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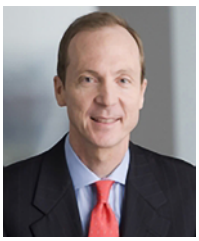
View From Groom: Final Regulations Issued Implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008



BY JON W. BREYFOGLE, VIVIAN HUNTER TURNER AND RYAN TEMME

On Nov. 13, 2013, three federal agencies, the Department of Treasury, Department of Labor and Department of Health and Human Services (collectively, the ''agencies'') jointly published final regulations (the ''final regulations'') implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (''MHPAEA'') and a related set of frequently asked questions.[1] The final regulations apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2014. This means the final regulations will be applicable on Jan. 1, 2015, for calendar year plans. The final regulations also apply to all individual market insurance, including grandfathered individual market coverage, for policy years beginning on or after July 1, 2014.

The final regulations include some positive news for plan sponsors and issuers, including:

- clarification that the MHPAEA testing is not an annual requirement,
- allowance for plan designs that include multiple tiers of providers,
- allowance for a parity analysis that takes into account an office visit copay versus cost-sharing for all other items and services,
- clarification that providing benefits solely to comply with the preventive services regulation does not require provision of the full range of benefits for the mental health/substance use disorder, and
- providing that an employee assistance program (''EAP'') that does not provide significant benefits may be treated as ''excepted benefits'' and thus not subject to the MHPAEA.

However, the final regulations include some surprises that will require issuers and plan sponsors to review plan designs that may have been compliant under the interim final regulations with fresh eyes in light of the final regulations such as benefit exclusions for certain types of mental health facilities, such as residential treatment facilities.

Background.

MHPAEA amends the Employee Retirement Income Security Act, the Public Health Service Act (''PHSA'') and the tax code to prohibit group health plans that pro-

[1] 78 Fed. Reg. 68240 (Nov. 13, 2013).

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vide mental health/substance use benefits from applying ''financial requirements'' or ''treatment limits'' to those benefits that are more restrictive than the ''predominant'' financial requirement or treatment limit that applies to ''substantially all'' medical/surgical benefits.[2] MHPAEA defines ''financial requirements'' to include deductibles, copayments, coinsurance and out-of-pocket expenses; ''treatment limitations'' to include limits on the frequency of visits, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and the term ''predominant'' to mean the most common or frequent of such type of limit or requirement.

On Feb. 2, 2010, the agencies published interim final regulations (the ''interim final regulations'') implementing the MHPAEA, which were followed by several frequently asked questions.[3] The interim final regulations provide that the MHPAEA's parity requirement applies to both quantitative and non-quantitative treatment limitations.[4] One of the most far-reaching aspects of the interim final regulations was a requirement that plans measure parity through non-quantitative measures.[5] A non-quantitative treatment limitation (''NQTL'') is a limitation that restricts coverage under the plan that is not expressed numerically. This requirement extends to medical management standards limiting benefits based on medical necessity or an exclusion for experimental/investigational treatments; prescription drug formulary design; and standards for determining provider admission in a network, including reimbursement rates.[6] The interim final regulations required group health plans to ensure that any processes, strategies, evidentiary standards or other factors used in applying ''non-quantitative treatment limits'' to mental health/substance use benefits must be comparable to, and 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.''

The requirement to comply with the NQTL requirement was a key issue for virtually all plans and employers and one of the most far-reaching aspects of the interim final regulations. Probably its most important impact has been the high level of scrutiny now applied to prior authorization requirements for outpatient mental health/substance use services, particularly if no (or very few) similar requirements are applied to medical/surgical outpatient services.

Under the interim final regulations, a plan's financial requirements and treatment limitations for mental health/substance use benefits are compared against the plan's requirements and limitations for medical/surgical benefits on a classification-by-classification basis. The specific classifications required by the interim final regulations are:

- Inpatient, in-network,
- Inpatient, out-of-network,
- Outpatient, in-network,
- Outpatient, out-of-network,
- Emergency care' and
- Prescription drugs.7

The Final Regulations

The final regulations build on the foundation established by the interim final regulations with some changes that codify guidance issued through frequently asked questions released after the interim final regulations and expand the reach of the MHPAEA's application, including:

- Addition of new sub-classifications for the six categories of benefits,
- Inclusion of new NQTLs that plans and issuers must consider in their parity analysis,
- Inclusion of new disclosure requirement for documents evidencing the parity analysis,
- Clarification that plans and issuers do not have to test plan designs that have not changed for parity each year,
- Clarification that a plan that provides coverage for a mental health/substance use condition solely to comply with the Affordable Care Act's preventive services mandate does not have to provide the full range of benefits for the mental health/substance use disorder under the MHPAEA,
- Clarification that EAPs that do not provide significant benefits may be treated as ''excepted benefits'' and will not be subject to the MHPAEA or the final regulations; and
- Clarification of the intersection of the MHPAEA parity requirements and state law mandates.

New Sub-Classifications. As previously described, the interim final regulations require plans to divide covered mental health and substance use benefits into six classifications and perform a parity analysis on a classification-by-classification basis. The final regulations allow two new sub-classifications in the six benefit categories: (1) a sub-tier for multiple tiers of network providers and (2) separate sub-tiers for copays for an office visit and all other items and services.[8] However, the final regulations prohibit sub-classifications not specifically permitted by the regulation, such as separate classifications for generalists and specialists.

Until further guidance is issued, plans that have an uneven number of tiers will be treated as complying with the financial requirement and quantitative treatment limitation rules under the MHPAEA if a plan or issuer treats *the least restrictive level* of the financial requirement or quantitative treatment limit that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification.[9] Effectively, this means that if a plan offers a lower cost-sharing tier to participants that enroll in a narrow network of medical providers, it may have to offer that same cost shar-

[2] ERISA § 712(a)(3)(A).
[3] 75 Fed. Reg. 5410 (Feb. 2, 2010).
[4] 29 CFR § 2590.712(a) (definition of Treatment limitation).
[5] 29 CFR § 2590.712(a) (definition of Treatment limitations).
[6] 29 CFR § 2590.712(c)(4).
7 7 CFR § 2590.712(c)(2)(ii).
[8] 29 CFR §§ 2590.712(c)(3)(iii)(B) and (C).
[9] 78 Fed. Reg. 68243.

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ing for mental health and substance use services even if a narrower network (with greater provider pricing concessions) has not been made available. Note that testing for financial requirements and quantitative treatment limits should occur if a plan takes advantage of the new rules for tiered networks.

The new classifications for the parity analysis are as follows:

- Inpatient, in-network;
  - Sub-classification for multiple network tiers;
- Inpatient, out-of-network;
- Outpatient, in-network;
  - Sub-classification for office visits;
  - Sub-classification for multiple network tiers;
- Outpatient, out-of-network;
  - Sub-classification for office visits;
- Emergency care; and
- Prescription drugs.

Key Takeaway: The final regulations codified guidance previously published through frequently asked questions establishing an enforcement safe harbor under which the departments would not take enforcement action against plans and issuers that divide benefits furnished on an outpatient basis into (1) office visits and (2) all other items and services. Additionally, in response to a push from plans that utilize tiered networks to manage costs and quality of care, the final regulations allow plans to conduct the parity analysis separately with respect to these various network tiers. However, it is important to note that plans and issuers are not required to take advantage of these permitted sub-classifications and should evaluate their plan designs to determine whether the new sub-classifications provide any advantages under the MHPAEA analysis.

Non-Quantitative Treatment Limits. Compliance with the NQTL requirement in the interim final regulations has been a major source of concern for employers and health insurers given both the breadth and vagueness of the standard and has been a priority for enforcement and compliance efforts by HHS and the Department of Labor. The final regulations, however, tightened this rule further by eliminating a provision that allowed differences in NQTLs between medical/surgical and mental health/substance use benefits ''to the extent that recognized clinically appropriate standards of care may permit a difference,'' which could make compliance with the NQTL rule more difficult to prove when there are disparities in approach for medical/surgical and mental health/substance use benefits.[10]

The NQTL rule was further tightened through a new NQTL that could require that plans provide a greater scope of services for covered mental health/substance use conditions. In this respect, neither the interim final regulations nor the final regulations specifically mandate that plans cover particular mental health conditions. The interim final regulations did provide that coverage in each of the six classifications of benefits be offered if a particular mental health condition was covered and medical/surgical benefits are offered in a given classification. However, beyond the classification rule the interim final rule did not mandate the scope of services that must be covered for a particular condition.

The final regulations address this purported gap by adding a new NQTL: coverage restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services must comply with the NQTL parity requirement.[11] This new NQTL throws into question, for example, a practice where a plan includes an exclusion for a particular type of facility that may treat a covered mental health condition. A new example illustrates this principle where a plan automatically excludes coverage for inpatient substance use disorder treatment in any setting outside of a hospital (such as a freestanding or residential treatment center) yet provides coverage for inpatient treatment outside of a hospital for medical conditions if the prescribing physician obtains authorization that the treatment is medically appropriate.[12] In this example, the final regulations provide that the plan violates the MHPAEA because the plan's unconditional exclusion of substance use disorder treatment in any setting outside of a hospital is not comparable to the conditional exclusion of inpatient treatment outside of a hospital for other conditions.

The final regulations do provide some helpful examples of how to apply the NQTL. For instance, one example provides an illustrative list of factors a plan may use in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits that provides plans and issuers a useful roadmap in factors they may consider under the MHPAEA to control costs:

- consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials),
- variability in cost and quality,
- elasticity of demand,
- provider discretion in determining diagnosis, or type or length of treatment,
- clinical efficacy of any proposed treatment or service,
- licensing and accreditation of providers, and
- claim types with a high percentage of fraud.[13]

Key Takeaway: Plans and issuers should re-evaluate exclusions and limitations on benefits for intermediate services to treat mental health/substance use conditions such as residential treatment centers and other treatment settings to ensure that the underlying methodology for coverage is applied equally between medical/surgical and mental health/substance use benefits.

Required Disclosure. The final regulations impose three disclosure requirements on plans and issuers. First, plans must provide contracting providers with plan information regarding criteria for medical necessity determinations.[14] Second, the reason for denial of a claim by a group health plan for reimbursement or payment of mental health/substance use services must be disclosed to the participant, or the participants autho-

[10] 78 Fed. Reg. 68245.

[11] 29 CFR § 2590.712(c)(4)(ii)(H).
[12] 29 CFR § 2590.712(c)(4)(iii)(Example 9).
[13] 29 CFR § 2590.712(c)(4)(iii)(Example 8).
[14] 29 CFR § 2590.712(d)(1).

rized representative (including authorized providers).[15] Finally, for plans that are covered by ERISA, the final regulations require that plan sponsors and insurance carriers disclose certain information on medical necessity criteria for both medical/surgical and mental health/substance use benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL. In fact, the final regulations consider these documents to be plan documents under which the plan is established or operated for purposes of responding to requests for documents by plan participants within 30 days of request under Section 104 of ERISA.[16] This is an expansive view of the documentation generally required to be disclosed under ERISA Section 104, and is made part of the final regulations themselves. The final regulations do *not* expand the parties entitled to receive these documents under Section 104, although DOL guidance indicates that a participant's authorized representative may request these documents under certain circumstances.[17] (Note: The agencies published another set of frequently asked questions contemporaneously with the final regulations which, among other things, solicits comments on whether and how to ensure greater transparency and compliance, so additional regulation on this point is possible.)

Key Takeaway: Plan sponsors and insurance carriers should document their NQTL analysis and develop strategies to analyze and handle document requests to ensure only required information is disclosed and that it is disclosed only to proper parties.

No Annual Parity Analysis. The final regulations clarify that a plan or issuer is not required to perform the parity analysis each plan year unless there is a change in plan benefit design, cost-sharing structure or utilization that would affect a financial requirement or treatment limitation within a classification (or subclassification).[18]

Preventive Services. The interim final regulations provide that if a plan or issuer provides mental health/substance use benefits in any classification, mental health and substance use benefits must be provided in every classification in which medical/surgical benefits are provided.[19] Public Health Service Act Section 2713, as added by the Affordable Care Act, requires nongrandfathered group health plans and issuers of nongrandfathered individual policies to provide coverage for certain preventive services without cost sharing. The required preventive services include, among other benefits, alcohol misuse screening and counseling, depression counseling and tobacco use screening. Since these benefits may be considered mental health/substance use benefits there was considerable confusion on whether coverage of preventative services alone (for a plan that did not otherwise provide mental health/substance use services) required coverage in every classification (e.g., inpatient, in-network; in-patient, out-of-network; prescription drug; emergency room; etc.). The final regulations clarify that plans that provide such benefits solely to comply with PHSA Section 2713 will not be required to provide the full range of benefits for such mental health/substance use disorder under the MHPAEA.[20]

Employee Assistance Programs. The final regulations provide that EAPs that do not provide significant benefits in the nature of medical care or treatment may be treated as ''excepted benefits'' until rulemaking is finalized, through at least 2014, and will not be subject to the MHPAEA or the final regulations.[21] On Dec. 24, 2013, the agencies published proposed rules setting forth criteria for an EAP to qualify as excepted benefits beginning in 2014.[22] Under the proposed rule, benefits provided under EAPs will be treated as excepted benefits if four criteria are met:

- The program does not provide significant benefits in the nature of medical care,
- The benefits are not coordinated with benefits under another group health plan,
- No employee premiums or contributions are required to participate in the EAP, and
- There is no cost sharing under the EAP.[23]

Interaction with State Insurance Laws. The preamble of the final regulations discusses the scope of preemption under the MHPAEA and laws that regulate insurance. The preamble makes clear that if state law requires an issuer to offer coverage for a particular condition or requires that an issuer offer a minimum dollar amount of mental health/substance use benefits that the benefits for that condition must be provided in parity with medical/surgical benefits under the MHPAEA.[24] This results in state mandates for mental health/substance use benefits surviving, while the MHPAEA would preempt any annual dollar limit on such benefits permitted by the state law. (Note also that the Affordable Care Act's essential health benefits requirement and prohibition on annual and lifetime dollar limits may require certain plans to remove dollar limits on mental health services.)

Some Concluding Thoughts. The final regulations and the MHPAEA create additional areas of compliance concerns for plan sponsors and health insurance issuers. As these new rules become effective, plans and plan sponsors face new uncertainty over whether current plan design and administration meets the MHPAEA's regulatory requirements. The likelihood of enforcement by the agencies and the focus of that enforcement, and the possibility of participant and provider-initiated challenges to plan design and administration, requires that plan sponsors and issuers ensure their compliance with the MHPAEA and the final regulations. Sponsors of self-insured plans should work closely with their third-party administrators to review their plans' cost sharing structure for mental health services and any restrictions on mental health services, such as prior authorizations, exclusions based on medical necessity and type or location of treatment to ensure that they are compliant with the final regulations.

[15] 29 CFR § 2590.712(d)(2).
[16] 29 CFR § 2590.712(d)(3).
[17] DOL Advisory Opinion 79-82A.
[18] 78 Fed. Reg. 68243.
[19] 29 CFR § 2590.712(c)(2)(ii).
[20] 29 CFR § 2590.712(e)(3)(ii).
[21] 78 Fed. Reg. 68251.
[22] 78 Fed. Reg. 77632 (Dec. 24, 2013).
[23] 45 CFR § 146.145(c)(3)(vi).
[24] 78 Fed. Reg. 68252.

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