New Mental Health/Substance Abuse Parity Rules Will Apply in 2015

It’s a simple goal: Make health plan benefits for one group of conditions at least as generous as the plan’s benefits for other conditions. That’s what the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires for health plans’ mental health and substance abuse disorder benefits. As with many simple goals, it is difficult and complex to explain exactly when a health plan has achieved the MHPAEA-required parity. Federal regulators first proved this in 2010 when they issued interim final MHPAEA regulations. Now, new final regulations have managed to increase the complexity.

Executive Summary

Federal agencies have issued final regulations tightening requirements that apply to employer group health plans under the MHPAEA. That 2008 law prohibits insurers and self-funded health plans from providing less generous benefits for mental health and substance abuse (MH/SA) treatment when compared to medical/surgical benefits. An employer-sponsored health plan (as well as a carrier providing coverage under the plan) must ensure that the financial requirements and treatment limitations applicable to MH/SA benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered by the plan. Federal agencies issued interim final rules back in 2010 that began to apply to most employer-sponsored plans in 2011 (for more information, see our Alert) and have now replaced those with final regulations.
The good news is the new rules largely follow the existing rules in how plans perform the parity analysis with respect to financial requirements (e.g., deductibles and copayments) and quantitative treatment limits (e.g., numerical limits on office visits and hospital days). In addition, provisions have been added allowing separate analysis of these items when plans include certain features (e.g., multiple tiers of providers, such as instances when a healthcare provider provides in- and out-of-network benefits to its employees coupled with even more favorable in-network benefits when the employee uses the provider’s own facilities).

The bad news is we have new, stricter rules for “nonquantitative treatment limits” (NQTLs), such as medical management techniques, that will require some scrutiny. While employers that sponsor health plans have potential liability for MHPAEA violations, it may be difficult for employers to get the information they need from claims payers in order to determine whether the rules’ requirements for NQTLs are being met. Therefore, employers may want to obtain assurances regarding application of NQTLs under their plans from the carriers and vendors that pay claims under their plans.

These new, final regulations will apply for the first plan year beginning on or after July 1, 2014 (Jan. 1, 2015, for calendar year plans). The new rules will apply to insured and self-funded employer plans, as well as non-grandfathered individual or small group policies. Self-funded governmental plans can still choose to opt out of the parity rules. (For more information on the opt-out, see our Alert.) “Excepted benefits” will continue to be exempt from the rules, as well.

**Lockton Comment:** Excepted benefits will include retiree-only medical plans, as well as most dental and vision programs. Employee assistance plans (EAPs) that do not provide significant medical benefits will be treated as excepted benefits. For now, employers can use a reasonable, good faith interpretation of what qualifies as significant medical benefits. (For more information, see our Alert.)

**Why the New Rules?**

The 2010 regulations required detailed analysis of anticipated claims to identify the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits. Just after the interim rules were issued in 2010, Congress passed the health reform law (ACA). The impact of the ACA, along with several questions that the interim final regulations did not answer, led the agencies to supplement them with subregulatory guidance which is now codified. The federal agencies determined the prior rules were ambiguous about medical management techniques and this may have resulted in restricted access to MH/SA benefits.

Under the ACA, MH/SA benefits are now considered “essential health benefits.” This means that non-grandfathered insured individual and small group policies must include MH/SA benefits. Self-funded and large insured plans are exempt from the requirement to cover essential health benefits.
**Lockton Comment:** Under the ACA, non-grandfathered plans must cover certain preventive services with no participant cost-sharing. These required preventive benefits include some MH/SA treatment services, such as alcohol abuse screening and depression counseling. Fortunately, the new regulations’ preamble indicates that, if a plan covers no MH/SA services other than the required MH/SA preventive care, the plan will not trigger compliance with the parity law. This is good news for employers who are contemplating certain “skinny plan” offerings. Some skinny plan variations are based on providing no health benefits other than the preventive care services required by the health reform law.

**Background**

The 2008 parity law does not require health plans to provide any MH/SA benefits. However, if a plan provides both MH/SA benefits and medical/surgical benefits, it must meet the MHPAEA parity standards.

**Lockton Comment:** Like the prior rules, the new regulations prohibit an employer from creating a separate plan for MH/SA benefits in order to avoid the parity requirements.

As noted above, the MHPAEA does not apply to a plan unless it provides both MH/SA benefits and medical/surgical benefits.

