

# The Mental Health Parity and Addiction Equity Act of 2008

## A Summary of the Final Rules: What You Need to Know

### Final Rules Published November 2013

These final regulations replace the interim regulations for parity and will begin to apply for plans on the first day of the plan year which begins or renews on or after July 1, 2014 (except for some plans which are subject to a collective bargaining agreement). The application of the interim final rules, which were effective beginning on the first day of the plan year which began or renewed on or after July 1, 2010, continue to apply until the final regulations supersede them as applicable to a plan based on that specific plan's effective date for the Final Rules.

A copy of the Final Rules can be found at:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-27086.pdf>

### What are the Interim Final Rules and how do they relate to the Final Rules?

The MHPAEA was signed into law on October 3, 2008 and required three federal agencies — the Treasury (IRS), Labor, and Health and Human Services — to draft and publish implementing regulations. The initial regulations were published in the Federal Register on February 2, 2010 at 75 FR 5410 as Interim Final Rules. A copy of these Interim Final Rules can also be obtained online at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>.

These initial regulations were published as "Interim Final Rules" (the "Interim Final Rules" or "IFR"). This means that, while these rules were official binding regulations (not proposed ones); they must be complied with by plans. The agencies considered additional comments and information regarding the IFR and subsequently issued a set of Final Rules on November 13, 2013 (the "Final Rule"). The Final Rules essentially replace the Interim Final Rules.

### When do the Final Rules take effect?

The Final Rules will begin to apply on the first day of the plan year which starts on or after July 1, 2014. For example, if the plan year runs on a calendar-year basis, the effective date would be January 1, 2015.

Note: There is a special rule for plans that are subject to a collective bargaining agreement that was executed prior to October 3, 2008 have to comply with the regulations on either July 1, 2014 or on the first day of the plan year beginning on or after the last of the collecting bargaining agreements relating to the plan terminates, whichever is later.

### Who does it cover?

All plans that are subject to the MHPAEA are subject to the Final Rules except for Medicaid Managed Care Plans, alternative benefit plans ("ABP's"), or the Children's Health Insurance Program (CHIP). On January 16, 2013, the Center for Medicare & Medicaid Services released a State Health Official Letter about the application of MHPAEA requirements to Medicaid Managed Care Plans, ABP's and CHIP and has indicated separate Medicaid/ABP/CHIP regulation will be forthcoming.

Note: Medicare Advantage plans are not subject to the parity law or these regulations unless they are a group plan sponsored by an employer for employees. Retiree-only plans are not subject to MHPAEA.

### Final Rules: Key Provisions

The Final Rules are similar to the Interim Final Rules in many respects. We have included a full review of all the provisions in the Final Rules, including those that are identical to the Interim Final Rules. We have highlighted changes and new developments added by the Final Rules but much of this summary will be familiar and redundant from the Interim Final Rules but we have included the complete substance of the Final Rules for context and ease of reference.

### General Information

- The Rules update the prior 1996 federal mental health parity law — which ONLY applied to annual and lifetime dollar maximums for benefits for mental health disorders — to now apply to both mental health and substance use disorder benefits.

- The Rules do not mandate coverage of any mental health and substance use disorder benefits. However, if a plan chooses to provide coverage for mental health and substance use disorder benefits, it must do so in compliance with the Rules. Plans may define which conditions they will cover and which they will not; however, fully insured plans are also subject to state law mandates and both fully insured and self-insured plans may be subject to mandates under the Affordable Care Act which include coverage of mental health and substance use disorder treatment benefits.
- The Rules add some additional terms and clarify the meaning of existing terms contained in the law. We will discuss these terms in the context of the various provisions of the Rules in the following sections.

## Parity Regulations for Financial Requirements and Treatment Limitations

### General Requirement

- As stated in the MHPAEA, plans must ensure that the financial requirements and treatment limitations applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits. The Rules amplify and explain the basis for determining this parity.

### Key Terms

- **Quantitative Treatment Limitations:** Benefit plan limits which are expressed in terms of a numeric amount that serves to limit the scope or duration of the benefits such as day limits, visit limits, limits on length of treatment or episodes of treatment.
- **Non-Quantitative Treatment Limitations:** Benefit plan limits that are not numeric but serve to limit the scope or duration of treatment such as medical management strategies, network admission standards, reimbursement methodologies.
- **“Classification” of benefits:** The Rules establish six classifications of benefits:
  - Inpatient, in-network (IIN)
  - Inpatient, out-of-network (ION)
  - Outpatient, in-network (OIN)\*
  - Outpatient, out-of-network (OON)\*
  - Prescription drugs
  - EmergencyParity must be determined on a classification-by-classification basis. This means parity is assessed for each requirement or

limitation between medical/surgical benefits and mental health and substance use disorder benefits of the same classification. If a plan offers medical benefits in one classification, it must also provide mental health and substance use disorder benefits in that classification as well, assuming the plan has chosen to provide coverage for mental health and substance use disorder benefits.

