# COMPLIANCE ALERT!

**Tuesday, January 28, 2014**

## Final Regulations and Frequently Asked Questions Released under the Mental Health Parity and Addiction Equity Act (MHPAEA)

The Departments of Treasury, Labor, and Health and Human Services (collectively, the "Departments") have jointly issued final regulations under the Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA") along with new Frequently Asked Questions (FAQs) guidance. As background, the MHPAEA provides parity between mental health and substance use disorder benefits and medical/surgical benefits regarding financial requirements and treatment limitations. The final regulations largely adopt the previously released interim final regulations and provide further clarifications on issues such as certain provisions within the Affordable Care Act (ACA), nonquantitative treatment limitations, and impact on employee assistance programs.

**Effective Date**

The final rules apply to group health plans that provide coverage for mental health and substance use disorder benefits for plan years beginning on or after July 1, 2014 (January 1, 2015 for calendar year plans) and will apply to both grandfathered and non-grandfathered plans. Until that time, plans and issuers must continue to comply with the interim final regulations issued in 2010.

**Overview**

In general, plans that provide mental health and substance use disorder benefits may impose financial requirements (such as copayments and coinsurance) or treatment limitations (such as visit limitations) on mental health/substance use disorder benefits, however they cannot be more restrictive than the predominant financial requirements or treatment limitations imposed on substantially all medical/surgical benefits. The "predominant/substantially all" test applies on a classification-by-classification basis, based on the six classifications of benefits retained from the interim final rule:

(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 plans may utilize further sub-classifications such as outpatient office visits and all other outpatient services. Group health plans may also use multiple provider network tiers provided that they are consistent with the parity requirements. Sub-classifications other than these, such as separate sub-classifications for generalists and specialists, are not permitted.

**Affordable Care Act**

*Interaction with Lifetime and Annual Limits for Essential Health Benefits.* Under the Affordable Care Act (ACA) group health plans are prohibited from imposing annual or lifetime dollar limits on essential health benefits which includes mental health and substance use disorder services. Although the final regulations retain parity requirements from the interim final regulations regarding lifetime and annual limits, they clarify that the rules only apply to the provision of mental health and substance use disorder benefits that are not essential health benefits.

*Preventive Health Services Mandate.* The ACA requires non-grandfathered group health plans to provide coverage for certain preventive services without cost sharing, including alcohol misuse screening and counseling, depression counseling, and tobacco use screening. The final regulations clarify that a group health plan that provides mental health and substance use disorder benefits in order to be in compliance with the ACA's preventive care requirements does not require a group health plan to provide a full range of mental health and substance use disorder benefits under the MHPAEA.

*Small Employer Exemption.* The final regulations clarify that although group health plans of employers with 50 or fewer employees are exempt from the MHPAEA, the ACA requirement to provide essential health benefits mandates that non-grandfathered health plans in the individual and small group markets must provide all categories of essential health benefits, including mental health and substance use disorder benefits.

**Nonquantitative Treatment Limitations**

The final regulations clarify 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 factors such as 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.

The final regulations do remove an exception from the interim final regulations to the NQTL requirements that permitted variation to the extent that recognized "clinically appropriate standards of care" permitted a difference. This exception has been determined to be confusing,

unnecessary, and subject to potential abuse. The underlying requirements regarding NQTLs (even without this exception) are sufficiently flexible to allow plans and issuers to take into account clinical and other appropriate standards when applying NQTLs such as medical management techniques to medical/surgical benefits and mental health or substance use disorder benefits. Thus, the final rules have eliminated this exception.

**Intermediate Levels of Care and Services**

The final regulations clarify how MHPAEA that applies to intermediate levels of care by noting that intermediate mental health/substance use disorder benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) must be assigned to one of the six classifications in the same way that they assign comparable medical/surgical benefits to these classifications. For example, if a plan sponsor classifies care in a skilled nursing facility or rehabilitation hospital as an inpatient benefit, then the plan must likewise treat mental health/substance use disorder residential treatment as an inpatient benefit.

**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.

**Increased Cost Exemption and Notice Requirements**

The MHPAEA contains guidance on the increased cost exemption which is available for group health plans that incur an increased cost of at least two percent in the first year that the MHPAEA applies to the plan or at least one percent in any subsequent year. In order to claim the increased cost exemption, the group health plan must furnish a notice of the plan's exemption from the parity requirements to the participants covered under the plan, the Departments, and certain state agencies. The final regulations do indicate that no employer has applied for a cost-based exemption since the release of the 2010 interim final regulations.

**Employee Assistance Plans**

The final regulations confirm that employee assistance plans are exempt from the MHPAEA as long as they do not provide significant benefits in the nature of medical care or treatment. Recently proposed regulations provided guidance addressing how to determine the employee assistance plan's status as an excepted benefit under the ADA, however the MHPAEA regulations indicate that through 2014, plans may use a reasonable, good faith interpretation to determine whether an EAP is exempt.

**Action Steps for Employers**

In summary, group health plans that implemented the 2010 interim final regulations will only need to review a few plan provisions and procedures to ensure their plan complies with the final regulations. The group health insurance carrier or third party administrator will be able to assist with this review to determine what plan design or procedural changes are required. Examples

include confirmation that the plan no longer includes annual or lifetime dollar limits on mental health or substance use disorder benefits that are considered essential health benefit, plan coverage for intermediate treatment services, and a review of the plan's nonquantitative treatment limitations.

**Regulatory Links**

Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation http://www.dol.gov/ebsa/faqs/faq-aca17.html

FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation http://www.dol.gov/ebsa/faqs/faq-aca18.html

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