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**Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program**

**Summary:**

Benefits for patients with mental health and substance use disorders must be treated equally with medical/surgical benefits by insurers under final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. The final rules, released Nov. 8, 2013, requires equity with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. The Affordable Care Act (ACA) builds on the Mental Health Parity and Addiction Equity Act and requires coverage of mental health and substance use disorder services as one of ten essential health benefits categories. Under the essential health benefits rule, individual and small group health plans are required to comply with these parity regulations. The rule also contains a technical amendment relating to external review with respect to the multi-state plan program administration by the Office of Personnel Management (OPM).

**Background:**

MHPAEA was enacted on Oct. 3, 2008, amending the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act) and the Internal Revenue Code of 1986 (Code). In 1996, congress enacted the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The law applied to employment related group health plans and health insurance coverage offered in connection with a group health plan. The changes made by MHPAEA are generally effective for plan years beginning after Oct. 3, 2009.

The ACA was enacted in 2010 and reorganizes, amends, and adds to the provisions in the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The ACA also amends ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans.

The ACA also extended MHPAEA to apply to the individual health insurance market and redesignated MHPAEA as it would apply to health insurance issuers and group health plans. In addition, the HHS final regulation regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets, through an Affordable Insurance Exchange or outside of an Exchange, to comply with the requirements of the MHPAEA regulations in order to satisfy the requirement to cover EHBs. Interim final rules were published in 2010. In light of the comments and other feedback, the departments issued clarifications in several rounds of Frequently-Asked-Questions (FAQs).

**Oversight Agencies**

- Department of the Treasury, Internal Revenue Service (IRS), 26CFR Part 54
- Department of Labor (DOL), Employee Benefits Security Administration (EBSA), 29 CFR Part 2590
- Department of Health and Human Services (HHS), 45 CFR Parts 146 and 147

**Action**

Final Rules

**Highlights of the Final Rule**

Federal mental health parity does not require plan sponsors to cover mental health or substance abuse benefits; however the ACA does include mental health and substance use treatment as part of the 10 essential health benefits which constitute credible coverage.

MHPAEA requires that employers and group health plans that provide both mental health (MH) and substance use disorder (SUD) services and medical/surgical benefits ensure that:

- The **financial requirements** applicable to such MH or SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost-sharing requirements that are applicable only to MH or SUD benefits.[7]
- The **treatment limitations** applicable to such MH or SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only to MH or SUD benefits.

MHPAEA also includes requirements that group health plans make available information related to MH/SUD **medical necessity criteria** and **reasons for any denials** for MH/SUD services. If requested, medical necessity criteria must be provided to plan administrators, potential participants, beneficiaries, and contracting providers. In addition, if requested, explanations of denials must be provided to participants or beneficiaries.

The rule provides specific **formulas for determining parity** which must be applied to the six benefit classifications (inpatient preferred, inpatient non-preferred, outpatient preferred, outpatient non-preferred, emergency, and pharmacy as noted above).

- The formulas are applied to determine what the "predominant" medical surgical financial requirement (e.g. member cost share such as co-pays or co-insurance) is that applies to "substantially all" medical/surgical benefits within a classification.
- In order to meet the "substantially all" requirement, a single type of member cost share (e.g.) co-pay must apply to at least two thirds of the medical/surgical benefits within a classification.
- If a single type of cost share does not occur at least two thirds of the time within a medical/surgical classification the result is that behavioral health benefits within that classification must be covered at 100 percent without any member cost share.
- If a single type of cost share does occur at least two thirds of the time within a medical/surgical classification, the next step is determining what the predominant cost share is within that same classification.
- These determinations must be made on a plan design specific basis.

***Interaction with State Insurance Laws*—**MHPAEA does not supersede state parity law unless state law prevents the application of a MHPAEA requirement.

***Classification of Benefits***

- Establishes an *enforcement safe-harbor* where the departments will not take enforcement action against plans and issuers that divide benefits furnished on an outpatient basis into two sub-classifications, (1) office visits, and (2) all other outpatient items and services, for the purposes of applying the financial requirement and treatment limitation rules under MHPAPEA. On July 1, 2010, DOL released safe harbor guidance that allows for the creation of office visit and outpatient/other (non-office visit) sub-classes within the outpatient classifications of benefits.