- **“Type” of financial requirements and treatment limitations:** This refers to a requirement or limitation of the same nature (e.g., copayments or annual day limits are different “types” of requirements/limitations).
- **“Level” of requirements/limitations:** The magnitude of a single type of requirement. For example, different levels of copayments (e.g., \$10 and \$25) within a single classification of benefits.
- **“Coverage Unit”:** The groupings of individuals covered by the plan (e.g., individual, individual-plus-spouse, family). Because requirements and limitations may vary by coverage unit, the Rules specify that general parity be assessed separately for separate coverage units.

## Financial Requirements and Quantitative Treatment Limitations

The Rules clarify how to apply the general parity requirement to financial requirements (copayments, coinsurance, deductibles) and quantitative treatment limitations (e.g., day limits, visit limits, number of episode limits, etc.) by means of a specific calculation method.

### FINAL RULES UPDATE

For purposes of applying the financial requirement and treatment limitation rules:

The rules reiterate the earlier safe-harbor guidance issued on July 1, 2010, that permits dividing the outpatient classifications into two subdivisions for (i) office visits and (ii) all other outpatient items and services in order to calculate parity of financial requirements and quantitative treatment limitations.

The law now accommodates testing multi-tier plans, such as one which includes out-of-network, in-network, and premier network benefits. It works by dividing the in-network tier into sub-classifications that reflect the in-network benefits and premier network benefits. The in-network sub-classifications must be created in compliance with the nonquantitative treatment limitation rules.

The method is as follows:

1. Determine whether a type of requirement or treatment limitation applies to “substantially all” medical/surgical benefits — meaning two-thirds or more of the medical/surgical benefits within the specific classification (or sub-classification) of benefits. “Substantially all” is based on the dollar amount of plan payments for benefits as determined by any reasonable method of the plan’s choosing.
2. If a type of financial requirement or treatment limitation does not apply to “substantially all” medical/surgical benefits in a classification (or sub-classification) of benefits, it cannot be applied to mental health or substance use disorder benefits in that classification (or sub-classification).

Example: If, for the outpatient, in-network office sub-classification, less than two-thirds of the benefits are subject to a copayment, then a copayment cannot be applied to the outpatient, in-network office-based mental health and substance abuse benefits.

3. If a single level of a type of requirement or limitation applies to more than half of the benefits in a classification (or sub-classification), then that is also considered the “predominant” requirement or limitation, which must be applied to office-based mental health and substance use disorder benefits in the same classification (or sub-classification).

Example: If the medical/surgical benefits have only one level of copayment for all outpatient, in-network office-based services (say, \$20), then that is the “predominant” requirement and the outpatient, in-network copayment for mental health and substance use disorder services cannot be more restrictive than that “predominant” copayment (so the mental health and substance use disorder copayment would need to be, in this case, \$20 or less).

4. If there is more than one level of a type of a requirement or limitation, then further analysis must be done to determine which of the various levels is the “predominant” level. The “predominant” level is the one which applies to more than half of all the benefits (again based on cost as noted under No. 1 above), which are subject to that type of requirement/limitation.

Example: A plan’s medical/surgical benefits provide two levels of copayments for outpatient, in-network office-based benefits: primary care at \$20 and specialty care at \$30. Upon analysis, the plan assesses that the \$20 copayment applies to more than half of the total plan payments for these benefits (and is considered the “predominant” copayment).

Therefore, the copayment for outpatient, in-network office-based mental health and substance use disorder benefits must be \$20 or less.

If no single level is considered to be “predominant,” then the Rules discuss combining levels until more than half of the benefits are subject to the requirement, and then the least restrictive level of those used to reach that threshold is considered the “predominant” level.

5. If a plan provides benefits for more than one coverage unit and applies different levels of a requirement/limitation based on coverage unit, then the “predominant” level is determined separately for each coverage unit.

In regards to benefits for prescription drugs, the Rules allow these benefits to be tiered based on “reasonable” factors (including cost, efficacy, generic vs. brand-name, and mail-order vs. pick-up). Parity is to be assessed separately based on these tiers.

### Cumulative Financial Requirements and Cumulative Treatment Limitations

The Rules define “cumulative financial requirements” and “cumulative treatment limitations” as ones that apply across covered expenses/treatments and which determine whether, and to what extent, benefits are provided. The most common examples are deductibles, out-of-pocket maximum limits, and day/visit limits.

The Rules expressly prohibit the use of separate cumulative financial requirements and cumulative treatment limitations for mental health and substance use disorder benefits. If a plan wishes to use such requirements and limitations, they must be combined and applied to both medical/surgical benefits and mental health and substance use disorder benefits together.

#### FINAL RULES & HEALTH CARE REFORM INTERACTION UPDATE

The only exceptions to this prohibition are for the annual and lifetime dollar limits on benefits. As stated in the earlier 1996 federal parity law, these may be maintained separately for mental health and substance use disorder benefits. However, note that these dollar limits may not be permissible under the Patient Protection and Affordable Care Act (“PPACA” or “ACA”).

## Non-Quantitative Treatment Limitations

The Rules define the category of “treatment limitations” from MHPAEA to include non-quantitative treatment limitations and sets forth a standard for assessing parity of these Non-Quantitative Treatment Limitations distinct from the calculation method noted above that is used for financial requirements and quantitative treatment limitations.

The standard is that a group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitations to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

The Rules call out the following examples of non-quantitative treatment limitations, but indicates that there are likely others:

1. Medical management standards limiting or excluding benefits based on medical necessity or appropriateness, or based on whether the treatment is experimental or investigational
2. Formulary design for prescription drugs
3. Standards for provider admission to participate in a network, including reimbursement rates
4. Plan methods for determining usual, customary and reasonable charges
5. Exclusions or limitations on particular therapies or treatments, unless another alternative treatment is attempted as a pre-condition — known as “fail first” or “step therapy” protocols
6. Restrictions based on geographic location, facility type or provider specialty.

The “processes” used to apply medical management standards (No. 1 above) include elements such as pre-authorization, concurrent review, retrospective review, case management, and utilization review.

The Rules explicitly note that EAP “gatekeeper” models — where a plan requires people to use all of their EAP visits before using the mental health and substance use disorder benefits — are a prohibited form of a “fail first” protocol (No. 5 above) because it has no equivalent on medical/surgical plans.

### **FINAL RULES AND HEALTH CARE REFORM INTERACTION UPDATE**

No. 6 above is a new example of specific non-quantitative treatment limitations explicitly stated in the Final Rules — geographic location, facility type or provider specialty. In conjunction with these new explicit examples, the regulators have indicated that intermediate levels of care (such as skilled nursing facility care residential treatment services or intensive outpatient services) need to be consistently mapped across medical/surgical and mental health/substance use disorder benefits into one of the six classifications and subjected to the parity standards — both for quantitative and non-quantitative limitations — required for services within that classification.

The Final Rules also confirmed that providing preventive benefits, such as alcohol screening, mandated by the PPACA preventive rules doesn’t on its own trigger mental health parity requirements to provide coverage in each of the six classifications for that particular mental health or substance use disorder condition.

## Availability of Plan Information and Plan Denial Disclosure Requirements

The MHPAEA contained two requirements for disclosure by plans:

1. The plan must provide the criteria for medical necessity determinations to any current or potential participant, beneficiary, or contracting provider upon request.
2. The plan must provide the reason for any denial of reimbursement or payment for services with respect to benefits under the plan.

These requirements already exist under other federal and state laws, and Optum is in compliance with these requirements. According to the Rules, plans that meet these requirements under existing federal and state laws will be deemed compliant with these requirements under MHPAEA to the same extent.

#### FINAL RULES UPDATE

The final rules include an example of the interaction between the MHPAEA and existing ERISA disclosure requirements. In the example, if a member makes an ERISA Section 104 request for instruments under which the plan is established or operated, a compliant response includes "documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a non-quantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. This same information is also to be provided upon request (at no cost to the member) if the member requests this information as part of the member's appeal of an adverse benefit determination.

#### FINAL RULES & HEALTH CARE REFORM INTERACTION UPDATE

Due to an interaction with the essential health benefit requirements under the Affordable Care Act, the previous small employer exemption under the Interim Final Rules is **only** available to grandfathered plans with 50 or fewer employees. For other small group plans, the prior exemption from parity no longer applies.

#### FINAL RULES UPDATE

**Cost-based exemption:** Prior regulations applicable to the 1996 federal parity law are repealed and a new cost-based exemption from MHPAEA is available. To qualify for a cost-based exemption, a plan must experience at least a 2% increase on total plan costs in the first plan year of parity, and a 1% increase in the case of each subsequent plan year. A cost-based exemption is good for a single year only, and only for alternating years. A formula is provided to calculate whether or not the exemption requirements are met, and such calculation is to be made and certified by a qualified and licensed actuary.

#### Miscellaneous Provisions

- **Separate plans by an employer/plan sponsor:** All medical care benefits provided by an employer or plan sponsor constitute a single group health plan for parity purposes. This means that an employer/plan sponsor cannot avoid parity requirements by establishing a separate group health plan just for mental health and substance use disorder benefits.
- **Applying parity to separate coverage plans:** Parity requirements for a single mental health and substance use disorder benefit package (e.g., a carve-out) and multiple medical/surgical coverage plans or benefit packages must be applied to each combination of medical/surgical and mental health and substance use disorder benefits.
- **Interaction with state laws:** State laws are only superseded or preempted if they prevent the application of the MHPAEA or the Rules. In most cases, this will not occur. However, state autism mandate laws in some cases specify annual benefit maximums expressed in quantitative amounts (e.g. annual dollar limits, hour limits, age limits etc.). It appears these limits will conflict with MHPAEA and the Rules, and would thus be preempted.

#### Some Requirements Remain Unclear

The Rules contain some language which remains ambiguous and open to interpretation. We expect further guidance will be forthcoming from the regulatory agencies through informational sessions and bulletins. We will provide timely updates of this guidance to you as they become available.

Optum stands ready to help you with planning and preparation for the new federal parity law. Call your Optum representative today.

This document is for informational purposes only and is not intended to provide legal advice to you or your Plan. We recommend you seek advice of counsel in assessing the requirements of the law and the impact on your plan.



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