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# Final Regulations Implementing Federal Mental Health Parity and Addiction Equity Act of 2008

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Final federal regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were issued on November 13, 2013.[i] The final regulations amended the interim final regulations ("interim regulations") and made them permanent.[ii] This publication describes the changes made to the interim regulations by the final regulations.

## 1. Effective date of the final regulations

The final regulations take effect on January 13, 2014.[iii] However, plans[iv] must comply with the new requirements for plan years beginning on July 1, 2014.[v] For example, if a plan's renewal date is July 1, 2014, the new requirements apply. However, if a plan's renewal date is June 1, 2014, the new requirements do not apply to that plan until the next renewal date, which would be June 1, 2015.

## 2. Highlights of the changes

Most of the provisions in the interim regulations are carried over into the final regulations, but there have been some major changes and additions. Here are the highlights:

1. <u>Additional types of plans subject to parity requirements</u>. The regulations implement the extension of the MHPAEA requirements under the Affordable Care Act (ACA) to health care plans offered in

the individual health insurance market, "qualified health plans" (QHPs) offered through health insurance marketplaces (exchanges) such as Covered California, and the same coverage offered outside of health insurance marketplaces, non-grandfathered employer-based plans required to provide essential health benefits (EHB) in the small group market, and Medicaid (Medi-Cal in California) alternative benefit plans (ABP).

2. Preventive services. Preventive services mandated under the Affordable Care Act, namely alcohol misuse screening and counseling, depression counseling, and tobacco use screening do not trigger parity requirements under the MHPAEA.

3. Financial requirements and quantitative treatment limitations. The final regulations clarify that the six classifications of benefits for purposes of financial requirements and quantitative treatment limitations under MHPAEA are comprehensive (with specific exceptions) and cover the complete range of benefits including so-called "intermediate" benefits such as residential treatment.

4. Nonquantitative treatment limitations. The exception to parity requirements for nonquantitative treatment limitations (NQTLs) based on "clinically appropriate standards of care" has been eliminated.

5. Transparency. Disclosure of underlying processes and standards for determining NQTL parity may require disclosure of this information with respect to medical/surgical benefits as well as mental health and substance use disorder benefits.

This memo does not discuss increased cost exemption rules for plans or changes to multistate plan (MSP) appeals rules, which are also contained in the final regulations.

## 3. Extension of the MHPAEA to additional types of plans and coverage under the ACA

Under federal law, health insurance coverage (including coverage offered through managed care organizations) is offered through the individual market, the small group market, and the large group market. Prior to the enactment of the ACA, large group market plans were plans offered by employers with more than 50 employees. The ACA changed this to more than 100 employees

effective January 1, 2014, or, at state election, January 1, 2016, for plans not subject to ERISA.[vi]

Prior to enactment of the ACA, the MHPAEA applied only to:

1. All plans offered through the large group market, including plans subject to ERISA.[vii]

2. Medicaid (Medi-Cal in California) managed care plans (with exceptions).[viii]

3. All benefits offered through a State Children's Health Insurance Program (CHIP).[ix] (CHIP was originally implemented in California as the Healthy Families Program (HFP)—it is now part of the Medi-Cal program.)

The ACA extended MHPAEA to the following:

1. All plans offered through the individual market.[x]

2. All "Qualified Health Plans" (QHPs), i.e., plans offered through health insurance marketplaces (exchanges) under the ACA, and the same plans offered outside of the exchanges. (In California the health insurance marketplace is called Covered California.)[xi]

3. Non-grandfathered plans in the small group market, i.e., small-group plans which are required to offer "Essential Health Benefits" (EHB) under the ACA.[xii]

4. Medicaid (Medi-Cal in California) non-managed care alternative benefit plans (ABPs) (with exceptions).[xiii]

The final regulations implement the extension of the MHPAEA to the individual market.[xiv] Other regulations implementing the ACA have already extended the MHPAEA to the other categories listed above.[xv]

The reason the MHPAEA applies to non-grandfathered plans in the small group market is because those plans are required to offer "Essential Health Benefits" (EHB) under the ACA.[xvi] Essential health benefits, as defined under the ACA, include mental health and substance use disorder benefits. Therefore, because mental health and substance use disorder benefits are offered under those plans,

parity between those benefits and medical/surgical benefits is required. While the MHPAEA does not by its own terms require that mental health benefits and substance use benefits be offered, once the benefits are offered, whether on a voluntary or mandatory basis, parity is required.

## 4. Preventive services required under the ACA do not trigger MHPAEA parity requirements

The final regulations treat preventive services mandated under the ADA differently than essential health benefits mandated under the ADA. Unlike mental health and substance use disorder benefits mandated as essential health benefits under the ADA, mental health and substance use disorder preventive services mandated under the ACA do not trigger MHPAEA parity requirements.[xvii] Preventive services mandated under the ACA include alcohol misuse screening and counseling, depression counseling, and tobacco use screening.[xviii] This specific exception in the regulations is designed to underscore the emphasis in the regulations that the offering of mental health and substance use benefits is not mandatory under the terms of the MHPAEA itself. Therefore, the specific requirement to offer certain preventive services does not trigger a requirement to offer broader mental health or substance use benefits that the plan does not choose to offer.[xix]

## 5. Financial requirements/Quantitative treatment limitations

The MHPAEA and implementing regulations draw a distinction between financial requirements/quantitative treatment limitations on the one hand, and nonquantitative treatment limitations (NQTLs) on the other hand.

Financial requirements and quantitative treatment limitations are numbers. The following definitions of these terms from the interim regulations have been carried over into the final regulations:

1. Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums.[xx]

2. Quantitative treatment limitations are expressed numerically (such as 50 outpatient visits per year).[xxi]

Because financial requirements and quantitative treatment limitations are numbers, application of the parity rules to them is simpler and more straightforward than application of parity rules to nonquantitative treatment limitations. This is because it is easier to compare numerical standards than non-numerical standards. However, there are some complications in comparing numerical standards as well. The final regulations provide clarifications in how to compare these numerical standards. The following is a brief description of the clarifications provided by the final regulations.

**Comprehensive classification of benefits**

The federal approach to numerical parity is to compare mental health and substance use disorder benefits to medical/surgical benefits in 6 separate categories or classes listed in the MHPAEA. This means that mental health/substance use disorder benefits and medical/surgical benefits must first be assigned to one of the 6 classifications. Then parity requirements are applied to all of the benefits within each classification. For example, inpatient mental health/substance use disorder benefits are compared only to inpatient medical/surgical benefits.

The final regulations emphasize that the 6 classifications of benefits listed in the statute are the only classifications used in applying the financial requirement/quantitative treatment limitation rules.[xxii] The following are the 6 classifications, which are carried over from the interim regulations:

1. Inpatient, in-network.
2. Inpatient, out-of-network.
3. Outpatient, in-network.
4. Outpatient, out-of-network.
5. Emergency care.
6. Prescription drugs (if otherwise offered).[xxiii]

According to the final regulations all mental health and substance use benefits as well as all medical/surgical benefits have to fit into these 6 categories.[xxiv] Therefore nothing can fall through the cracks. Plans cannot claim that a benefit

is not covered or subject to parity requirements on the basis that that the benefit does not quite fit into one of the 6 categories.

This means that so called “intermediate” levels of care such as residential services, partial hospitalization and intensive outpatient treatment must be covered if mental health/substance use disorder benefits are covered under the plan and there are analogous medical/surgical benefits under the plan.[xxv]

Benefits in these “intermediate” levels cannot be denied just because they do not fit neatly into one of the 6 categories. The intermediate services must be classified to one of the 6 categories depending on how similar medical/surgical benefits are classified to the 6 categories by the plan. For example, if a plan provides for medical/surgical rehabilitation as an inpatient benefit, it must provide mental health/substance use disorder rehabilitation as an inpatient benefit as well.[xxvi] By contrast, if a plan provides for medical/surgical rehabilitation as an outpatient benefit, it must provide mental health/substance use disorder rehabilitation as an outpatient benefit as well.

In addition, sub-classifications are prohibited under the final rules except with respect to outpatient benefits and multiple tiers of in-network providers, discussed below.[xxvii]

## Sub-classifications of outpatient benefits

The final regulations do not allow sub-classifications of benefits except that outpatient benefits may be sub-classified into office visits on the one hand and all other outpatient benefits on the other hand.[xxviii]

## Multiple tiers of in-network providers

The final regulations do not allow sub-classifications of providers except for different cost sharing requirements among multiple tiers of in-network providers.[xxix] Tiering has to be based on reasonable factors and without regard to whether a provider is a mental health/substance use disorder provider or a medical/surgical provider. Presumably, this means that a plan can charge a copayment of, say, $20 for a visit to a primary care provider and a higher copayment of, say, $40 for a visit to a specialist so long as the plan applies the same formula uniformly to mental health/substance use disorder benefits and medical/surgical benefits.

**Managed behavioral health organization (MBHOs) subcontractors**

Many plans subcontract with managed behavioral health organizations (MBHOs) to provide mental health or substance use disorder benefits. The final regulations provide that plans cannot evade parity requirements by subcontracting.[xxx] In addition, the MBHOs are subject to parity requirements within the scope of their subcontracts.[xxxi]

**Annual and lifetime benefit limits for grandfathered small group plans**

The original federal Mental Health Parity Act (MHPA) did not prohibit annual and lifetime limits, but it did provide that annual and lifetime limits for mental health benefits could not be higher than those for medical/surgical benefits.[xxxii] The MHPAEA did not change this requirement but extended it to substance use disorder benefits as well. However, the ACA prohibits annual and lifetime limits for many types of coverage. Nevertheless, the final regulations leave the prior annual and lifetime limit rules in place for non-grandfathered plans not subject to the new ACA requirements.[xxxiii] These non-grandfathered plans are small group plans that are not required to offer essential health benefits (EHBs) under the ACA.

## 6. Non-quantitative treatment limitations (NQTLs)

Non-quantitative treatment limitations are limitations which limit the scope or duration of benefits for treatment under a plan or coverage that are not expressed numerically.[xxxiv] MHPAEA requires that any processes, strategies, evidentiary standards, or other factors used in applying any NQTL to mental health or substance use disorder benefits in any 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 same classification.[xxxv] This requirement applies to any NQTL under the terms of the plan as written and in operation.[xxxvi]

Comparisons of non-quantitative treatment limitations for parity purposes are more difficult than comparison of the numerical treatment limitations described above. This is because treatment interventions for any given condition vary at least somewhat from the treatment interventions for any other condition no matter what the condition is. For example, treatment interventions in response to a heart attack are not going to be the same as treatment interventions for clinical depression. However, to the extent that comparisons can be made, parity is required.

The final regulations provide additional guidance on how to make comparisons with respect to NQTLs. Much of the additional guidance is in the form of examples that explain how to apply the general parity requirement rather than in changes to the interim rules themselves.

**<u>Recognized clinically appropriate standards of care that permit different treatment</u>**

This is one area in which the final rule represents a change from the interim rule. The interim rule contained an exception to the parity requirement with respect to processes, strategies, evidentiary standards or other factors that are used in applying any NQTLs "…to the extent that recognized clinically appropriate standards of care may permit a difference." The final rule eliminates the exception.[xxxvii] The exception was eliminated because it was unnecessary, unworkable and was subject to abuse.[xxxviii]

According to the preamble to the final regulations, the exception is unnecessary because the NQTL standard itself already gives plans the flexibility to take into account clinically appropriate standards of care when determining whether and to what extent medical management techniques and other NQTLs apply to medical/ surgical benefits and mental health and substance use disorder benefits.[xxxix] The NQTL standard allows flexibility so long as the processes, strategies, evidentiary standards, and other factors used in applying an NQTL to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits.[xl]

In addition, an expert panel convened to provide input on NQTLs for mental health and substance use benefits was unable to identify situations for which the clinically appropriate standard of care exception was warranted, in part because of the flexibility inherent in the NQTL standard itself.[xli] This suggests that to the extent that standards of care can be compared they must be compared so that NQTLs are applied no more stringently with respect to mental health and substance use disorder benefits than to medical/surgical benefits. However, this does recognize that even though there are no inherent differences between mental health and substance use benefits as compared to medical/surgical benefits such that a "clinically appropriate standard of care" exception would be justified, there may still be questions about the extent to which particular standards of care are comparable to begin with.

