfathered plans" are plans that were established before March 23, 2010 and have not been significantly changed since that date

visit limits) on MH/SUD that accumulate separately from the cumulative financial or quantitative treatment limits for medical/surgical in the same classification.

For example, a plan may not have a $500 deductible for medical/surgical services and a separate $500 deductible for MH/SUD services, which could result in an enrollee paying a $1,000 deductible. Rather, the deductible must be combined so the enrollee would only have to pay one $500 deductible.

Scope of Service

The IFR requested comments on the scope of services (also called a "continuum of care") that a plan must offer. The Final Rule clarified the scope of service issue by stating:

1. The 6 classifications of benefits scheme outlined in the IFR (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential).
2. The language in the Final Rule on scope clarifies that the Departments had intended that each classification and sub-classification must meet all parity tests within each classification. The Final Rule states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers."
3. The Final Rule clarifies, consistent with the IFR, that any restrictions or criteria that limit the "scope or duration of benefits" constitute an NQTL.
4. In the preamble of the Final Rule, the regulators clarified that a scope of services was expressed in the IFR by virtue of the 6 classifications of benefits: "The IFR established six broad classifications that in part define the scope of services under MHPAEA."
5. Although neither the IFR nor Final Rule mandates specific services required to be offered by plans under the 6 classification scheme, the Final Rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assign intermediate levels of services for medical/surgical conditions. The Final Rule provides an example on page 68247:

   > *For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.*

   This language, coupled with the new specific examples around intermediate levels of care, makes it clear that MH/SUD services have to be comparable to the range and types of treatments for medical/surgical within each class.

   The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor with the rule) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

> The Final Rule further provides examples of application of the NQTL rule to exclusions that affect the scope of services provided under the plan. Thus, a plan that automatically excludes certain types of treatments/ treatment settings while not automatically excluding similar types of treatments/treatment settings for medical/surgical conditions would be non-compliant with MHPAEA. Examples 9 & 10 on page 68273 in the Final Rule provide additional detail on how this rule impacts residential SUD facilities. In Example 9, a plan would violate the Final Rule if it automatically excludes coverage for inpatient substance use disorder treatment outside of a hospital but allows conditional coverage (i.e. medically necessary) for inpatient treatment outside of a hospital for other medical conditions. In Example 10, a plan would violate the Final Rule if it excludes coverage for inpatient addiction treatment in a different state but does not have a similar exclusion on the medical/surgical benefit covered by the plan.

The Final Rule defers to States to define the package of insurance benefits that must be provided in a State through the EHB package required under the ACA. In so doing, States and plans must comply with the parity requirements of MHPAEA and the Final Rule with respect to the mental health and substance use disorder EHB category of benefits.

Non-Quantitative Treatment Limitations

The IFR established that plans may not apply "non-quantitative treatment limits" (NQTLs) on MH/SUD benefits more stringently than on medical/surgical benefits. The rules define NQTLs as "limits on the scope or duration of treatment that are not expressed numerically (such as medical management techniques like prior authorization)."

Neither the IFR nor the Final Rule set a quantitative floor or formula for NQTLs like the two thirds rule for quantitative treatment limits. However the FR, consistent with the IFR, uses multiple examples that illustrate that quantity and magnitude are elements in assessing whether or not an NQTL is comparable and no more restrictive. See Example 1 in the Final Rule:

> *Facts:* "A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan."
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> *Conclusion:* "In this Example 1, the plan violates the [NQTL] rules…because it is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits."

The Final Rule restates what was in the IFR that plans need to disclose the "processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit it subject to an NQTL be comparable and applied no more stringently for MH/SUD than for medical/surgical."

The Final Rule made several changes or clarifications to the rules around NQTLs:

- **Deleted the Recognized Clinically Appropriate Standard of Care Exemption**. The Final Rule struck the exception included in the IFR that permitted plans to apply more stringent limits on MH/SUD treatment to the extent that a "recognized clinically appropriate standard of care that permitted a difference."
- **Geographic and Facility Type Restrictions are NQTLs**. As referenced above, the Final Rule clarifies that NQTLs include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). This makes it clear that plans cannot require a patient to go to an MH/SUD facility in their own state, if the plan allows plan members to go out of state for other medical services.
- **Provider Reimbursement Rates are a Form of NQTL**. The Preamble Final Rule reconfirms that provider reimbursement rates are a form of NQTL. The Preamble states that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience and licensure of providers. These factors must be applied comparably and no more stringently with respect to MH/SUD providers. Additional comments will be solicited, if questions persist with respect to provider reimbursement rates.
- **Plans can Use Tiered Networks.** The Final Rule allows plans and issuers to use multiple provider network tiers, but only if they are not imposing these tiered networks more stringently on MH/SUD, subject to the general test provided for NQTLs.
- **Plans can Have Multi-Tiered Prescription Drugs**. A plan may have multi-tiered prescription drug programs (i.e., a program that applies different levels of financial requirements to different tiers to prescription drugs in accordance with the NQTL rules). A plan may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.

Plan Documents and Disclosure

The Final Rule does not express any new disclosure requirements that were not present in the IFR and or the statute but does provide additional details and examples regarding the disclosure requirements for both MHPAEA and ERISA**.** MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. With respect to employer health plans, the Final Rule incorporates disclosure requirements that plans are to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits. The Preamble to the Final Rule also provides a reminder that regulations under the ACA and guidance under FAQs issued by the Department of Labor (DOL) require certain plans and issuers to provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.

Enforcement

The Final Rule clarifies, as codified in existing federal and state law, that states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of effectuating the implementation of MHPAEA. However, the DOL continues to be the primary enforcer for all self-insured employer plans which currently represent the majority of employees affected by MHPAEA.

The Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply. DOL has primary enforcement authority over self-funded employer plans. We want to note, however, that the majority of beneficiaries in employer sponsored plans are self-funded and are under the sole jurisdiction of the DOL.

State Preemption

MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA and other applicable provisions. For example, while MHPAEA does not require plans or issuers to offer any mental health benefits, once state-mandated benefits are offered, MHPAEA will generally apply to a given state's mandated benefits. In addition, a state that has strong consumer protections in insurance law will not have those laws preempted.

Medicaid Managed Care, CHIP and Alternative Benefit Plans

The Final Rule does not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The Final Rule states more guidance on this will be forthcoming.

The CMS letter dated January 16, 2013 to State Health Officials and Medicaid Directors made it clear that sections of the IFR and now the Final Rule do apply to Medicaid managed care organizations (MCOs) - specifically CMS stated that NQTLs apply to Medicaid MCOs just as they do to commercial plans

Cost Exemption for Plans and Issuers

The Final Rule provides a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the law raise costs by at least 2% in the first year.

Health plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption (have an increased cost of at least two percent in the first year that MHPAEA applies to the plan or at least one percent in any subsequent plan or policy year) are

exempt from the parity requirements for the following plan or policy year, and the exemption lasts for one plan or policy year. The Final Rule confirms achieving the exemption must be based on the estimated increase in actual costs incurred by the plan or issuer that is directly attributable to expansion of coverage due to the requirements of this section and not otherwise due to occurring trends in utilization and prices, a random change in claims experience that is unlikely to persist, or seasonal variation commonly experienced in claims submission and payment patterns. When estimating costs attributable to MHPAEA, a plan or issuer must rely on actual claims or encounter data incurred in the benefit period reported within 90 days of the end of the benefit period. Determinations as to increases in actual costs attributable to implementation of the requirements of MHPAEA must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries.