Proskauer

Final Regulations for the Mental Health Parity and Addiction Equity Act of 2008

December 2, 2013

On November 8, 2013, the Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") jointly issued final regulations under the Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA"). In general, the MHPAEA requires that group health plans offering mental health/substance use disorder benefits that apply any financial requirements or treatment limitations to these benefits cannot apply requirements or limitations that are more restrictive than the requirements or limitations applied to medical/surgical benefits.

The final regulations largely adopt the previously released interim final regulations and are accompanied by additional guidance in the form of frequently asked questions ("FAQs"). This client alert summarizes the guidance included in the final regulations and the FAQs. Please refer to our previous client alert here for a summary of the interim final regulations.

Effective Date

The final regulations apply to group health plans for plan years beginning on or after July 1, 2014 (*i.e.*, January 1, 2015 for calendar year plans). Until that time, plans and issuers must continue to comply with the interim final regulations, which were effective for plan years beginning on or after July 1, 2010.

Background

The MHPAEA requires parity between mental health/substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. Plans providing mental health/substance use disorder benefits generally may impose financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limitations) or quantitative treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment) on mental health/substance use disorder benefits, as long as the requirements or limitations are on par with those imposed on medical/surgical benefits. Specifically, the requirements or limitations can be no more restrictive than the "predominant"[1] financial requirements or treatment limitations applied to "substantially all"[2] medical/surgical benefits.

As previously announced in the interim final regulations, the "predominant/substantially all" test applies on a classification-by-classification basis, based on six classifications of benefits: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs. The final regulations provide that office visits can be split out as a subclassification separate from outpatient services. The final regulations specifically prohibit subclassifications for generalists and specialists.

Nonquantitative Treatment Limitations (NQTLs)

The rules confirm a separate parity requirement for nonquantitative treatment limitations ("NQTLs"). NQTLs are limits on the scope or duration of treatment that are not expressed numerically (such as medical management standards, formulary design and methods for determining usual, customary and reasonable charges).

For NQTLs, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to mental health/substance use disorder benefits within a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation for medical/surgical benefits in the classification.

Elimination of Exception for Clinically Appropriate Standards of Care

The interim final regulations included an exception to the parity requirements for NQTLs that allowed for variation in benefit levels "to the extent that recognized clinically appropriate standards of care may permit a difference."

The final regulations eliminate this exception on the basis that it has been determined to be confusing, unnecessary, and subject to abuse. But, the Departments note that the final regulations do permit some flexibility in that they "do not require plans and issuers to use the same NQTLs" for mental health/substance use disorder benefits and medical/surgical benefits. The preamble to the final regulations clarifies that "[d]isparate results alone do not mean that the NQTLs in use do not comply with these requirements." In short, plans are not required to use the same NQTLs for both mental health/substance use disorder benefits and medical/surgical benefits. The MHPAEA requirements will be met as long as (i) the processes, strategies and standards used to determine whether (and to what extent) an NQTL applies is comparable as between mental health/substance use disorders and medical/surgical conditions and (ii) the processes, strategies and standards are applied no more stringently to mental health/substance use disorders.

Illustrative List of NQTLs

The final regulations include the illustrative list of commonly used NQTLs that appeared in the interim regulations and add two NQTLs to this list: (i) network tier design, and (ii) 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 or coverage.

Intermediate Levels of Care

The interim final regulations and the final regulations do not address how the six benefit classifications apply to intermediate levels of care, such as residential treatment facilities, partial hospitalization, or intensive outpatient treatment. However, the preamble to the final regulations confirms that parity does apply to intermediate levels of care by noting that intermediate mental health/substance use disorder benefits must be assigned to the benefit classifications in the same way that comparable medical/surgical benefits are assigned. The preamble notes that there is no requirement that greater mental health/substance use disorder benefits be provided than benefits for medical/surgical conditions, but plans and issuers cannot exclude intermediate levels of care. Rather, the Departments left the classification of these intermediate levels of care to the plan or issuer.