Finally, some plans were using the exception to justify applying an NQTL to all mental health or substance use disorder benefits in a given classification, while

only applying the NQTL to a limited number of medical/surgical benefits in the same classification.[xlii] These plans and issuers generally argued that fundamental differences in treatment of mental health and substance use disorders as compared to medical/surgical conditions, justify applying stricter NQTLs to mental health or substance use disorder benefits than to medical/surgical benefits under the exception in the interim final regulations.[xliii] This interpretation undercut the general requirement of the regulations that NQTLs which are applied to mental health and substance use disorder benefits be comparable to, and applied no more stringently than, NQTLs with respect to medical/surgical benefits. Repeal of the exception eliminates the argument that NQTLs can be applied more broadly or more stringently to mental health and substance use benefits than to comparable medical/surgical benefits.

**New examples added with respect to restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits and with respect to network tier design**

The final regulations reorganize the examples of NQTLs contained in the regulations and add two additional examples.[xliv] The new examples relate to:

1. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits

2. Network tier design for plans that have tiered networks

**NQTL examples are illustrative**

The final regulations emphasize that NQTL examples are illustrative.[xlv] The general rule provides that the processes, strategies, evidentiary standards and other factors used in applying NQTLs cannot be specifically designed to restrict access to mental health or substance use disorder benefits in any case.

For example, the preamble to the regulations clarifies that while the following plan standards are not listed in the examples in the regulations, they must be applied in a manner in accordance with the regulations.

1. In and out of network geographic limitations

2. Limitations on inpatient services in situations where a beneficiary is a threat to self or others

3. Exclusions for court ordered and involuntary holds

4. Experimental treatment limitations

5. Service coding

6. Exclusions for services provided by clinical social workers

7. Network adequacy[xlvi]

None of these standards are listed in the final rules or in the examples contained in the final rules, but they fall within the parity requirements based on the general prohibition of differences in NQTLs.[xlvii]

## 7. Disclosure of underlying processes and standards

Under the MPAEA, plans must provide beneficiaries with the plan's criteria for medical necessity determinations and with the reasons for denial of payment for mental health and substance use disorder services.

Concerns have been raised about what kind of information plans must disclose. For example, it is difficult to evaluate mental health and substance use disorder medical necessity standards without access to information about the processes, strategies, evidentiary standards, and other factors used to apply the medical necessity standard. Likewise, it is difficult to determine comparability with medical/surgical medical necessity standards unless information as well as the processes, strategies, evidentiary standards, and other factors used to apply those standards is disclosed as well.

The final regulations handle this by incorporating a reminder to plans that the specific MPAEA disclosure requirements are in addition to disclosure requirements contained in other statutes, such as ERISA.[xlviii] For example, for plans subject to ERISA, plan administrators must furnish instruments under which the plan is established or operated to plan participants.[xlix] According to the preamble to the MHPAEA final regulations, instruments under which the plan is established or operated include documents with information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan.[l] This information is also required when a beneficiary files an appeal under federal

regulations governing ERISA plans and other plans subject to the ACA.[li] Therefore, under these and possibly other regulations, plans must disclose information that will enable participants to determine whether or not medical necessity standards and other NQTLs comply with mental health and substance use disorder parity requirements.

The Departments of Labor and Health and Human Services are also publishing another set of MHPAEA FAQs, which, among other things, solicit comments on whether and how to ensure greater transparency and compliance with MHPAEA NQTL requirements.[lii]

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[i] 78 Fed.Reg. 68240 (Nov. 13, 2013). Parallel final mental health and substance use disorder parity regulations were issued by the Internal Revenue Service, 78 Fed.Reg. 68266, 26 C.F.R. § 54.9812–1, Department of Labor, Employee Benefits Security Administration, 78 Fed.Reg. 68276, 29 C.F.R. § 2590.712, and Department of Health and Human Services, 78 Fed.Reg. 68286, 45 C.F.R. § 146.136. The preamble ("preamble") to the final regulations was issued jointly by the three agencies. Citations in this memo to the parity regulations will be to the Department of Health and Human Services regulations.

[ii] 78 Fed.Reg. 68241 (Nov. 13, 2013). The interim final regulations were adopted on February 2, 2010, and were published at 75 Fed.Reg. 5410 (Feb. 2, 2010).

[iii] 78 Fed.Reg. 68240 (Nov. 13, 2013). One technical amendment took effect on December 13, 2013. See, 78 Fed.Reg. 68240, 68253 (Nov. 13, 2013).

[iv] In this memo, plans and issuers subject to MHPAEA will be referred to collectively as "plans."

