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For your information®

Volume 37 | Issue 06 | January 14, 2014

Final mental health parity regulations issued

The Mental Health Parity and Addiction Equity Act of 2008 requires group health plans that offer mental health and substance use disorder benefits to cover those benefits on terms that are no more restrictive than they are for medical and surgical benefits. Final regulations under the law were issued in November and generally become effective for plan years beginning on or after July 1, 2014. The final regulations largely retain the content of the interim final regulations and incorporate subsequently issued guidance. They also clarify certain aspects of the application of the law in connection with the ACA.

Background

The Mental Health Parity Act of 1996 (MHPA) sought to ensure parity between medical/surgical benefits and mental health benefits offered under group health plans by prohibiting these plans from imposing lower annual or lifetime dollar limits on mental health benefits than on medical/surgical benefits. However, plans were permitted to impose other limits, such as limits on the frequency of treatment or the number of visits, even if similar limits were not imposed on medical/surgical benefits. The MHPA applied only to mental health and not to substance use disorder benefits.

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) expanded the MHPA parity rules to prohibit group health plans from imposing financial requirements (such as copays and deductibles) or treatment limitations (limits on the frequency of treatment or number of visits) on mental health benefits that are more restrictive than the predominant requirements and limitations imposed on medical/surgical benefits. The MHPAEA also extended these parity requirements to substance use disorder benefits.

The MHPAEA does not require group health plans to provide mental health or substance use disorder benefits. However, if a plan does provide these benefits, it is subject to the parity requirements

Interim final regulations interpreting the MHPAEA were issued in 2010. Those regulations established six classifications of benefits for purposes of the parity rules, and they required that a plan offering both medical/surgical benefits and mental health or substance use disorder benefits in any

classification satisfy the parity requirements in each classification. To satisfy those requirements, a plan may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (more than one-half) financial requirement or treatment limitation of that type applied to substantially all (at least two-thirds of) medical/surgical benefits in the same classification. The plan must also provide parity in the application of its nonquantitative treatment limitations (NQTLs), which are plan features that may limit the scope or duration of treatment but are not expressed numerically. NQTLs include standards for determining medical necessity, formulary design for prescription drugs, determination of usual, customary, and reasonable charges, and network standards for provider admission or reimbursement. (See our March 2, 2010 *For Your Information* for a detailed discussion of those regulations.)

Parity must be provided in each of the following six classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

Since the interim final regulations were issued in 2010, the Departments of Labor, Health and Human Services and the Treasury have provided additional guidance and interpretation of the MHPAEA requirements in the form of FAQs. (See our July 6, 2010, January 25, 2011, and December 23, 2011 *For Your Information* publications.)

In November 2013, the Departments issued final regulations under the MHPAEA. As detailed below, the final regulations generally retain the substance of the interim final regulations, with certain modifications. They also incorporate the FAQ guidance and provide additional interpretation and clarification.

Financial requirements and quantitative treatment limitations — use of subclassifications

Outpatient benefits

The final regulations retain the six classifications of benefits set out in the prior regulations. They also incorporate the terms of the FAQ that permitted outpatient benefits to be divided into two sub-classifications: office visits (such as physician visits and psychologist visits) and other outpatient services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items). After the sub-classifications are established, a plan may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than that applied to substantially all medical/surgical benefits in the sub-classification. Sub-classifications other than those specified in the regulations, such as for generalists and specialists, are not permitted.

Multiple tiers of in-network benefits

In addition, the final regulations permit a plan that provides in-network benefits through multiple tiers of providers (such as an in-network tier of preferred providers with more generous cost sharing for participants than a separate in-network tier of participating providers) to divide those benefits into sub-classifications that reflect those network tiers. The tiering must be based on reasonable factors and without regard to whether a provider is a mental health or substance use disorder provider or medical/surgical provider. Noting that some plans may not have an equal number of tiers for medical/surgical benefits and mental health and substance use disorder benefits, the Departments indicated that a plan will be considered compliant if it applies the least restrictive level of the

financial requirement or quantitative treatment limitation (i.e., the most generous) imposed on substantially all medical/surgical benefits across all provider tiers in a classification to mental health or substance use disorder benefits in the same classification. The Departments also stated that they may provide further guidance on multiple tiers in the future, if necessary.

