Issue Brief

Final Mental Health Parity Regulations Released

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The DOL, IRS and HHS jointly released final rules regarding the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). For those group health plans offering both medical/surgical benefits and mental health (MA) or substance abuse (SA) benefits, the plans must provide MH and SA benefits at least equal ("in parity") to the medical/surgical benefits provided.

It is important to note that while the rules apply to both self-funded and fully insured plans, most employers (especially smaller employers) who sponsor fully insured plans will have very little control over the detailed structure of the MH benefits provided in the plan. Carriers selling fully insured group health plans will generally structure the plans to be in compliance with these regulations.

MHPAEA does not require group health plans to provide MH or SA benefits, but if they do offer such benefits, the parity requirements apply. Note, however, that the Affordable Care Act (ACA) requires small group fully insured plans to offer "essential health benefits," which include MH and SA coverage. Also, while the ACA does not require that large group fully insured and self-funded plans offer essential health benefits, any essential benefits offered may not be subject to an annual or lifetime dollar maximum limit.

Background

MHPAEA amended the Mental Health Parity Act (MHPA) of 1996. MHPAEA added provisions relating to SA benefits and imposed additional parity requirements. Interim final rules as well as several FAQs have been provided since 2008 to guide the implementation of MHPAEA. Recently, final regulations were released to formally adopt and clarify the interim final rules and FAQs and to further implement the various provisions of MHPAEA.

Effective Dates

MHPAEA first became effective for plan years beginning on or after 10/3/2009. Previously released interim final rules became effective for plan years beginning on or after 7/1/2010. These final rules become effective for plan years beginning on or after 7/1/2014. Until 7/1/2014, plans must continue to comply with the interim final rules.

Plans Exempt from MHPHA

The following are exempt from compliance with the parity rules:

<u>Small Employer Exception</u>

Small employers are generally exempt from MHPAEA. For MHPAEA purposes, small employer is defined as an employer who employed not more than 50 employees on business days during the previous calendar year. Non-federal governmental employers with fewer than 100 employees are also exempt.

However, the ACA includes MH and SA benefits as an essential health benefit for fully insured small employers. Employers subject to the ACA essential health benefit rules are required to provide these benefits in a manner that meets the MHPHA parity rules. Consequently, due to the ACA essential health benefit requirement, small fully insured employers will generally be required to offer MH and SA benefits in parity with other benefits offered in the plan.

Significant Increase in Cost

Employers who experienced an increased cost attributable to the MH/SA benefits of at least 2% in the first year MH and SA benefits were offered, or any subsequent year cost increase of 1% or more, may be able to avoid the MHPHA requirements for one year. It is very rare for a plan to take advantage of the cost exception. An employer/plan sponsor must follow detailed financial analysis rules defined in the regulations, and have their compliance certified by an actuary, to take advantage of this exemption. Furthermore, the cost exception applies for only one plan year. If the plan continues to offer MH and SA benefits, it would need to return to meeting the parity rules for the next plan year after taking advantage of the exemption.

Other Exceptions

There are other limited exceptions to the MHPHA rules, including: excepted benefits as defined by HIPAA, retiree-only plans, and self-funded state and local governmental (non-federal) plans that choose to opt out.

General Parity Rules

If a group health plan (fully insured or self-funded) provides medical/surgical benefits and MH or SA benefits, the plan is generally subject to the following parity requirements:

- Same or more generous annual/lifetime limits as apply to medical/surgical benefits;
- Equality of financial requirements and quantitative treatment limitations; and
- Equal treatment for non-quantitative treatment limitations.

The final rules include an important clarification relative to the interaction between the ACA and the MHPAEA requirements. Employers who sponsor non-grandfathered large group fully insured or self-funded plans are not required to provide the ACA essential benefits (including MH/SA benefits), but are required to provide preventive health services (which include some preventive MH/SA benefits such as SA screening and counseling and depression counseling). However, if the only MH/SA benefits provided by the plan are due to the ACA preventive service requirement, the plan is not required to comply with MHPAEA based solely on provision of these preventive services.

If an employer or organization has multiple arrangements by which it provides health care benefits, and any participant can simultaneously receive coverage for medical/surgical benefits and MH or SA benefits, such combination of arrangements is considered to be a single group health plan subject to the parity requirements.

Annual and Lifetime Limits

The proposed regulations contained detailed rules related to lifetime and annual limits. However, MH/SA benefits are considered to be an “essential health benefit” according to the ACA, and all health plans (fully insured and self-funded) are prohibited from imposing any annual or lifetime limits on any essential health benefit provided under the plan.

The final regulations make it clear that a plan is required to provide equivalent lifetime and annual maximum coverage for MH/SA benefits. This requirement makes the lifetime and annual maximum rules specific to MH/SA coverage largely irrelevant for most plans since there will be no lifetime or annual maximum on any essential health benefit including MH and SA benefits. Only if a plan imposes lifetime or annual maximum limits on more than 1/3 of all medical surgical benefits would any kind of limit on MH/SA services be allowed. Under ACA rules, it would be unlikely for a plan to be able to impose lifetime and annual limits on non-essential health benefits that would comprise more than 1/3 of all medical surgical benefits.

Financial Requirements and Quantitative Treatment Limitations

A group health plan that provides both medical/surgical benefits and MH or SA benefits must ensure that the financial requirements and quantitative treatment limitations are no more restrictive for MH or SA benefits than the predominant financial requirements and treatment limitations that apply for substantially all of the medical/surgical benefits.

Definitions

- Financial requirements – includes deductibles, copays, coinsurance and out-of-pocket expenses, but excludes annual/lifetime limits.
- Treatment limitations – includes limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.
- Substantially all – applies to at least 2/3 of all medical/surgical benefits in that classification.
- Predominant – the most common or frequent of such type of limit or requirement.
- Predominant level – generally the level that applies to more than 1/2 of medical/surgical benefits in that classification. If there is no single level that applies to more than 1/2, the plan may combine levels until the combination applies to more than 1/2 – known as the “aggregate rule” – the least restrictive level within the combination is the predominant level (*Ex. Copays of $50, $25 and $15 may apply to 1/2 of medical/surgical benefits, so the $15 copay is the predominant level)*.

Classifications

Parity of any financial requirements and treatment limitations applies on a classification-by-classification basis, and definitions for these classifications must be made uniformly for medical/surgical benefits and MH or SA benefits. Plans must provide MH or SA benefits in parity for all classifications in which medical/surgical benefits are available, including intermediate services such as residential treatment and intensive outpatient treatment.

Scope of benefits has not been defined in detail, but the final regulations added that any restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration must also comply with the parity rules.

The parity rules apply based on the following six designated classifications:

- Inpatient, in-network;
- Inpatient, out-of-network;
- Outpatient, in-network;
- Outpatient, out-of-network;
- Emergency care; and
- Prescription drugs.

Additional rules in regard to the six designated classifications are as follows:

- The final regulations adopted a rule that was previously included only in a department FAQ. Outpatient services may be sub-classified into (a) office visits and (b) all other outpatient items and services.
- The final regulations clarified that multiple providers for in-network tiers may be used as a further sub-classification so long as the tiering is not based on whether a provider is a provider of medical/surgical services or MA or SA services.
- If the plan provides coverage for out-of-network providers for medical/surgical benefits, then coverage must also be provided for MH or SA benefits.
- Plans may generally not further sub-classify generalists and specialists.
- No separate cumulative financial requirement or quantitative treatment limitation may apply to MH or SA benefits, even if the limits are equal to those imposed on medical/surgical benefits. In other words, separate but equal is not allowed (e.g. deductibles, out-of-pocket maximums, visit limits that accumulate separately from those for medical/surgical benefits in the same classification).

Non-quantitative Treatment Limitations (NQTLs)

A group health plan that provides both medical/surgical benefits and MH or SA may not impose any processes, strategies, evidentiary standards or other factors used to apply NQTLs to MH or SA benefits that are any more stringent than those applied to medical/surgical benefits within a classification. Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity/appropriateness or based on whether treatment is experimental/investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for high-cost therapy until it is shown that a lower-cost therapy is not effective; and
- Exclusions based on failure to complete a course of treatment.

Note that the interim regulations included an exception that allowed variation to the extent that "recognized clinically appropriate standards of care" permitted a difference. This exception was eliminated in the final regulations. The agencies have acknowledged that not all treatments or settings for MH and SA correspond to those

for medical/surgical benefits. Therefore, until further guidance is provided, the best practice is to determine whether or not there is an analogous medical/benefit treatment or setting and act accordingly.

Disclosures

Plan information and claim adjudication disclosures related to MH and SA coverage are subject to the existing ERISA and other disclosure rules (such as inclusion in an SBC). If the plan is not subject to ERISA, the reason for the claim denial must be provided upon the request of a participant or beneficiary within a reasonable time and manner.

State Laws

MHPAEA does not preempt any state law that establishes any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage unless the state law prevents application of any MHPAEA requirements. A chart outlining the states' MH parity laws is available at the National Conference of State Legislatures website: http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx

Summary

To a large extent, the final rules are very similar to the rules plans have been following since the release of proposed regulations that went into effect in 2010; however, as described in this brief, there are some clarifications and adjustments to the rules. Employers who sponsor fully insured plans should be aware of the impact the final rules have on coverage for MH and SA benefits in their employer sponsored plans, but other than very large employers, most will have little control over the MH and SA coverage provided in their plans. Self-funded employers, on the other hand, must work carefully with their administrators and advisors to ensure that MH and SA claims are being processed in accordance with these final rules.

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