[v] 78 Fed.Reg. 68240, 68252-53 (Nov. 13, 2013). 45 C.F.R. § 146.136(i).

[vi] 45 C.F.R. § 144.403.

[vii] 68248.

[viii] 78 Fed.Reg. 68248, 68252 (Nov. 13, 2013), See: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[ix] Id.

[x] 78 Fed.Reg. 68251 (Nov. 13, 2013), 45 C.F.R. §§147.140, 147.160.

[xi] 45 C.F.R. §§ 147.150, 156.115.

[xii] 78 Fed.Reg. 68248 (Nov. 13, 2013), 45 C.F.R. § 156.115(a)(3), See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 8, available at http://www.dol.gov/ebsa/faqs/faq-aca5.html and

http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

[xiii] 78 Fed.Reg. 68252 (Nov. 13, 2013), See: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[xiv] 45 C.F.R. § 147.160.

[xv] 45 C.F.R. §§ 147.150, 156.115, See: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[xvi] 78 Fed.Reg. 68248 (Nov. 13, 2013), 45 C.F.R. § 156.115(a)(3), See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 8, available at http://www.dol.gov/ebsa/faqs/faq-aca5.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

[xvii] 78 Fed.Reg. 68244 (Nov. 13, 2013), 45 C.F.R. § 146.136(e)(3)(ii)

[xviii] Id.

[xix] Id.

[xx] 45 C.F.R. § 146.136(a)

[xxi] Id.

[xxii] 78 Fed.Reg. 68243 (Nov. 13, 2013).

[xxiii] 45 C.F.R. § 146.136(c)(2)(ii).

[xxiv] 78 Fed.Reg. 38243 (Nov. 13, 2013).

[xxv] 78 Fed.Reg. 68246-47 (Nov. 13, 2013).

[xxvi] 78 Fed.Reg. 68247 (Nov. 13, 2013).

[xxvii] 78 Fed.Reg. 68243 (Nov. 13, 2013), 45 C.F.R. § 146.136(c)(2)(ii).

[xxviii] 78 Fed.Reg. 68242 (Nov. 13, 2013), 45 C.F.R. § 146.136(c)(3)(iii)(C).

[xxix] 78 Fed.Reg. 68242 (Nov. 13, 2013), 45 C.F.R. § 146.136(c)(3)(iii)(B).

[xxx] 78 Fed.Reg. 68250 (Nov. 13, 2013).

[xxxi] Id.

[xxxii] 78 Fed.Reg. 38244 (Nov. 13, 2013).

[xxxiii] 78 Fed.Reg. 68244 (Nov. 13, 2013), 45 C.F.R. § 146.136(b)

[xxxiv] 78 Fed.Reg. 68241 (Nov. 13, 2013).

[xxxv] 78 Fed.Reg. 68241, 6824444 (Nov. 13, 2013), 45 C.F.R. § 146.136(b)(4).

[xxxvi] 78 Fed.Reg. 68244-45 (Nov. 13, 2013), C.F.R. § 146.136(b)(4).

[xxxvii] 78 Fed.Reg. 68244-45 (Nov. 13, 2013).

[xxxviii] Id.

[xxxix] 78 Fed.Reg. 68245 (Nov. 13, 2013).

[xl] Id.

[xli] 78 Fed.Reg. 68245, fn. 17 (Nov. 13, 2013).

[xlii] 78 Fed.Reg. 68245 (Nov. 13, 2013).

[xliii] Id.

[xliv] 78 Fed.Reg. 68246 (Nov. 13, 2013), 45 C.F.R. § 146.136(c)(4)(ii).

[xlv] 78 Fed.Reg. 68246 (Nov. 13, 2013).

[xlvi] 78 Fed.Reg. 68246 (Nov. 13, 2013).

[xlvii] Id.

[xlviii] 78 Fed.Reg. 68247 (Nov. 13, 2013), (d)(3).

[xlix] 78 Fed.Reg. 68247-48 (Nov. 13, 2013).

[l] 78 Fed.Reg. 68247 (Nov. 13, 2013).

[li] Id.

[lii] 78 Fed.Reg. 68248, fn. 30 (Nov. 13, 2013), See See FAQs about Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation, question 8, available at http://www.dol.gov/ebsa/faqs/faq-aca5.html and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html.

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