Classification of Benefits

The final regulations permit subclassification of in-network benefits into tiered networks for the application of the parity rules to financial requirements and quantitative treatment limitations. The tiering must be based on reasonable factors and without regard to whether a provider provides mental health/substance benefits or medical/surgical benefits.

The preamble to the final regulations emphasizes that the only permissible classifications are the six classifications plus the sub-classifications specifically described in the regulations, and no benefits may be categorized outside of these classifications (*e.g.*, as noted above, subclasses for generalists and specialists are prohibited).

Affordable Care Act

Lifetime and Annual Limits for Essential Health Benefits

The final regulations also address the interaction of the MHPAEA with the Affordable Care Act (the "ACA"), which was enacted after the MHPAEA. The ACA prohibits group health plans from imposing annual or lifetime dollar limits on essential health benefits ("EHB"). The definition of EHB in the Affordable Care Act includes mental health and substance use disorder services, including behavioral health treatment. Although the final regulations retain parity requirements from the interim final regulations regarding lifetime and annual limits, the final regulations apply only to benefits that are not EHB (because plans are now prohibited under the ACA from applying annual or lifetime dollar limits to EHBs, which include mental health/substance use disorder benefits).

Application of the MHPAEA under the ACA

The preamble to the final regulations clarifies that although the final regulations exempt small employers (those that employed no more than 50 employees during the previous calendar year), the EHB regulations issued under the ACA require that non-grandfathered individual and small group plans comply with the MHPAEA regardless of the small employer exemption.

Preventive Health Services

The ACA also requires that non-grandfathered group health plans provide coverage for specified preventive services without cost sharing, including alcohol misuse screening and counseling, depression counseling and tobacco use screening. The preamble to the final regulations notes that compliance with the ACA's preventive care requirements should not require a group health plan or insurance provider to provide a full range of mental health/substance use disorder benefits under the MHPAEA. Accordingly, group health plan or insurance providers that provide mental health/substance use disorder benefits only to the extent required by the ACA are not required to provide additional mental health/substance disorder benefits in any classification.

State Insurance Laws

The preamble to the final regulations notes that in the event state law mandates require that an insurance provider offer mental health/substance use disorder benefits, the MHPAEA would then apply and may require that the plans or insurance coverage provide additional mental health/substance use disorder benefits beyond the state law mandates in order to comply with the parity requirements.

Procedures for Increased Cost Exemption

The MHPAEA includes an increased cost exemption under which, if certain requirements are met, plans that incur increased costs of at least two percent in the first year that the MHPAEA applies, or at least one percent in any subsequent year, can be exempt from the statutory parity requirements. The final regulations adopt standards and procedures for claiming the increased cost exemption, including a requirement that the plan or issuer provide notice of the exemption to the participants, the Departments, and appropriate state agencies. The Departments issued FAQs in conjunction with the final regulations that provide the contact information for the Departments for the plans and issuers to send their notices.

Action Steps for Employers

- Employers should review their provisions in their plans to confirm that there is parity between mental health/substance use disorder benefits and medical/surgical benefits in the six benefits classifications and permissible subclassifications. In particular, if the employer relied on the exception for clinically appropriate standards of care, which has been eliminated, the employer should revisit the variation in benefits and determine whether it is permissible under the final regulations.
- If an employer contracts with a managed behavioral health organization ("MBHO") to provide mental health/substance use disorder benefits, the employer should ensure that it provides the information necessary to the MBHO to ensure compliance with the parity requirements of the MHPAEA. The preamble to the final regulations notes that it is the responsibility of the plan and the issuer to ensure compliance and that the use of an MBHO does not relieve the plan or issuer from their obligations under the MHPAEA.

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[1] The predominant level of a type of financial requirement or quantitative treatment limitation is the level that applies to more than one-half of medical/surgical benefits in the classification. If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or treatment limitation in a classification, plan payments for multiple levels of the same type of financial requirement or treatment limitation can be combined.

[2] A financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification.