

# The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

## A Summary of the Final Rules: What you need to know

### Background

The Mental Health Parity Act, as amended by the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), requires parity between mental health or substance use disorder (MH/SUD) benefits and medical/surgical benefits.

Under MHPAEA, if a plan covers both medical/surgical benefits and MH/SUD, MHPAEA requires that the financial requirements and treatment limitations imposed on MH/SUD benefits be no more restrictive than the predominant financial requirements and restrictions that apply to substantially all medical/surgical benefits. Plans must also provide parity with respect to the use of non-quantitative treatment limitations.

MHPAEA and the Final Rules do not require plans to cover MH/SUD benefits. However, if a plan chooses to provide coverage for MH/SUD benefits, the plan must comply with the Federal Parity requirements. In addition, fully insured plans are subject to state law mandates, and both fully insured and self-insured plans may be subject to mandates under the Affordable Care Act (ACA) that require the coverage of MH/SUD treatment benefits.

### When do the Final Rules take effect?

Final Rules (FR) were issued in November, 2013 and are effective on the first day of the plan year that 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.

A copy of the Final Rules can be found at <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=27169>.

**Note:** Interim Final Regulations (IFRs) were published in the Federal Register on February 2, 2010. Plans must continue to comply with the IFR until the date that the Final Rule becomes effective for the particular plan.

A copy of the Interim Final Rules can be found at <http://webapps.dol.gov/FederalRegister/PdfDisplay.aspx?DocId=23511>.

**Collectively Bargained Plans:** There is a special effective date rule for plans that are subject to a collective bargaining agreement that was executed prior to October 3, 2008. Such plans must comply with the regulations on the later of (a) July 1, 2014, or (b) the first day of the plan year beginning on or after the last of the collective bargaining agreements relating to the plan terminates.

### What plans are subject to the mental health parity requirements?

#### Large group plans

Initially, MHPAEA applied only to fully insured and self-funded health plans covering 51 or more employees. However, the ACA and its implementing regulations, extended MHPAEA's applicability to individual and some small group plans.

#### Individual and Small group plans

MH/SUD services are classified as essential health benefits (EHBs) under the ACA. As such, non-grandfathered health plans in the individual and small group markets must cover these benefits in order to comply with the requirements of the ACA. Because these plans are now required to include MH/SUD coverage, they will be required to comply with the requirements of the Federal parity rules.

FAQs issued on January 9, 2014 provided the following summary of how the ACA affects the application of the Federal parity rules:

Non-grandfathered individual market coverage not otherwise subject to the Health and Human Services (HHS) transitional policy must include coverage for MH/SUD benefits, and that coverage must comply with the Federal parity requirements.

Grandfathered individual market coverage is not subject to the EHB requirements and therefore is not required to cover MH/SUD benefits. However, if a grandfathered individual plan does include coverage of MH/SUD benefits, that coverage must comply with Federal parity requirements.

Non-grandfathered small group market coverage (on or off exchange) that is not otherwise subject to the HHS transitional policy must include coverage for MH/SUD benefits, and that coverage must comply with the Federal parity requirements.

Grandfathered small group market coverage is not required to comply with either the EHB provisions or MHPAEA.

### Small Employer Exemption

MHPAEA still contains an exemption for small group plans with 50 or fewer employees. However, as described above, under the ACA requirement to provide EHB, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits and these benefits are subject to the Federal parity rules.

### Increased Cost Exemption

The increased cost exemption remains available to plans that meet the requirements for the exemption. The final rules establish standards and procedures for claiming an increased cost exemption under MHPAEA.

### Opt Out Election for non-federal government plans

Plans for State and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken.

### Other Exemptions

- Retiree only plans
- Plans offering only excepted benefits (as defined by HIPAA)
- TriCare
- Medicare
- Traditional Medicaid (FFS, non-managed care).

## Final Parity Regulations

### General Requirement

- ▶ As stated in the MHPAEA, plans must ensure that the financial requirements and treatment limitations applied to MH/SUD benefits are no more restrictive than those applied to medical/surgical benefits.

### Key Terms

- ▶ **“Financial Limits”** include deductibles, copays, coinsurance and maximum out-of-pocket limits.
- ▶ **“Quantitative treatment limitations”** are treatment limits expressed numerically such as day/visit/episode limits.

