Crowell

CLIENT ALERT

Final Mental Health Parity Regulations Issued

November 11, 2013

On Friday, November 8, the the Departments of Labor, Treasury and Health and Human Services (collectively, the "Departments") issued final regulations under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). (The rules are scheduled to be published in the Federal Register on November 13, 2013.)

The final rules largely adopt the interim final rules (IFRs) that were issued in February 2010, along with subregulatory changes made in several frequently asked questions (FAQs) issued by the Departments over the last few years. A high-level summary of the important changes in the final rules follows:

Effective Date

- The final rules are effective for plan and policy years beginning on and after July 1, 2014. As a result, any calendar year plan or policy will be first subject to the final rules on and after January 1, 2015. Prior to that date, the IFRs will continue to apply.

Nonquantitative Treatment Limitations

- Under the IFRs, any nonquantitative treatment limitation (NQTLs), i.e., a limitation on the scope or duration of benefits that isn't measured numerically, applied to mental health/substance use disorder benefits must be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits, with variations allowed "to the extent that recognized clinically appropriate standards of care may permit a difference." This variation/exception has reportedly been relied on by many plans and issuers but its use was believed (based on informal comments by regulators) to be disfavored by the Departments.
    - In the final rules, the Departments have eliminated this variation/exception entirely.
    - The Departments have justified this change by stating in the preamble that "[p]lans and issuers will continue to have the flexibility contained in the NQTL requirements 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, as 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."
    - The preamble goes on to note that the final rules "do not require plans and issuer to use the same NQTLs" for both medical/surgical and mental health/substance-use disorder benefits, so long as the plan or issuer uses a comparable (and no more stringent) process to determine whether and to what extent a benefit is subject to an NQTL. It is not entirely clear from the final rule how the Departments intend for this to apply, but the

Departments do note that "[d]isparate results alone do not mean that the NQTLs in use do not comply with these requirements."

- The final rules also add several examples explaining the proper application of the NQTL rules. Notably, one example appears to state that explicit, predetermined caps on the number of visits for mental health and substance use disorder benefits may not be used if medical/surgical benefits in the same classification are not subject to the same type of cap (even where the cap results in arguably more generous mental health/substance use disorder benefits).
- The preamble notes that some commenters had requested that NQTL compliance be tested via a mathematical formula, a view that the Departments have rejected.
- The final rules have added two more examples to the illustrative list of NQTLs found in the IFR: 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."
- In response to several commenters raising the issue, the preamble also notes that provider reimbursement rates are NQTLs, but states that "[p]lans and issuers may consider a wide array of factors in determining provider reimbursement rates for both medical/surgical services and mental health and substance use disorder services," including geographic market, demand for services, supply of providers, etc. Notably, the preamble reiterates that, in this area as well, disparate results alone do not mean that there has been a violation of the NQTL requirements.

Disclosure of Medical Necessity Criteria and NQTL Processes

- The final rules note that, under section 104 of ERISA, plans are required to provide to participants, upon request, "instruments under which the plan is established or operated." This phrase has been widely interpreted in different manners, including in several court decisions reaching varied decisions on the meaning of this phrase. The final rules, however, state that "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."
    - As a result, ERISA plan participants (and, as the final rule notes in the preamble, ***prospective*** participants) may now rely on section 104 of ERISA to request both medical necessity criteria and NQTL criteria, on ***both*** the medical/surgical and mental health and substance-use disorder sides.
- Similar to the disclosure obligations under section 104 of ERISA, the final rules note that, under ERISA claims-procedure rules, medical necessity criteria and NQTL processes would also need to be produced to participants pursuing a claim under a plan or policy.

Classification of Benefits

- The final rules formally adopted the enforcement safe harbor from a prior FAQ that permitted plans and issuers to subdivide, for purposes of determining parity compliance, outpatient benefits into (1) office visits and (2) all other outpatient items and services.
- Additionally, the final rules added an additional category of sub-classifications that may be used for purposes of determining parity compliance, namely that for tiered networks. Specifically, the final rules provide that if a plan or policy provides in-network benefits through multiple tiers of in-network providers (such as an in-network tier of

preferred providers with more generous cost sharing to participants than a separate in-network tier of participating providers), the plan or policy can sub-classify (for parity testing purposes) in-network benefits to reflect those tiers. Notably, the tiering must be based on reasonable factors and must be done without regard to whether a provider is a mental health or substance use disorder provider or a medical/surgical provider.

- The final rules also strongly reinforced the view that separate sub-classifications for generalists and specialists must not be used for purposes of determining parity. Hence, it appears that under the final rules mental-health professionals may not uniformly be classified as "specialists" and hence compared only to "specialists" on the medical/surgical side.
- The preamble to the final rules notes that the 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), plus the sub-classifications described in the final rule (and summarized above) are intended to be "comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by plans and issuers." Hence, according to the preamble, no benefits (either medical/surgical or mental health/substance abuse) may be categorized as offered outside of these classifications and as a result not subject to a parity analysis.

Testing of Parity Compliance

- The preamble to the final rules notes that "[c]ross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Departments do not believe is feasible." Hence, it appears that, in testing compliance (including NQTL compliance), the testing must look broadly to ***all*** medical/surgical benefits in a category, and cannot be limited solely to specific medical/surgical benefits.
- With regard to testing of compliance with the quantitative parity rules, the preamble notes that plans and issuers are ***not*** required to perform a parity analysis each plan year, unless there has been a change in plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or treatment limitation within a benefit classification.

Limited-Purpose Mental Health/Substance-Use Disorder Benefits

- The preamble to the final rules notes that section 2713 of the Public Health Service Act (as added by the Affordable Care Act) requires non-grandfathered group health plans and issuers (offering non-grandfathered group and individual coverage) to provide certain preventive services without a cost share, including, among other things, alcohol misuse screening and counseling and depression counseling. Because this could result in certain plans providing certain limited mental health and substance-use disorder benefits where they might otherwise not provide such benefits, the final rules provide that the provision of benefits under PHS Act section 2713 does not require, through an application of the final rules, the provision of any additional mental health or substance use disorder benefits (although other applicable laws, such as those applicable to Essential Health Benefits under the ACA, could certainly on their own mandate broader mental health/substance use disorder benefits).

Scope of Services

- The preamble to the final rules, while largely eschewing any broader discussion of the impact of the rules on the scope of services provided under any plan or policy, do note that the Departments do not intend for the final rules to impose a

benefit mandate that would require ***greater*** benefits for mental health and substance-use disorder benefits than for medical/surgical benefits.

- The preamble also notes that any "intermediate" level of care (such as residential treatment or intensive outpatient services) must be considered within the six benefit classifications described above, a view which rejects the request of some commenters that a separate benefit classification for intermediate levels of care be created. Hence, as described by the preamble, if a plan or issuer, for example, treats care in a skilled nursing facility or rehabilitation hospital as inpatient benefits, then the plan or issuer must treat any covered care in residential treatment facilities for mental health or substance use disorders as an inpatient benefit.

Managed Behavioral Health Organizations (MBHOs)

- Finally, the preamble to the final rules, while noting the role of MBHOs in the administration of mental health and substance use disorder benefits in many plans and policies, states that the use of an MBHO "does not, however, relieve the employer, issuer, or both of their obligations under MHPAEA." The preamble further notes that "[l]iability for any violation of MHPAEA rests with the group health plan and/or health insurance issuer."

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Jeffrey L. Poston
Partner – Washington, D.C.
Phone: +1.202.624.2775
Email: jposton@crowell.com