Intermediate mental health and substance use disorder services

The preamble to the final regulations states that all benefits offered under a plan must be assigned to one of the six classifications and that intermediate mental health and substance use disorder benefits, such as residential treatment, partial hospitalization, or intensive outpatient treatment, that do not clearly fall within a particular classification must be assigned to a classification in the same manner as comparable medical/surgical benefits. Therefore, for example, if a plan classifies medical care in a skilled nursing facility as an inpatient benefit, it would have to treat mental health or substance use disorder care in a residential treatment facility as an inpatient benefit.

> Buck comment. This is an important clarification because, prior to the issuance of the final regulations, many plans considered intermediate care to be outside the six classifications and, therefore, not subject to the parity obligations.

Nonquantitative treatment limitations

The final regulations make some changes to the rules governing non-quantitative treatment limitations and provide some additional clarification.

Elimination of clinically appropriate standards of care

The interim final regulations generally prohibit a plan from imposing an NQTL on mental health or substance use disorder benefits unless the factors it uses in applying the limitation are comparable to, and are applied no more stringently than, those used for medical/surgical benefits. However, those regulations also include an exception to this rule for variations “to the extent that recognized clinically appropriate standards of care may permit a difference.”

Although the final regulations retain the general rule, they eliminate the “clinically appropriate standard of care” exception. The Departments explained in the preamble that the NQTL rules already provide plans with the flexibility to consider clinically appropriate standards of care in making the parity analysis.

> Buck comment. The Departments rejected the idea of incorporating a mathematical parity analysis for NQTLs similar to that used for financial requirements and quantitative treatment limitations. The subjective nature of the NQTL parity analysis will create a challenge for plans trying to demonstrate compliance in the event of litigation.

Clarification of scope of NQTLs

The Departments note in the preamble that although the factors taken into account by a plan in applying an NQTL on mental health or substance use disorder benefits must be comparable to those it applies to medical/surgical benefits, the plan is not required to use the same NQTLs for both types of benefits. They also note that disparate results do not necessarily mean that an NQTL does not comply with the parity requirements. In one example in

the regulations, a plan required concurrent review for inpatient care where variation in the length of stay exceeded a certain numerical threshold; the application of this standard resulted in concurrent review of 60% of mental health or substance use disorder conditions, but only 30% of medical conditions. The regulations note that even though there was disparity in the results, the plan complies with the parity rules because the same evidentiary standard was applied no more stringently for mental health/substance use disorder conditions than for medical/surgical conditions.

The final regulations also clarify that the list of NQTLs in the regulations is not exhaustive; any plan standard that operates to limit the scope or duration of treatment of mental health or substance use disorder benefits is considered to be an NQTL subject to the parity analysis. The preamble notes that NTQLs may include restrictions or limits on services based on geographic location, facility type, network adequacy, and even provider reimbursement rates.

> Buck comment. Employers are responsible for ensuring that their plans satisfy the parity requirements even if a behavioral health management organization is administering the mental health and substance use disorder benefits. Thus, employers will need to work with those organizations to ensure that their plans satisfy the parity requirements.

Employee assistance programs under the MHPAEA rules

The Departments note in the preamble to the final regulations that an employee assistance program (EAP) is not subject to the MHPAEA if it is an excepted benefit. Under current guidance applicable through at least 2014, an EAP is an excepted benefit if it does not provide significant benefits in the nature of medical care or treatment. Employers may use a reasonable, good faith interpretation of whether an EAP provides significant medical benefits.

Proposed regulations on excepted benefits state that beginning in 2015, an EAP will qualify as an excepted benefit only if it does not provide significant benefits in the nature of medical care, no employee premiums or contributions are required to participate in the plan, and there is no cost-sharing under the EAP. In addition, the EAP's benefits cannot be coordinated with benefits under another group health plan in the following ways: (1) participants cannot be required to exhaust EAP benefits before being eligible for benefits under the medical plan; (2) EAP eligibility cannot be conditioned on participation in the health plan; and (3) EAP benefits cannot be financed by another group health plan. (For more information about the proposed regulations on excepted benefits, see our December 24, 2013 *For Your Information*.)

