OLR RESEARCH REPORT

December 10, 2013 2013-R-0437

FEDERAL MENTAL HEALTH PARITY INSURANCE REQUIREMENTS

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This memo summarizes the final regulations implementing the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The act and the final regulations require parity between mental health and substance use disorder benefits and medical and surgical benefits with regard to financial requirements (e.g., co-payments) and treatment limitations under group health insurance plans, and group, and individual health insurance coverage. The final regulations also reflect changes the federal Patient Protection and Affordable Care Act (ACA) made to the health insurance market. (For related information, see OLR report 2013-R-0086 on mental health parity.)

SUMMARY

Among other things, the final regulations establish transparency requirements for health insurance plans, including disclosure rights of plan participants and providers. In most cases, they require that co-payments, deductibles, and limits on visits to health care providers be no more restrictive or less generous for mental health and substance use disorder benefits than for medical and surgical benefits. They also restrict the use of nonquantitative treatment limitations such as prior authorization requirements.

Under the final regulations, the parity requirements apply to all plan standards, including geographic limits, facility-type limits, and network adequacy. They also apply to intermediate levels of care received in residential treatment or intensive outpatient settings.

The final regulations provide for temporary exemptions from their requirements for insurance plans if they cause the cost of a plan to increase by specified amounts. The final regulations do not apply to Medicaid managed care plans, alternative benefit plans (e.g., Medicaid expansion plans under the ACA), or the Children's Health Insurance Program.

The U.S. departments of Health and Human Services (DHHS) and Labor (DOL) and the Internal Revenue Service issued the final regulations on November 13, 2013, after reviewing more than 5,400 public comments on the interim final regulations, which had been issued in 2010.

The mental health parity provisions of the final regulations apply to health plans and health insurance issuers for plan years (policy years in the individual market) beginning on or after July 1, 2014. Certain technical amendments are effective December 13, 2013.

FEDERAL LAW

In 1996, Congress enacted the Mental Health Parity Act, which prevents group health plans and health insurance issuers that provide mental health and substance use disorder benefits from imposing more stringent limitations on those benefits than on medical/surgical benefits (Division C of Pub. L. 110-343). The act requires parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. These requirements apply to employment-related group health plans and health insurance coverage offered in connection with a group health plan. The act does not require health plans and their health insurance issuers to provide mental health benefits, but if they do the benefits must be on a par with medical/surgical benefits. The MHPAEA, adopted in 2008, expanded the scope of the 1996 act. DHHS has published a fact sheet on the MHPAEA.

The MHPAEA applies to group health plans sponsored by private and public sector employers with more than 50 employees, including both self-insured and fully-insured arrangements. It also applies to health insurance issuers who sell coverage to employers with more than 50 employees.

The ACA extended these parity requirements to apply to the individual health insurance market and to the qualified health plans that act established, in the same way as they apply to health insurers and group health plans. The act also prohibits lifetime and annual limits on the

dollar amount of essential health benefits, which it defines to include mental health and substance use disorder services such as behavioral health treatment. DOL has a website responding to frequently asked questions regarding the ACA, including its mental health parity provisions.

The final mental health parity regulations apply to health plans and health insurance issuers for plan years (policy years in the individual market) beginning on or after July 1, 2014. Until the final rules become applicable, plans and issuers must continue to comply with the mental health parity provisions of the 2010 interim final regulations.

The MHPAEA does not supersede any provision of state law that establishes, implements, or continues in effect any standard or requirement on health insurance issuers in connection with group health insurance coverage, except to the extent that a standard or requirement prevents the application of a requirement of the act and other applicable provisions of federal law.

FINAL RULE

Definitions

Under the final regulations, "mental health benefits" and "substance use disorder benefits" mean benefits with respect to services or items for mental health conditions or substance use disorders, respectively, as defined under the terms of the plan and in accordance with applicable federal and state law.

The final regulations require that the plan terms defining whether the benefits are (1) mental health or substance use disorder benefits or (2) medical/surgical benefits be consistent with generally recognized standards of current medical practice, such as the most current version of the Diagnostic and Statistical Manual of Mental Disorders.

The final regulations define treatment limitations to include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include quantitative treatment limitations, such as 50 outpatient visits per year, and nonquantitative treatment limitations. The latter include such things as:

1. medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or for experimental or investigative treatments;

2. formulary design for prescription drugs;
3. standards for provider admission to participate in a network, including reimbursement rates;
4. plan methods for determining usual, customary, and reasonable charges of providers; and
5. refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

Disclosure of Underlying Processes and Standards

The MHPAEA requires that insurers:

1. make the criteria for determining whether services with respect to mental health or substance use disorder are medically necessary available to any current or potential participant, beneficiary, or contracting provider upon request and
2. explain the rationale for any denial of reimbursement or payment for services with respect to these disorders to the participant or beneficiary on request or as otherwise required by the plan administrator in accordance with the implementing regulations.