What qualifies as a MH/SA benefit is defined under the terms of the plan, consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual (DSM-5), the most current version of the International Classification of Diseases (ICD-9), or state guidelines). Consequently, nothing in the MHPAEA or the regulations requires plans to provide benefits for any particular MH/SA condition, and plans may continue to include broad exclusions for treatment of autism, eating disorders, etc. However, insured and non-ERISA plans may be subject to state regulation on these matters. For example, many states have required that insured plans provide coverage for the diagnosis and treatment of autism.

Requirements of the federal health reform law that apply to small insured health plans mean that the small employer exemption that previously applied under the MHPAEA has been largely eviscerated.

**Parity for Financial Requirements and Treatment Limitation**

*Note: Method of analysis largely unchanged from prior rules.*

Like the prior rules, the new regulations require parity with respect to financial requirements and treatment limitations. Among other things, an employer-sponsored health plan (as well as a carrier providing coverage under the plan) must ensure that the financial requirements and treatment limitations applicable to MH/SA benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered by the plan (or coverage). In addition, health plan may not apply separate financial requirements or treatment limitations to MH/SA benefits that
don't also apply to medical and surgical benefits. Financial requirements include deductibles, copayments and out-of-pocket maximums. Treatment limitation includes annual, episode and lifetime day and visit limits. Plans will also have to demonstrate compliance with medical management techniques referred to in the regulation as nonquantitative treatment limitations (NQTLs).

Specifically, a plan cannot apply any financial condition or treatment limitation to mental health and substance abuse benefits that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits. The regulations apply a multistep process for determining parity. This test is applied to each of six classifications of benefits:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

A financial requirement or treatment limitation applies to “substantially all” medical/surgical benefits in a classification if it applies to at least two-thirds of the medical/surgical benefits in the class. The “predominant” financial requirement or treatment limit is the level that applies to more than half the medical/surgical benefits in the classification that is subject to the financial requirement or treatment limitation.

Like the prior rules, the regulations require that plan sponsors “spreadsheet” the financial requirement and treatment limitation that apply to MH/SA benefits in each of the six classifications of benefits (as applicable). Sponsors then must determine if each applies to “substantially all” of the medical/surgical benefits in the corresponding classification and, if so, the “predominant” level of the financial requirement or treatment limitation.

**Lockton Comment:** The new regulations allow outpatient benefits to be divided into two subclasses for purposes of the analysis: office visits (which often require copays) and all other outpatient services (where coinsurance typically applies). Other subclasses, such as generalists and specialists, are not permitted. As discussed below, a special analysis applies to multitiered networks.

An example of the analysis is, perhaps, the best explanation of the method: An employer’s plan provides inpatient, out-of-network medical/surgical benefits and applies five different levels of coinsurance to those benefits. Using a reasonable method, the plan projects benefit payments for the year within the inpatient, out-of-network classification at the various coinsurance levels will equal the amounts shown.
<table>
<thead>
<tr>
<th>Coinsurance Rate</th>
<th>0%</th>
<th>10%</th>
<th>15%</th>
<th>20%</th>
<th>30%</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected payments at the coinsurance level</td>
<td>$200,000</td>
<td>$100,000</td>
<td>$450,000</td>
<td>$100,000</td>
<td>$150,000</td>
<td>$1 million</td>
</tr>
<tr>
<td>Percentage of projected payments at the coinsurance level</td>
<td>20%</td>
<td>10%</td>
<td>45%</td>
<td>10%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Percentage of projected payments that are subject to coinsurance at coinsurance level</td>
<td>N/A (no coinsurance)</td>
<td>12.5%&lt;sup&gt;1&lt;/sup&gt;</td>
<td>56.25%</td>
<td>12.5%</td>
<td>18.75%</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> $100,000/$800,000 = 12.5%

In the example, 80 percent of all expected inpatient, out-of-network medical/surgical payments under the plan are subject to coinsurance. Thus, a coinsurance requirement is said to apply to “substantially all” inpatient, out-of-network medical/surgical benefits and can be applied to inpatient, out-of-network MH/SA benefits. The “predominant” level of coinsurance for inpatient, out-of-network medical/surgical care is 15 percent, because the plan expects more than half (i.e., 56.25 percent) of its inpatient, out-of-network medical/surgical benefits will be subject to coinsurance at the 15 percent coinsurance level. Consequently, the plan may not impose more than 15 percent coinsurance with respect to inpatient, out-of-network MH/SA disorder benefits.

**Special Rules**

*Note: Method of analysis largely unchanged from prior rules.*

The new regulations recycle several special and significant rules from the prior rules for purposes of applying these tests:

*Parity Applies Across Classifications (Including Benefit Package and Coverage Tier)*

If a plan provides MH/SA benefits in *any* of the six classifications, it must provide MH/SA benefits in *every* classification in which medical/surgical benefits are provided, including out-of-network care. In addition, the parity requirements apply separately to each tier of coverage (e.g., single versus family coverage) and each plan option (e.g., PPO, HMO, etc.).

*Lockton Comment:* MH/SA benefits provided solely to comply with the preventive care mandate, with no additional MH/SA benefits being provided, will not trigger this requirement. Likewise, just because an employer has an employee assistance plan (EAP), it does not trigger a requirement to provide MH/SA benefits in all
classifications in which medical/surgical benefits are provided, assuming that the EAP does not provide significant benefits in the nature of medical care.

Combining Levels of Coverage or Benefits

If there is no “predominant” financial or treatment limitation that applies to a classification (because no single level of a financial requirement or treatment limitation applies to more than half the medical/surgical benefits the plan expects to pay in that classification that are subject to the financial requirement or treatment limitation), the plan can combine financial or treatment limitation levels to determine the predominant level. However, the plan cannot apply a financial requirement or treatment limitation that is more restrictive than the least restrictive financial requirement or treatment limitation in the combination. Our Alert on the 2010 interim regulations provides a detailed example of how this rule operates.

Special Rule Applies to Multitiered Prescription Drug Benefits

Prescription drug programs that base tiers of coverage on reasonable factors as discussed below with respect to NQTLs (e.g., efficacy or brand name versus generic), are deemed to satisfy the parity requirement for financial requirements and treatment limitations.

No "Gatekeeper” EAP

An EAP cannot be used as a gatekeeper for an enrollee to access comprehensive MH/SA benefits unless the plan has a comparable requirement for medical/surgical benefits.

No “Separate But Equal” Cumulative Financial Requirements or Treatment Limitation for MH/SA Benefits

This means that plans must have a combined deductible that applies to medical/surgical and MH/SA benefits. As a result, a separate deductible for MH/SA benefits is not allowed, even if the deductible is equivalent to the deductible that applies to medical/surgical benefits. The same applies to other cumulative financial requirements and treatment limits, such as out-of-pocket maximums and hospital days per year.

Notice Requirements

Upon request, plans will be required to disclose their criteria for making medical necessity determinations for MH/SA treatment. Claim denials for MH/SA benefits must be communicated in accordance with ERISA’s claims procedures.

What’s New for 2015

Stricter Procedural Parity Requirements for NQTLs

Like the old rules, the new regulations require parity between “nonquantitative treatment limits” (NQTLs) for MH/SA benefits and for medical/surgical benefits. NQTLs affect the scope or duration of benefits under the plan, but are not numerical limitations.
Like the 2010 regulations, the final regulations provide an illustrative list of NQTLs:

1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative.
2. Formulary design for prescription drugs.
3. Network tier design for plans with multiple network tiers (such as preferred providers and participating providers).
4. Standards for provider admission to participate in a network, including reimbursement rates.
5. Usual, customary and reasonable charge determinations.
6. Step-therapy protocols (refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is ineffective).
7. Exclusions based on failure to complete a course of treatment.
8. 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.

As before, any processes, strategies, evidentiary standards or other factors used in applying an NQTL to MH/SA benefits must be comparable to, and cannot be applied more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to similar medical/surgical benefits. Under the interim final rules, variations in the application of NQTLs were permissible to the extent justified by “clinically appropriate standards of care.” The final regulations do not include this exception to the parity requirements for NQTLs and do not explain how plans should change their analyses of NQTLs given that omission.

A discussion of this change in the preamble to the final regulations focuses on plans that may have relied on this language to justify applying an NQTL to all MH/SA benefits in a classification, while applying the NQTL to only a limited number of medical/surgical benefits in the same classification. Apparently, that is not permitted. Even so, the preamble and regulations are clear that, plans may continue to take into account clinically-appropriate standards of care when determining whether and to what extent NQTLs apply to medical/surgical benefits and MH/SA benefits.

The regulations provide the following examples of permissible and impermissible application of NQTLs, as noted below.

**Permissible**

- Applying the clinically appropriate standards of care for MH/SA and medical/surgical benefits, even if doing so results in a dissimilar number of approved days of coverage for MH/SA treatment compared to medical/surgical benefits.
- Uniformly requiring network providers to meet the highest level of clinical experience required for licensing, even if this results in MH/SA providers needing greater amounts of supervised training.
Applying the same factors when choosing medical management techniques for MH/SA and medical/surgical benefits (e.g., cost or clinical efficacy), even if doing so results in a dissimilar number of approved days of coverage (or visits) for MH/SA treatment compared to medical/surgical benefits.

**Impermissible**

- Requiring preapproval that a course of treatment is medically necessary and applying comparable criteria for determining medical necessity, but then paying no MH/SA benefits for items that are not preapproved, while providing reduced medical/surgical benefits for items that are not preapproved.
- Requiring physician authorization for antidepressant drugs with potential adverse side effects, but not requiring authorization for other drugs with similar potential for adverse side effects.

**Lockton Comment:** The two examples above were included in the 2010 regulations, but now omit the wording “except to the extent of clinically appropriate standards of care.”

- Applying medical necessity criteria in a way that results in routinely approving inpatient MH/SA benefits for one day, but routinely granting seven-day approval for inpatient medical/surgical benefits.
- Providing no benefits for out-of-state, out-of-network substance abuse treatment when there is no comparable exclusion for medical/surgical benefits.
- Applying a predetermined cap on the number of visits for which outpatient MH/SA benefits will be approved pursuant to any one request when there is no such predetermined cap applied when approving a request for medical/surgical benefits.
- Not providing MH/SA benefits for inpatient treatment at a residential treatment center, but providing medical/surgical benefits for inpatient treatment outside a hospital setting (see “scope of services” discussion below).

For those of us who are not managed healthcare professionals, what does all this mean? If challenged by a claimant, the plan will have to produce evidence that demonstrates it is applying comparable factors for cost management of MH/SA benefits as it does for other benefits and applying them no more stringently. Because MH/SA benefits are often carved out (administered by a third-party administrator that is different from the one processing the plan’s medical/surgical claims), it may make sense to ask each vendor to confirm that it is coordinating with the other and regarding criteria and application. Frankly, some additional agency guidance on these murky issues would be helpful.

**Lockton Comment:** The preamble notes the regulations “do not require plans and issuers to use the same NQTLs for both MH/SA benefits and medical/surgical benefits.” It seems like the issue may be more of documenting and demonstrating why an NQTL applied to MH/SA benefits is appropriate and can be considered comparable to an NQTL applied to medical/surgical benefits in the same classification.
**Multitiered Networks**

The regulations contain a new rule that applies to multitiered networks, such as a plan that provides 1) out-of-network benefits, 2) an in-network tier of preferred providers with generous cost-sharing to participants, and 3) a separate in-network tier of participating providers with less generous benefits when compared to tier two. In this example, the plan can choose to divide in-network benefits within a classification into two subclasses when performing the parity analysis described above.

What happens if the tiering for MH/SA benefits is “uneven” compared to medical/surgical benefits (e.g., a two-tier design for medical/surgical benefits but a three-tier design for medical/surgical)? A plan will be okay if it uses the financial requirements and treatment limitations of the least restrictive tier (number two, above) when performing the “predominant,” “substantially all” parity analysis.

**Scope of Services**

Plans must assign all plan benefits to one of the six benefit classifications described above, and must assign them consistently. For example, when assigning covered intermediate MH/SA disorder benefits to the existing six benefit classifications a plan would do so in the same way it assigns comparable intermediate medical/surgical benefits to these classifications. If a plan classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient for purposes of medical/surgical benefits, then the plan must likewise treat any covered care in residential treatment facilities for MH/SA as inpatient MH/SA benefits. In addition, if a plan treats home healthcare as an outpatient medical/surgical benefit, then any covered intensive outpatient MH/SA service or partial hospitalization must be considered an outpatient MH/SA benefit.

**Opt Out for Increased Costs**

Plans that can demonstrate a cost increase of at least one percent (two percent for the first year of application) may apply for an exemption from the law’s requirements. The new regulations provide a mathematical formula for this calculation. If the percentage threshold is exceeded, the plan is exempt for the plan year following the year the cost was incurred. The prospective nature of the exemption will be unpalatable to most employers.

**Action Steps**

Employers will need to consult with their plan’s insurers and TPAs in 2014 in order to ensure compliance by the effective date of the regulations. Plans that do not currently provide for residential treatment of MH/SA may need to do so in 2015 if the plan classifies medical/surgical benefits provided outside a hospital setting as inpatient benefits. When redesigning programs for compliance, plan sponsors will need to be sensitive to cost considerations.

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*Compliance Services*
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