- Prohibits a plan or issuer from imposing any *financial requirements or quantitative treatment limitation* on mental health or substance use disorder benefit in a sub classification (i.e., office visit or non-office visits) that is more restrictive than the financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification.

- Plans that provide *benefits through multiple tiers* of in-network providers, may also divide the benefits into sub-classifications reflecting those tiers as long as mental health and substance use benefits are treated equitably with the medical/surgical benefits. Prohibits the imposition of additional financial requirements or more restrictive quantitative treatment limits on mental health or substance use disorder benefits.

- The final rule retains the *six classifications* specified in the interim final rule as permissible sub-classifications with parity required for each: inpatient in-network; inpatient out-of-network; outpatient in-network;

- MHPAEA does not supersede state parity law unless state law prevents the application of a MHPAEA requirement.

**Measuring Plan Benefits—**The final rule retains the "substantially all" and "predominant" tests as formulated in the interim final rule. It provides that the determination of the portion of medical/surgical benefits in classification of benefits subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. The dollar amount of plan payments is based on the amount the plan allows rather than the amount the plan pays because payment based on the allows amount covers the full scope of the benefits being provided.

**No Lifetime Limits or Annual Limits—**Notwithstanding the provisions of MHPAEA that permit aggregate lifetime and annual dollar limits with respect to mental health and substance use disorder benefits as long as those limits are in accordance with the parity requirements for the limits, dollar limits are prohibited with respect to mental health and substance use disorder benefits that are covered as essential health benefits (EHBs).

**Cumulative Financial Requirements and Cumulative Quantitative Treatment Limitations (QTL)—**The compliance standard is that a particular type of financial requirement or QTLs (e.g., copays vs. coinsurance or limits on the number of outpatient visits) must apply to substantially all (i.e., at least two-thirds) of the medical/surgical benefits in a classification before it may be applied to mental health or substance use disorder benefits in that classification, the permissible level of the financial requirement or treatment limit is set by determining the predominant level that applies to at least 50 percent of the medical/surgical benefits subject to that of requirement or limit.

**Exceptions for Clinically Appropriate Standards of Care—**The final rule retains the provisions of the interim final rule regarding annual and lifetime limits which apply to the provisions of mental health and substance use disorder benefits that are not EHBs. Limits not expressed numerically that otherwise limit the scope or duration of benefits include but are not limited to:

- Medical management standards,
- Prescription drug formulary designs,
- Standards for provider admission to participate in a network,
- Determination of usual, customary, and reasonable (UCR) amounts,
- Requirements for using lower cost therapies before a plan will cover expensive therapies, and
- Conditional benefits based on completion of a course of treatment.

***ERISA-governed fully-insured group health benefit plans and ERISA-governed self-insured group health benefit plans—*** MHPAEA applies to all ERISA-governed group health plans and health insurance offered in connection with group health plans that offer coverage for both medical and surgical benefits and MH or substance abuse disorder benefits. MHPAEA also applies to group health plans and health insurance offered in connection with such plans in the non-ERISA market. Thus, MHPAEA applies to group health plans sponsored by private and public sector employers with more than 50 employees, including self-insured

as well as fully-insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees. MHPAEA exempts small employers (i.e., employers having an average of 50 or fewer employees). Under the Patient Protection and Affordable Care Act (PPACA), the small employer exemption in the Public Health Service (PHS) Act is increased to 100 or fewer employees. DOL has determined that this upward revision in the PPACA of the size of small employer groups for PHS Act purposes does not affect ERISA-governed plans, whose small employer exemption remains at 50.

***Medicaid and CHIP Managed Care Plans—***MHPAEA is incorporated by legislative reference into Medicaid, but only for certain forms of Medicaid coverage such as Medicaid Managed Care. MHPAEA also is incorporated by legislative reference into CHIP, although in states in which CHIP operates as a Medicaid expansion, the Medicaid expansion component of CHIP would be subject to Medicaid standards rather than to standards applicable to separately administered CHIP programs. MHPAEA also applies to Medicaid benchmark (a.k.a. alternative benefit plans) that will be offered by states that opt to extend Medicaid coverage to the low-income childless adult population as authorized by the PPACA.

