Labor and Employment Alert: Mental Health Parity and Addiction Equity Act Parity Analysis is Fine Tuned

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Summary: New final regulations under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) apply to group health plans in plan years beginning on or after July 1, 2014 (January 1, 2015 for calendar year plans). The regulations generally incorporate the 2010 interim final regulations and subsequent FAQs, with some notable clarifications:

- Employers may need to revisit their parity analysis with respect to medical management (i.e., non-quantitative treatment limitations) of mental health and substance abuse treatment.
- If a plan has multiple tiers of in-network providers, mental health/substance abuse parity may be tested separately for each tier.

Background

A group health plan that covers both mental health/substance use disorder benefits and medical/surgical benefits must cover the mental health/substance use disorder benefits in parity with the medical/surgical benefits. Generally, this means that the financial requirements (e.g., coinsurance, deductibles, out-of-pocket maximums) and treatment limitations (e.g., visit limits, days in a waiting period, days of coverage) that apply to mental health/substance use disorder benefits cannot be more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.

The MHPAEA parity analysis is conducted on a classification-by-classification basis, with six specific classifications identified: (1) inpatient/in-network; (2) inpatient/out-of-network; (3) outpatient/in-network; (4) outpatient/out-of-network; (5) emergency care; and (6) prescription drug.

New Final Regulations

The new final regulations retain the six classifications and confirm that mental health/substance use disorder benefits, and medical/surgical benefits, cannot be characterized outside of these six classifications for

purposes of the MHPAEA parity analysis.

Some of the notable changes that were made from the 2010 regulations include:

- **Clarification of Non-Quantitative Treatment Limitations (NQTLs).** While the list of NQTLs in the regulation is, by its terms, illustrative and not exhaustive, the list was nonetheless expanded in the final regulations to specifically include: network tier design, 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." NQTLs must be applied no more stringently to mental health and substance use disorder benefits than to medical/surgical benefits in the same classification.

- **Variations in NQTLs for Recognized Clinically Appropriate Standards of Care.** Group health plans may not impose NQTLs – such as medical management standards that limit or exclude benefits based on medical necessity, or plan methods for determining usual, customary and reasonable charges – on mental health/substance use disorder benefits ***unless*** the standards or processes used in applying the limitation are applied *no more stringently* to those benefits than to medical/surgical benefits in the same classification. Previously, an exception allowed for variation "to the extent that recognized clinically appropriate standards of care may permit a difference." This exception was deleted from the final regulations. Now, compliance with the NQTL requirements is required without such an exception. The preamble explains that plans will be able to take into account clinically appropriate standards of care in the parity analysis.

- **Disclosure of Processes and Standards.** Several disclosure requirements apply. The plan administrator must disclose the criteria for a "medical necessity" determination whenever requested by a current or potential participant, beneficiary, or contracting provider. For plans not subject to ERISA, the reason for any denial of benefits must be provided upon request by a participant or beneficiary. For plans subject to ERISA, which is typically the case for non-governmental group health plans, enhanced disclosures apply. The plan documents must be provided within 30 days of a request by a participant (or an employee potentially eligible to enroll). The documents would include medical necessity criteria as well as the processes and other factors used to apply NQTLs. ERISA's well-developed claims and appeals procedure would also apply to the denial of a claim.

- **Sub-Classification Permitted for In-Network Tiers.** A plan or insured coverage that provides benefits through multiple tiers of in-network providers – for example, preferred providers associated with differing levels of cost-sharing – is likewise permitted to break down those benefits into sub-classifications that reflect the tiers. The sub-classifications must be based on reasonable factors and determined without regard for whether a provider is a mental health/substance use disorder provider or a medical/surgical provider.

- **Sub-Classification Permitted for Outpatient Benefits.** In conducting the parity analysis, outpatient benefits can further be broken down into two sub-classifications: *office visits*, and *all other outpatient items and services*. This sub-classification acknowledges that plans often require a co-pay for office visits while requiring co-insurance for all other outpatient services. This change incorporates informal guidance previously issued in a FAQ.

- **Interaction with Preventive Health Services.** Theoretically, a group health plan that excludes all mental health/substance use disorder benefits is not subject to the MHPAEA. The exception is lost if the plan provides any sort of mental health/substance use disorder benefit in any category (triggering the requirement to provide mental health/substance use disorder benefits in full parity to medical/surgical benefits). The new regulation creates one exception: mental health/substance use disorder benefitsthat are included in preventive care. The Patient Protection and Affordable Care Act (PPACA) 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 regulations make clear that, if a group health plan provides mental health/substance use disorder benefits only to the extent required under the PPACA, the MHPAEA will not operate to require that additional mental health/substance use disorder benefits be offered in order to satisfy the parity requirement.

- **Small Employer Exemption.** The final regulations continue to provide an exemption from the MHPAEA for group health plans of small employers (i.e., who had no more than 50 employees on business days during the preceding calendar year). However, the preamble cautions that this exemption is essentially eliminated for insured small employer plans that are not grandfathered under the PPACA. This results from regulations issued by the Department of Health and Human Services (HHS) in February 2013 regarding the essential health benefits (EHBs) required under the PPACA. Among other benefits, EHBs include "mental health and substance use disorder services, including behavioral health treatment." (The exact parameters of the EHB coverage is determined based on benchmark plans that are selected by each state, however). The HHS regulations require issuers of non-grandfathered, small group plans to cover EHBs in compliance with the MHPAEA regardless of the MHPAEA small employer exemption. Retiree-only plans (i.e., with no more than two current employees) remain exempt.

- **Increased Cost Exemption.** The final regulations flesh out this exemption, which is available to group health plans that make the necessary changes to comply with the MHPAEA and incur an increased cost of at least two percent in the first year the MHPAEA applies, or at least one percent in any subsequent year. The exemption is based on the prior plan or policy year, and applies for only one year. As a result, an exemption can potentially be claimed only in alternating years. The formula is spelled out in the regulations, with the plan's increased cost calculated net of the five-year average annual spending growth attributable to secular trends. The determination must be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. Notice of the exemption must be provided to the plan participants and beneficiaries, and must also be provided to the Secretary of the Treasury, Labor and/or Department of Health and Human Services, and to the appropriate state agencies.