Brought to you by Muneris Benefits

Mental Health and Substance Use Disorder Benefits—Parity Requirements

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan's medical and surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. The MHPAEA generally became effective for plan years beginning on or after Oct. 3, 2009.

This Legislative Brief provides an overview of the federal parity requirements for MH/SUD coverage. It also addresses how the Affordable Care Act (ACA) impacts a health plan's provision of MH/SUD benefits.

FINAL RULE

On Nov. 13, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) jointly issued a **final rule** implementing the MHPAEA. This rule finalizes an MHPAEA interim final rule that was published on Feb. 2, 2010, and became effective for plan years beginning on or after July 1, 2010. The mental health parity provisions of the final rule apply for plan years beginning on or after **July 1, 2014** (Jan. 1, 2015 for calendar year plans).

In conjunction with the final rule, the Departments also issued **FAQs** regarding implementation of the MHPAEA, as amended by the ACA.

OVERVIEW

Under the MHPAEA, the financial requirements and treatment limits that health plans and issuers apply to MH/SUD benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. The MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The MHPAEA also extended the parity requirements to substance use disorder benefits.

In general, if a health plan provides MH/SUD benefits, the MHPAEA requires the plan to:

- Offer the same access to care and patient costs for MH/SUD benefits as those that apply to medical/surgical benefits;
- Treat MH/SUD coverage and medical/surgical coverage equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review; and
- Contain a single combined deductible for MH/SUD coverage and medical/surgical coverage.

AFFECTED HEALTH PLANS

The MHPAEA generally applies to group health plans sponsored by employers with **more than 50 employees**, including self-insured plans and fully-insured arrangements.

Mental Health and Substance Use Disorder Benefits—Parity Requirements

The MHPAEA does not *require* large group health plans and their issuers to cover MH/SUD benefits. The MHPAEA's requirements apply only to large group health plans and their issuers that choose to include MH/SUD benefits in their benefit packages.

However, other state and federal laws may require a plan to provide these benefits. The ACA builds on the MHPAEA and requires some plans to cover MH/SUD services as one of ten essential health benefits categories. Specifically, **non-grandfathered health plans in the individual and small group markets** are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements, effective for 2014 plan years.

Nonfederal governmental plans that are self-funded may elect to opt out of the MHPAEA's parity requirements. In order to opt out, the plan must file an election with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each plan year and must notify the plan participants of its choice to opt out.

Also, the ACA applies the MHPAEA to health insurance issuers offering individual health insurance coverage (both through the Health Insurance Marketplaces, also known as Exchanges, and outside the Marketplaces). These changes are effective for policy years beginning on or after Jan. 1, 2014. The final MHPAEA rule applies to individual health insurance coverage (grandfathered and non-grandfathered) for policy years beginning on or after July 1, 2014.

KEY PARITY REQUIREMENTS

Financial Requirements and Quantitative Treatment Limitations

> ***General Rule:*** The general parity rule requires that, where MH/SUD benefits and medical/surgical benefits are provided, a group health plan may not apply any financial requirement or quantitative treatment limitation to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification.

Financial requirements include, for example, deductibles, copayments, coinsurance and out-of-pocket limits. Quantitative treatment limitations include, for example, limits on the frequency of treatment, number of visits or days of coverage.

Plans must apply parity requirements for financial requirements and treatment limitations based on each "coverage unit" (for example, self-only, family and employee-plus-spouse). More information on classifications of benefits is provided below.

Numerical Standards

The final rule includes the following numerical standards for the "substantially all" and "predominant" requirements:

- *Substantially All:* A type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to **at least two-thirds** of all medical/surgical benefits in that classification. If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to MH/SUD benefits in that classification.
- *Predominant:* If a type of financial requirement or treatment limitation is the most common or frequent of a type of limit or requirement, then it is predominant. The predominant level is the level that applies to **more than one-half** of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification.

6/10, EM 5/15

The final rule clarifies that a plan or issuer is not required to perform the parity analysis each plan year unless there is a change in plan benefit design, cost-sharing structure or utilization that would affect a financial requirement or treatment limitation within a classification.

