Mental Health Parity

February 20, 2014

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Mental Health Parity

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “questions” box located on your webinar control panel.

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Agenda

- Who Must Comply
- Background
- Annual/Lifetime Limits
- Classifications
  - Financial Requirements & Quantitative Treatment Limitations
  - Non-Quantitative Treatment Limitations
- Enforcement

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WHO MUST COMPLY

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Who Must Comply

- Any group health plan that provides mental health or substance use disorder benefits must comply unless they meet one of the exemptions
  - Group health plans are not required to provide mental health or substance use disorder benefits, but if they do offer such benefits, the "parity" requirements apply
  - Any combination of arrangements to provide health care benefits under which a participant can simultaneously receive coverage for medical/surgical benefits and mental health or substance use disorder benefits is considered to be a single group health plan subject to the parity requirements

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Who Must Comply

- Exemptions to "parity" requirements
  - **Excepted benefits** (i.e. health FSAs, limited scope vision and dental, hospital indemnity policies or policies providing coverage only for a specific disease/illness)
  - **Small employers**
    - Generally, 50 and under (total employees/headcount, not total eligible)
    - 100 and under for non-federal governmental plans
  - **Retiree-only plans**
  - **Self-funded state and local governmental plans (non-federal)** that choose to opt out and follow the required procedures
  - **Employers who experience significant cost increases** (1% first year or 2% any year thereafter)
    - Procedures and mathematical equations for calculating an overage as well as the requirements for reporting in the final rules

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Who Must Comply

Effects of the ACA on who must comply…

- Small fully-insured groups are required to provide mental health and substance use disorder benefits as part of the "essential health benefits"
  - The parity rules must be followed in order for the offering to meet what is required under "essential health benefits"
  - Many more plans required to comply in 2014; grandfathered and self-funded groups may still qualify for the small group exception
- Non-grandfathered plans required to provide preventive health services (which include some preventive mental health or substance use disorder benefits) are not required to comply with MHPAEA based solely on provision of these preventive services

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Who Must Comply

- Fully-insured plans
  - Carriers selling fully insured group health plans will generally structure the plans to be in compliance with these regulations
  - Most will have little control over the coverage provided in their plans

- Self-funded plans
  - Work carefully with administrators and advisors to ensure that mental health and substance use disorder benefits are compliant with final rules

* Final rules clarified that a plan does not need to perform the parity analysis annually unless there is a change in plan benefit design, cost-sharing structure, or utilization that would affect a financial requirement or quantitative treatment limitation within a classification

BACKGROUND

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Background

Mental Health Parity Act of 1996 (MHPA)

- Required group health plans with annual/lifetime limits for medical/surgical benefits to provide the same (or higher) limits to mental health benefits

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Background

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Amended MHPA by adding provisions relating to substance use disorder benefits and imposing additional parity requirements (treatment limits and financial requirements)
- Effective for plan years beginning on or after 10/3/2009
- Interim final rules effective for plan years beginning on or after 7/1/2010 established parity standards for financial requirements, quantitative treatment limits and non-quantitative treatment limits on a classification-by-classification basis
- Final rules effective for plan years beginning on or after 7/1/2014 further clarified the rules; plans must continue to comply with interim rules for now

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Background

Mental Health Parity Rule:

For those group health plans offering both medical/surgical benefits and mental health or substance use disorder benefits, the plans must provide mental health and substance use disorder benefits at least equal ("in parity") to the medical/surgical benefits provided

- Same or more generous **annual/lifetime limits**
- Equal **financial requirements** (i.e. deductible, copays, out-of-pocket maximum) and **quantitative treatment limitations** (i.e. number of treatments, visits or days of coverage)
- Equal **non-quantitative treatment limitations** (i.e. medical management standards)

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Background

- **Medical/Surgical Benefits**
  - as defined under the plan in accordance with applicable federal/state law, but do not include mental health or substance use disorder benefits
- **Mental health benefits** and **Substance use disorder benefits**
  - as defined under the plan in accordance with applicable federal/state law

* Final rules clarify these terms include benefits for items as well as services and that both federal and state law apply

* Terms must be consistent with generally recognized standards of current medical practice (such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); International Classification of Diseases (ICD-10; or State guidelines)

ANNUAL/LIFETIME LIMITS

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Annual/Lifetime Limits

NOTE – mental health or substance use disorder benefits considered to be an “essential health benefit” may not have any annual or lifetime limits under the ACA; therefore, most annual/lifetime limits will disappear

- Only if a plan imposes lifetime or annual maximum limits on more than 1/3 of all medical surgical benefits would any kind of limit on mental health or substance use disorder benefits be allowed
- Unlikely for a plan to be able to impose lifetime and annual limits on non-essential health benefits that would comprise more than 1/3 of all medical surgical benefits

Annual/Lifetime Limits

- 1/3 Rule
  - if the plan does not include annual or lifetime limits for any medical/surgical benefits, or less than 1/3 of all medical/surgical benefits, it may not impose any annual or lifetime limits on mental health or substance use disorder benefits
- 2/3 Rule
  - if the plan includes annual or lifetime limits for at least 2/3 of all medical/surgical benefits, it must either:
    - Apply the annual or lifetime limit to both the medical/surgical benefits and mental health or substance use disorder benefits and not distinguish between the different benefits; or
    - Make sure not to include annual or lifetime limits on mental health or substance use disorder benefits that are less than the annual or lifetime limits applying to the medical/surgical benefits

Annual/Lifetime Limits

- Plans not fitting into either category may either:
  - Include no annual or lifetime limit
  - Include an annual or lifetime limit ≥ weighted average of the annual/lifetime dollar limits for the applicable category of medical/surgical benefits
- Final rules clarified the 1/3 and 2/3 rule are based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year
  - Any reasonable method may be used to determine the dollar amount expected to be paid under the plan
  - Dollar amount is based on the amount the plan allows before participant cost-sharing, not the amount the plan pays after participant cost-sharing

