SEYFARTH SHAW

Health Care Reform Management Alert Series

Mental Health Parity and Health Care Reform

Issue 76

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This is the seventy-sixth issue in our health care reform series of alerts for employers on selected topics in health care reform. (Our general summary of health care reform and other issues in this series can be accessed by clicking here.) This series of Health Care Reform Management Alerts is designed to provide a more in-depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Departments of Treasury, Labor, and Health and Human Services (the "Departments") issued their final rule in November under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) following up on their interim final rules (IFRs) issued in 2010. The final rule does not significantly depart from the IFRs. In addition to providing clarification to financial requirements and quantitative treatment limitations, the final rule eliminates an exception to the nonquantitative treatment limitations parity requirement and adds new guidance on the interaction between MHPAEA requirements and the Affordable Care Act (ACA).

Plans will need to comply with the final rule for plan years beginning on or after July 1, 2014. Until the final rule takes effect, group health plans will need to continue to comply with the provisions of the IFRs.

Background

Under MHPAEA, a group health plan or policy that includes medical/surgical benefits and mental health and substance use disorder ("mental health") benefits cannot impose financial requirements (*e.g.*, deductibles and co-payments) or quantitative treatment limitations (*e.g.*, number of visits or days of coverage) on mental health benefits that are more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "substantially all/predominant test"). The IFR established six classifications of benefits and provided that this parity analysis be applied on a classification-by-classification basis.

The IFR also set forth parity requirements with respect to nonquantitative treatment limitations (*e.g.*, medical management standards, formulary design and determination of usual/customary/reasonable amounts).

Six Classifications of Benefits

- in-patient/in-network,
- in-patient/out-of-network,
- out-patient/in-network,
- out-patient/out-of-network,
- emergency care, and
- pharmacy benefits.

Sub-classifications and Multiple Tiers of In-Network Providers

Under the final rule, plans and issuers may use sub-classifications to conduct the parity analysis outlined above. Specifically, plans and issuers may subdivide outpatient benefits into:

- office visits, and
- all other outpatient items and services.

The Departments recognize that tiered networks have become an important tool to manage care and control costs. Therefore, for plans and issuers that provide multiple tiers of in-network providers (such as a tier of preferred providers with more generous cost-sharing to participants), the final rule allows plans to divide in-network benefits into sub-classifications that reflect those tiers. However, if sub-classifications are established for tiered networks, the tiers will need to be based on reasonable factors and without regard to whether a provider is a mental health provider or medical/surgical provider. Furthermore, if there are an uneven number of tiers, the plan will be considered to be in compliance with the final rules if it treats the least restrictive level (of the financial requirement or quantitative treatment limitation) that applies to at least 2/3 of medical/surgical benefits across all provider tiers as the predominant level for mental health benefits. Finally, sub-classifications not specifically permitted in the final rule, such as separate sub-classifications for generalists and specialists, cannot be used for purposes of determining parity.

Scope of Services

The final rule clarifies how MHPAEA affects the scope of coverage for intermediate services (such as residential treatment, partial hospitalization, and intensive outpatient treatment) and how these services fit within the six classifications of benefits. Group health plans cannot exclude intermediate levels of care covered under the plan from the parity requirements, but instead must assign covered intermediate mental health benefits to the existing six benefit classifications. As an example from the preamble, if a plan classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan would be required to treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit as well. This means a plan with day limits on skilled nursing facilities and not on inpatient benefits generally would not be able to impose day limits on residential treatment facilities for mental health inpatient benefits

Nonquantitative Treatment Limitations

The standards for nonquantitative treatment limitation (*e.g.*, medical management standards, formulary design and determination of usual/customary/reasonable amounts) (NQTL) for mental health benefits in any classification must be comparable to, and no more stringent than, the standards (i.e., the processes, strategies, evidentiary standards or other factors) used in applying the limitation for medical/surgical benefits in the same classification. The final parity rule eliminates the previous exception for NQTL and no longer permits a variation "to the extent that recognized clinically appropriate standards of care may permit a difference." Group health plans, however, may continue to apply medical management techniques to medical/surgical benefits and mental health benefits. Moreover, plans need not use the same NQTLs for both mental health benefits and medical/surgical benefits, so long as the plans use comparable (and no more stringent) processes to determine whether and to what extent a benefit is subject to an NQTL. Finally, the final parity rule added two more examples of NQTLs to the illustrative list of NQTLs found in the IFRs: network tier design and "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."

Disclosure Requirements

MHPAEA requires that standards for medical necessity determinations and reasons for any denial of benefits relating to mental health benefits must be disclosed upon request to any current or potential participant, beneficiary, or contracting provider. The final rule explains that as part of the required ERISA disclosures to participants, group health plans will need to provide upon request by the participant copies of documents with medical necessity criteria for both medical/surgical benefits

and mental health benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to medical/surgical benefits and mental health benefits. Medical necessity criteria and NQTL processes would also need to be produced to participants pursuing a claim with the plan under the ERISA claims-procedure rules.

Interaction with Affordable Care Act provisions

The IFRs permitted lifetime and annual dollar limits on mental health benefits in accordance with the parity rules for such limits. On the other hand, the Affordable Care Act (ACA) prohibits lifetime and annual dollar limits on essential health benefits, which includes mental health services and behavioral health treatments. Although the final rule generally retains the parity rules found in the IFRs, it clarifies that the parity rules only apply to mental health benefits that are not essential health benefits. No dollar limits may apply to mental health benefits that are considered essential health benefits.

Precisely what mental health benefits will be considered essential health benefits depends on the applicable benchmark. The Departments have indicated that they will consider self-insured plans, insured plans in the large group market, and grandfathered plans to have used a permissible definition of essential health benefits if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). (*See Issue 46* for additional information on benchmark plans.)

Although self-insured and insured plans in the large group market are not required to offer mental health benefits, the IFRs provided that if a plan provides mental health benefits in any classification, they had to be provided in every classification in which medical/surgical benefits were provided. The ACA, however, requires non-grandfathered group health plans to provide coverage for certain preventive services without cost sharing, including, among other things, alcohol misuse screening and counseling, depression counseling, and tobacco use screening. According to the final rule, the provision of these limited mental health benefits by a group health plan as required by ACA will not trigger a broader requirement to provide additional mental health benefits in any classification.

Next Steps for Plan Sponsors

Plan sponsors will need to review their group health plan designs and documentation for compliance with the new final rules. At this time, it would be worthwhile for group health plan sponsors to review their administrative practices for disclosures to participants and for compliance with the ERISA claims procedures.

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