Intermediate Services

The final rule provides that if a plan or issuer provides coverage for MH/SUD benefits in any classification, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. The final rule also applies the parity requirements to benefits for intermediate levels of care for MH/SUD (such as residential treatment, partial hospitalization and intensive outpatient treatment).

Under the final rule, plans and issuers must assign covered intermediate MH/SUD benefits to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. 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 MH/SUD as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well.

Cumulative Limits

The final rule provides that a plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for MH/SUD benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification.

Thus, for example, **combined deductibles are required for MH/SUD benefits and medical/surgical benefits**. Separate deductibles are prohibited. That is, a plan may not apply one deductible to MH/SUD benefits and another deductible to medical/surgical benefits.

Nonquantitative Treatment Limitations

The MHPAEA restricts the nonquantitative treatment limitations (NQTLs) that plans may place on MH/SUD benefits. Under the final rule, a plan or issuer may not impose an NQTL with respect to MH/SUD benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than those used in applying the limitation with respect to medical/surgical benefits in the same classification.

The final rule includes an illustrative list of NQTLs that plans and issuers commonly use. These NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including provider reimbursement rates;
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment;
- Network tier design; and

6/10, EM 5/15

- Restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services provided under the plan (including access to intermediate level services).

The final rule also clarifies that, despite the illustrative list, all NQTLs imposed on MH/SUD benefits by plans and issuers subject to the MHPAEA are subject to the law's parity requirements.

The interim final rule contained an exception to the NQTL requirements allowing for variation "to the extent that recognized clinically appropriate standards of care may permit a difference." According to the Departments, this exception has been determined to be confusing, unnecessary and subject to potential abuse. Thus, the final rule **eliminates this exception**.

CLASSIFICATIONS OF BENEFITS

The final rule established six classifications of benefits and requires plans to apply the MHPAEA's parity requirements on a classification-by-classification basis. The six classifications of benefits are as follows:

Classifications of Benefits		
Inpatient, in-network	Outpatient, in-network	Emergency care
Inpatient, out-of-network	Outpatient, out-of-network	Prescription drugs

The final rule also specifies permissible sub-classifications and provides that the parity analysis be performed within each classification and sub-classification.

The classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and MH/SUD benefits offered by health plans and issuers. Health plans and issuers cannot avoid the parity analysis by categorizing medical/surgical benefits and MH/SUD benefits outside of these classifications.

Prescription Drug Tiers

The final rule permits plans to divide prescription drug coverage into tiers and apply the parity requirements separately to each tier of drug coverage based upon reasonable factors and without regard to whether the drug is generally prescribed with respect to medical/surgical benefits or with respect to MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick up.

Outpatient Benefits

After the interim final rule was released, the DOL issued an FAQ indicating that enforcement action will not be taken against plans that divide outpatient benefits into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules. **Outpatient benefits can be divided into office visits and all other outpatient items and services.** This means that a plan can apply the "substantially all" test separately for physician office visits that have copayments and for outpatient benefits that may be subject to other financial requirements. The final rule incorporates the terms of this FAQ and permits sub-classifications for office visits and other outpatient services.

Multiple Provider Tiers

In addition, the final rule provides that if a plan provides in-network benefits through **multiple tiers of in-network providers** (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers), the plan may divide its benefits furnished on an in-network basis

into sub-classifications that reflect those network tiers. To classify benefits based on multiple tiers of in-network providers, the tiering must be based on reasonable factors and without regard to whether a provider is an MH/SUD provider or a medical/surgical provider.

Some plans may have an uneven number of tiers between medical/surgical providers and MH/SUD providers (for example, three tiers of medical/surgical providers and two tiers for MH/SUD providers). Until the issuance of further guidance, the Departments will consider a plan or issuer to comply with the financial requirement and quantitative treatment limitation rules under MHPAEA if a plan or issuer treats the least restrictive level of the financial requirement or quantitative treatment limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to MH/SUD benefits in the same classification.