The final regulations note that other federal requirements apply in these areas. These include (1) DOL's claims procedure regulations and (2) DOL's and DHHS' regulations under the ACA, which set rules regarding claims and appeals, including the right of claimants appealing an adverse benefit determination. The ACA regulations also require insurers to provide claimants reasonable access to and copies of all information relevant to claims for benefits, upon request and free of charge.

The final mental health parity regulations require that a plan provide documents of a comparable nature regarding medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits. The plan must also provide the processes, strategies, evidentiary standards, and other factors used to apply nonquantitative limits with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.

Parity Analysis

Classification of Benefits. The final regulations require that the parity analysis be conducted in six classes of benefits. These are (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. The final regulations specify the permissible sub-classifications, such as office visits versus other types of outpatient services. After the sub-classifications are established, a plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any classification or sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits.

The parity analysis must be performed within each classification and sub-classification. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then it must also treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. Similarly, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

Financial Requirements and Treatment Limits. Under the final regulations, a plan or issuer may not apply cumulative financial requirements (such as deductibles and out-of-pocket maximums) or cumulative quantitative treatment limitations (such as annual or lifetime day or visit limits) for mental health or substance use disorder benefits in a classification that accumulate separately from any cumulative requirement or limitation established for medical/surgical benefits in the same classification. The parity requirements regarding annual and lifetime limits in the final regulations only apply to mental health and substance use disorder benefits that are not essential health benefits, since the ACA prohibits such limits for essential health benefits.

Nonquantitative Limitations. The final regulations also restrict the use of other treatment limitations such as prior authorization requirements. The final regulations generally bar a plan or issuer from imposing such limits with respect to mental health or substance use disorder benefits in a classification unless any processes, strategies, evidentiary standards, or other factors used to limit mental health or

substance use disorder benefits are comparable to, and are applied no more stringently than, the factors used to apply the limitation with respect to medical/surgical benefits in the same classification.

Exemptions

Increased Costs. The MHPAEA allows an exemption for plans and health insurance issuers that make changes to comply with the law and incur an increased cost of at least 2% in the first year that the act applies to the plan or coverage or at least 1% in any subsequent plan or policy year. Under the act, plans or coverage that (1) comply with the parity requirements for one full plan year and (2) satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan or policy year. This exemption lasts for one plan or policy year. Thus, the increased cost exemption may only be claimed for alternating plan or policy years.

The final regulations establish standards and procedures for claiming an increased cost exemption. An exemption must be based on the estimated increase in actual costs incurred by the plan that is directly attributable to expanding coverage due to the requirements of the act section and not otherwise due to (1) occurring trends in utilization and prices, (2) a random change in claims experience that is unlikely to persist, or (3) seasonal variation commonly experienced in claims submission and payment patterns. If granted, the plan must provide participants and beneficiaries a summary of the information on which the exemption was based, on request and at no charge. These provisions apply to plan or policy years beginning on or after July 1, 2014.

Small Employers. The MHPAEA exempted group health plans (or health insurance issuers offering coverage in connection with a group health plan) for small employers, but this exemption has largely been superseded by regulations implementing the ACA. The final mental health parity regulations that are the subject of this report note that on February 25, 2013, DHHS published a final regulation on essential health benefits. That regulation, issued to implement the ACA, requires issuers of non-grandfathered plans in the individual and small group markets to ensure that they provide all mental health and substance use disorder benefits that are designated as essential by the states. That final regulation also requires issuers providing essential health benefits to provide mental health and substance use disorder benefits in compliance with the requirements of the MHPAEA regulations, even where those requirements would not otherwise apply directly. Thus, all insured, non-

grandfathered, small group plans must cover essential health benefits in compliance with the MHPAEA, regardless of the act's small employer exemption.

Opt-out by Certain Self-Insured Plans

The MHPAEA permits plans for state and local government employees that are self-insured to opt-out of its requirements if certain administrative steps are taken. Among other things, the plan must notify the Centers for Medicare and Medicaid Services and notify enrollees of the opt-out when they enroll and annually thereafter.

HYPERLINKS

Final regulations:

- https://www.federalregister.gov/articles/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act

DHHS fact sheet on the MHPAEA:

- http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

DOL frequently asked questions on mental health provisions of the ACA:

- http://www.dol.gov/ebsa/mentalhealthparity/

(All last visited on December 3, 2013)

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