> Buck comment. Even if an EAP is not subject to the MHPAEA, an employer that has both a major medical plan and an EAP must consider how the EAP may interact with the plan's mental health or substance use disorder benefits. For example, a requirement that a participant exhaust counseling sessions under the EAP before accessing mental health benefits under the medical plan would be an NQTL subject to the parity analysis.

Interaction between the MHPAEA and the ACA

The interim final regulations were issued before the enactment of the Affordable Care Act (ACA). The final regulations address how the requirements of the ACA and the MHPAEA interact.

Aggregate lifetime and annual dollar limits

The MHPAEA permits plans to impose annual or aggregate lifetime dollar limits on mental health and substance use disorder benefits as long as the parity requirements are satisfied. However, the ACA prohibits plans from imposing lifetime and annual dollar limits on essential health benefits, which include certain mental health and substance use disorder services. The Departments note in the preamble that even though the MHPAEA may permit dollar limits in some circumstances, the ACA rules will limit their application to benefits that are not essential health benefits.

> Buck comment. Plan sponsors that want to impose dollar limits on any particular mental health or substance use disorder benefit will have to determine whether that benefit is essential or nonessential. It is unclear whether many mental health or substance use disorder benefits will be considered nonessential.

Coverage of preventive services

The MHPAEA does not require plans to cover mental health and substance use disorder benefits. However, if a plan covers those benefits in any classification, it must cover them for all classifications for which it offers medical/surgical benefits. In contrast, the ACA requires non-grandfathered plans to cover, without cost-sharing, certain mental health and substance use disorder benefits that are preventive services (which currently include alcohol misuse screening, depression screening, and tobacco use screening). The final regulations clarify that if a plan covers mental health and substance use disorder benefits only to the extent needed to comply with the ACA preventive services mandate, the MHPAEA does not require the plan to cover additional mental health and substance use disorder benefits in any classification.

Small employer exemption

The MHPAEA does not apply to group health plans maintained by small employers. The final regulations clarify that for plans subject to ERISA or the Code, a small employer is one with 50 or fewer employees. For non-federal governmental plans, which are subject to MHPAEA through the Public Health Service Act, a small employer is one with 100 or fewer employees.

Notwithstanding the MHPAEA small employer exemption, coverage provided by small employers that purchase coverage in the small group market may be required to satisfy the parity requirements. This is because final ACA-related regulations on essential health benefits require insured non-grandfathered plans in the small group market to cover mental health and substance use disorder benefits in compliance with the MHPAEA, even where those requirements otherwise would not directly apply.

Increased cost exemption

An exemption from the MHPAEA is available for plans that can demonstrate an increase in cost as a result of meeting the parity requirements. If a plan satisfies the conditions of the exemption for a particular year, it will be exempt from the parity requirements for the following year; thus, the exemption will be available in alternating plan years. A plan claiming the exemption must provide an actuarial determination that it incurred an increase in cost

of at least 2% in the first year of compliance or at least 1% in any subsequent year. In addition, a plan must provide notice to participants, the Departments, and relevant state agencies before claiming the exemption and must make available to participants, on request, a summary of the information on which the exemption was based.

> Buck comment. As noted in the preamble to the regulations, no plans have applied for the increased-cost exemption. It is possible that the conditions for using the exemption (together with its limited application, e.g., every other year) make the exemption too administratively difficult and costly to be worthwhile.

Applicability dates

The final regulations apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2014. Until that date, plans and issuers must continue to comply with the interim final regulations.

In **closing**

Employers whose plans provide both medical/surgical benefits and mental health or substance use disorder benefits should carefully review their plans to ensure parity between those benefits in accordance with the final regulations. Although the final regulations are largely similar to the interim final regulations and most plans were in compliance with the latter, the final regulations add nuance and make certain notable changes. Employers should give particular attention to some of the less clear-cut requirements, including modification of the analysis of NQTLs and the treatment of EAPs.

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