Other Classifications

Other sub-classifications, such as separate sub-classifications for generalists and specialists, may not be used for purposes of determining parity.

DEFINING MH/SUD BENEFITS

MH/SUD benefits mean benefits with respect to items or services for mental health conditions or substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law.

Also, so that benefits are not misclassified, plans and issuers must use generally recognized independent standards of current medical practice in defining whether benefits are MH/SUD benefits (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders, the most current version of the International Classification of Diseases or state guidelines).

DISCLOSURES

Under the MHPAEA, the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available by plans and issuers to any participant, beneficiary or contracting provider upon request. Also, plans must provide information about the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

In addition to the MHPAEA's disclosure requirements, other laws require plans and issuers to disclosure of information relevant to medical/surgical and MH/SUD benefits. For example, the DOL's claims procedure regulations for ERISA plans, as well as the Departments' claims and appeals regulations under the ACA (applicable to all non-grandfathered plans and issuers), include the right of claimants to be provided by the plan or issuer, upon request and free of charge, reasonable access to and copies of all documents records, and other information relevant to the claimant's claim for benefits. According to the DOL, this includes documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.

COST EXEMPTION

The MHPAEA includes an exemption for increased costs that is available for plans and issuers that make changes to comply with the law and incur an increased cost of at least two percent in the first year that the MHPAEA applied to the plan or coverage or at least one percent in any subsequent year. The cost exemption may only be claimed for alternating plan years.

The final rule includes standards and procedures for claiming an increased cost exemption under the MHPAEA. The test for an 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 MHPAEA's requirements and not otherwise due to occurring

6/10, EM 5/15

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.

INTERACTION WITH STATE PARITY LAWS

The final rule addresses how the MHPAEA interacts with state insurance laws regarding MH/SUD benefits. A state law, for example, may mandate than an issuer offer coverage for a particular condition or require that an issuer offer a minimum dollar amount of MH/SUD benefits. According to the DOL, these state law provisions do not prevent the application of the MHPAEA and, thus, would not be preempted.

To the extent the state law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition or disorder must be provided in parity with medical/surgical benefits under the MHPAEA. This means that an issuer subject to the MHPAEA may be required to provide MH/SUD benefits beyond the state law minimum in order to comply with the MHPAEA.

ACA CHANGES

Annual and Lifetime Limits

Effective for plan years beginning on or after Jan. 1, 2014, the ACA prohibits group health plans and issuers from placing lifetime limits on the dollar value of essential health benefits (EHB). The definition of EHB includes MH/SUD services, including behavioral health treatment. The final rule clarifies that the parity requirements regarding annual and lifetime limits only apply to the provision of MH/SUD benefits that are not EHB.

Preventive Services

Also, as a general parity rule, if a plan or issuer provides MH/SUD benefits in any classification, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under the ACA, non-grandfathered group health plans and issuers offering non-grandfathered group and individual coverage are required to provide coverage for certain preventive services without cost-sharing. These preventive services presently include, among other things, alcohol misuse screening and counseling, depression counseling, and tobacco use screening as provided for in the guidelines issued by the United States Preventive Services Task Force.

The final rule clarifies that the MHPAEA does not require a group health plan or issuer that provides MH/SUD benefits only to the extent required under the ACA's preventive services mandate to provide additional MH/SUD benefits in any classification.

EHB Requirement

On Feb. 25, 2013, HHS issued a final rule that requires issuers of non-grandfathered plans in the individual and small group markets to ensure that these plans provide all EHB, including MH/SUD benefits. The extent of the coverage of EHB is determined based on the benchmark plans that are selected at the state level. The final rule also requires issuers providing EHB to provide MH/SUD benefits in compliance with the MHPAEA, even where those requirements would not otherwise apply. Thus, all insured, non-grandfathered, small group plans must cover EHB in compliance with the MHPAEA, regardless of the MHPAEA's small employer exception.

6/10, EM 5/15