- ▶ **“Non-quantitative treatment limitations”** are not expressed numerically, but serve to limit the scope or duration of treatment, and include medical management strategies, network admission standards, or reimbursement methodologies.
- ▶ **“Type” of financial limits and quantitative treatment limitations** 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 financial limits and quantitative treatment limitations** is 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”** refers to 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

To test for parity, the financial requirements and quantitative treatment limitations applicable to MH/SUD benefits must be compared to the financial requirements and quantitative treatment limitations that apply to the medical/surgical benefits. The IFR required that this comparison must be done on a classification by classification basis using the following six categories (and no others):

- inpatient/in-network;
- inpatient/out-of-network;
- outpatient/in-network;
- outpatient/out-of-network;
- pharmacy and
- emergency services.

The Final Rules maintained this classification scheme as well as formalizing a previously approved safe harbor which allows plans to further split the outpatient classification into two subclasses: (a) office visits, and (b) all other outpatient items and services (“all other”).

In addition, the Final Rules retain the requirements in the IFR that if a plan provides MH/SUD benefits in any of the six classifications, then benefits must be provided in every classification in which medical/surgical benefits are provided. 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 MH/SUD condition.

## Quantitative Testing

Under the parity rules, financial and quantitative treatment limits for MH/SUD services under a plan can be no more restrictive than the “predominant” financial limits or quantitative treatment limits that apply to “substantially all” of the plan’s medical/surgical benefits.

A financial or treatment limit applies to “substantially all” of the medical/surgical benefits in a classification, if it applies to at least two-thirds of the medical/surgical benefits. If the limit applies to less than two-thirds of the medical/surgical benefits in that classification, then that limit cannot be applied to the MH/SUD benefits in that 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 MH/SUD benefits.

If the “substantially all” test is met, then the “predominant” level of that financial requirement or treatment limitation must be determined. The predominant level of the financial or treatment limitation allowable for MH/SUD benefits in a classification is the lowest level that applies to at least 50 percent of the medical/surgical benefits in that classification.

**Example 1:** 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 MH/SUD services cannot be more restrictive than that “predominant” copayment (so the MH/SUD copayment would be, in this case, \$20 or less).

**Example 2:** 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 determines 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 MH/SUD 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.

If plan provides benefits for more than one type of 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 regard 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 versus pickup). Parity is to be assessed separately based on these tiers.

The Final Rules specifically accommodate 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 non-quantitative treatment limitation rules.

## Cumulative Financial Requirements and Cumulative Treatment Limitations

As in the IFR, the FR continues the prohibition against separate cumulative financial requirements or separate cumulative quantitative treatment limitations for MH/SUD benefits and medical/surgical benefits.

If a plan wishes to use such requirements and limitations, they must be combined and applied to both medical/surgical benefits and MH/SUD benefits together. For example, a plan cannot have a deductible or out-of-pocket limit for MH/SUD and a separate deductible or out-of-pocket limit for medical/surgical. Both the MH/SUD and medical/surgical benefits must accumulate to the same deductible and out-of-pocket limit.

## Non-Quantitative Treatment Limitations

Under MHPAEA, a plan may not impose a non-quantitative treatment limitation with respect to MH/SUD 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 MH/SUD 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 Final Rules contained the following examples of non-quantitative treatment limitations:**

1. Medical management standards (prior authorization, concurrent review, bed day review, etc.) or limiting/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

There is no mathematical test for non-quantitative treatment limitations, so for each classification of MH/SUD benefits, the application/operation of these limits must be “manually” compared to such limits applying to medical/surgical benefits in the same classification.

## 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.

## Employee Assistance Programs

The Rules explicitly note that Employee Assistance Programs (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.

## 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 UnitedHealthcare 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.

However, the Final Rules clarify that in addition to these two requirements, provisions of other applicable law also require disclosure of information relevant to MH/SUD benefits. For example, ERISA plans are required to provide the instruments under which the plan is established or operated to members upon request. This would include documents with information on any medical necessity criteria for both MH/SUD and medical/surgical benefits, as well as the “processes, strategies, evidentiary standards and other factors used to apply a non-quantitative limitation to MH/SUD and medical/surgical benefits. 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.

## 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.

## FINAL RULES AND HEALTH CARE REFORM INTERACTION UPDATE

Due to an interaction with the EHB requirements under the ACA, 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 once EHB requirements are applicable to the small group plan.

## 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 two percent increase on total plan costs in the first plan year of parity, and a one percent 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.

UnitedHealthcare stands ready to help you with planning and preparation for the recently issued federal parity regulations. Call your UnitedHealthcare representative today.

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