***Employee Assistance Programs (EAPs)—***The final rule retains provisions of the interim final regulations which clarified that a plan or issuer that limits eligibility for mental health and substance use disorder benefits until after benefits under an EAP are exhausted has established a nonquantitative treatment limitations (NQTL), such as medical management techniques, and if no comparable requirement applies to medical/surgical benefits, the requirement could not be applied to mental health or substance use disorder benefits.

***Retiree-only plans—***The Departments previously clarified in FAQs that the exceptions of ERISA, including the exception for retiree-only health plans, remain in effect. Since the provisions of MHPAEA contained in ERISA, group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate) are exempt from the requirements of MHPAEA and the final regulations.

***Non-federal governmental plans—***Non-Federal Government health plans are likewise ERISA-exempt, but their coverage would be subject to the MHPAEA's PHS Act provisions, whose scope reaches both the insurance market and non-Federal Government plans. At the same time, the law permits non-federally administered self-insured government health plans to opt out of these provisions.

***State regulated insurance products sold in the small group or individual markets—***HHS has proposed to incorporate the MHPAEA requirements into the EHB requirements for coverage of mental health (MH) and substance use disorders (SUD) benefits under the PPACA. According to this interpretation, the MHPAEA compliance will be a required feature of all health insurance plans sold in the individual and small group markets starting in 2014.

***The state health insurance exchange market established under the PPACA—***Because PPACA applies MHPAEA to all qualified health plans, health plans sold in state health insurance exchanges will be required to comply with federal parity requirements.

***Church plans—***Because of their ERISA exemption, church plans are not affected by the MHPAEA's ERISA requirements. However, to the extent that an ERISA-exempt church purchases a product through a state health insurance exchange, or a state-regulated group insurance product governed by the PHS Act, the product would be subject to parity requirements, unless the church is otherwise exempt under state law.

***TriCare (the health program for uniformed service members, retirees, and their families) and the Federal Employee Health Benefit Plan (FEHBP)—***Although there is not a specific legislative requirement applying MHPAEA to the FEHBP program, these requirements do apply to the FEHBP through Executive Order and incorporation of these requirements into the purchasing and coverage standards issued by the Office of Personnel Management. MHPAEA does not generally apply to TriCare. The U.S. Department of Defense has not incorporated the MHPAEA's provisions into their purchasing and coverage standards.

***Increased Cost Exemption***—Increases the cost exemption that is available for plans and health insurance issuers that make changes to comply with the law to incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan or policy year. Plans or coverage that comply with the parity requirements for one full year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan or policy year, and the exemption lasts for one plan or policy year. In effect the increased cost exemption may only be claimed for alternating plan or policy years.

***Enforcement—***Currently, the Centers for Medicare and Medicaid Services (CMS) believes that most states have the authority to enforce MHPAEA and are acting in the areas of their responsibility. In states that lack the authority to enforce MHPAEA, CMS is either directly enforcing MHPAEA or collaborating with state departments of insurance to ensure enforcement. The Departments of Labor and the Treasury generally have primary enforcement authority over private sector employment-based group health plans, while HHS has primary enforcement authority over non-federal governmental plans, such as those sponsored by state and local government employers.

**Effective Date:**

The final rules generally apply to group health and health insurance issuers offering *group health insurance coverage* for plan years on or after July 1, 2014. Until the applicability date of the final rules, plans and issuers subject to MHPAEA must continue to comply with the final interim rules.

The ACA amended the Public Health Service (PHS) Act to apply MHPAEA to health insurance issuers offering *individual health insurance coverage* (both through the Health Insurance Marketplaces (Exchanges), and outside the Marketplaces). These

changes are effective for policy years beginning on or after Jan. 1, 2014. The final rules apply to *individual health insurance coverage* for policy years beginning on or after July 1, 2014, and apply to both grandfathered and non-grandfathered plans.

**Resources**

- CMS Mental Health Parity and Addiction Equity Fact Sheet
- Substance Abuse and Mental Health Services Administration Mental Health Parity Webpage and Resources
- MentalHealth gov
- U.S. Department of Labor Mental Health Parity Webpage and Resources
- Congressional Research Service Report (CRS): **Mental Health Parity and the Patient Protection and Affordable Care Act of 2010** (Dec. 28, 2011)
- HHS Assistant Secretary of Planning and Evaluation (ASPE): Substantial Improvements to Mental Health and Substance Use Disorder Coverage in Response to the Mental Health Parity and Addiction Equity Act of 2008 (Nov. 2013)

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