CLASSIFICATIONS

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Classifications

- Parity applies on a classification-by-classification basis for financial requirements, quantitative treatment limitations and non-quantitative treatment limitations
  - Definitions for these classifications must be made uniformly for medical/surgical benefits and mental health and substance use disorder benefits
- Interim rules designated six classifications (no other classifications are permitted):
  - Inpatient, in-network;
  - Inpatient, out-of-network;
  - Outpatient, in-network;
  - Outpatient, out-of-network;
  - Emergency care; and
  - Prescription drugs

Classifications

Parity rules:

- Plans must provide mental health and substance use disorder benefits in parity for all classifications in which medical/surgical benefits are available
- Final rules clarified that plans must provide intermediate services such as residential treatment and intensive outpatient treatment in parity for all classifications in which they are available as medical/surgical benefits
- Final rules formalized the previous safe harbor that outpatient services may be sub-classified into (a) office visits and (b) all other outpatient items and services
- Plans may generally not further sub-classify generalists and specialists

Classifications

Parity rules:

- Final rules clarified that multiple providers for in-network tiers may be used as a further sub-classification so long as the tiering is not based on whether a provider is a provider of medical/surgical services or mental health or substance use disorder services
  - For plans with an uneven number of tiers between medical/surgical and mental health or substance use disorder, the plan uses the least restrictive level of financial requirement and/or quantitative treatment limitation that applies to at least 2/3 of medical/surgical benefits across all provider tiers in a classification as the predominant level
- No separate cumulative financial requirement or quantitative treatment limitation may apply to mental health or substance use disorder benefits, even if they're equal to those for medical/surgical benefits
  - Separate but equal is not allowed (e.g. deductibles, out-of-pocket maximums, visit limits that accumulate separately from those for medical/surgical benefits in the same classification)

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FINANCIAL REQUIREMENTS & QUANTITATIVE TREATMENT LIMITATIONS

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Financial Requirements & Quantitative Treatment Limitations

A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits must ensure that the financial requirements and quantitative treatment limitations are no more restrictive for mental health or substance use disorder benefits than the predominant financial requirements and treatment limitations that apply for substantially all of the medical/surgical benefits

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Financial Requirements & Quantitative Treatment Limitations

Definitions

- **Financial requirements** – includes deductibles, copays, coinsurance and out-of-pocket expenses, but exclude annual/lifetime limits
- **Quantitative treatment limitations** – includes limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment
- **Substantially all** – if it applies to at least 2/3 of all medical/surgical benefits in that classification

Financial Requirements & Quantitative Treatment Limitations

Definitions

- **Predominant** - the most common or frequent of such type of limit or requirement
- **Predominant level** – the level that applies to more than ½ of medical/surgical benefits in that classification (if there is no single level that applies to more than ½, the plan may combine levels until the combination applies to more than 1/2) – known as the "aggregate rule" – the least restrictive level within the combination is the predominant level)
  - *Ex. Copays of $50, $25 and $15 may apply to ½ of medical/surgical benefits…the $15 copay is the predominant level*

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NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTL)

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NQTLs

- Non-quantitative treatment limitations are limitations that affect the scope or duration of benefits under the plan that cannot be expressed numerically
- Examples of NQTLs include:
  - Medical management standards limiting/excluding benefits based on medical necessity/appropriateness or based on whether treatment is experimental/investigative
  - Formulary design for prescription drugs
  - Standards for provider admission to participate in a network, including reimbursement rates
  - Plan methods for determining usual, customary and reasonable charges
  - Refusal to pay for high-cost therapy until it is shown that a lower-cost therapy is not effective
  - Exclusions based on failure to complete a course of treatment

NQTLs

A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not impose any processes, strategies, evidentiary standards or other factors used to apply NQTLs to mental health or substance use disorder benefits that are any more stringent than those applied to medical/surgical benefits within a classification

*Note that the interim regulations included an exception that allowed variation to the extent that “recognized clinically appropriate standards of care” permitted a difference; this exception was eliminated in the final rules

NQTLs

- Scope of benefits has not been defined in detail, but the final rules clarified that any restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration must also comply with the parity rules
- Not all treatments or settings for mental health and substance use disorder correspond to those for medical/surgical benefits
- Until further guidance is provided, best practice is to determine whether or not there is an analogous medical/benefit treatment or setting and act accordingly

NQTLs

Disclosures

- Criteria for medical necessity determinations or the reasons for denial of mental health or substance use disorder benefits must be made available in accordance with applicable regulations upon the request of current or potential participants, beneficiaries or contracting providers
- Under ERISA, such documentation must be made available to participants within 30 days of request
- Under the ACA, individuals must be provided reasonable access (free of charge) to and copies of all documents, records and other information relevant to the individual's claims
- Final rules requested additional commentary on how best to provide greater transparency

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ENFORCEMENT

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Enforcement

No specific penalty or enforcement for MHPA or MHPAEA, but there may be…

- Civil lawsuits under ERISA for breach of fiduciary duty for failure to comply with MHPAEA and damages for unpaid benefits, interest and attorney's fees
- IRS excise taxes of $100 per day for each affected individual

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Enforcement

State law applicability

- ERISA does not preempt any state law except to the extent that the state law prevents application of MHPAEA
  - fully-insured plans will be subject to more generous state laws, but self-funded groups will not due to preemption under ERISA
- Chart outlining the states' mental health parity laws is available at the National Conference of State Legislatures website - http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx

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Thank you.

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