Stephens
Stephens Insurance, LLC

111 CENTER STREET
LITTLE ROCK, AR 72201
(800) 852-5053
INSURANCE@STEPHENS.COM
WWW.STEPHENSINSURANCE.COM
ARKANSAS INSURANCE AGENCY #301051

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 - KEY CLARIFICATIONS MADE BY FINAL REGULATIONS

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) seeks to ensure that medical plans, including group health plans, that provide mental health and substance use disorder benefits do so in a manner that generally is on par with the medical benefits offered under the plans.

The MHPAEA applies to both self-insured and fully insured plans sponsored by employers with more than 50 employees. It is worth noting that while the MHPAEA does not require medical plans to cover expenses for mental health or substance use disorder services, plans that must provide "essential health benefits" under the Affordable Care Act (ACA), must include benefits for mental health or substance use disorder services.

On Nov. 13, 2013, the Departments of Labor, Health and Human Services and Treasury together issued final regulations to implement the MHPAEA. Those regulations become effective for plan years beginning on and after July 1, 2014, but until that time, plans must comply with the interim final regulations currently in effect. The final regulations incorporate clarifications issued by the Departments through a number of Frequently Asked Questions (FAQs) since the issuance of the interim final regulations.

The discussion below summarizes some of the key changes the final regulations made to the interim final regulations.

- **CLASSIFICATIONS**
  Under MHPAEA, plans may not impose "a financial requirement or quantitative treatment limitation on mental health and substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the same classification." The interim final regulations set forth that a parity analysis be conducted on a classification-by-classification basis in six specific classifications of benefits: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs.

  The final regulations retain these classifications, but also incorporate an enforcement safe harbor announced in one of the FAQs mentioned above. That is, plans may separate outpatient services into two sub-classifications - (1) office visits and (2) all other

outpatient services - for purposes of conducting the parity analysis. Sub-classifications not expressly permitted in the final regulations (such as sub-classifications for generalists and specialists) are not permitted. The final regulations also permit sub-classifications for plan designs that include tiered networks. The final regulations confirm that the parity analysis be performed within each classification and sub-classification.

- **NONQUANTITATIVE TREATMENT LIMITATIONS (NQTLS)**
  The interim regulations provided that mental health or substance abuse disorder benefits could not be subject to nonquantitative treatment limitations (NQTLs) in a classification (see above) unless, in general, the limitations to which medical/surgical benefits in the same classification are subject are just as stringent. The interim regulations allowed for differences in the application of NQTLs, however, where clinically appropriate standards of care permitted a difference. The final regulations eliminated this exception because the Departments believe that it created confusion and that there is enough flexibility in the general rule.

- **MEASURING PLAN BENEFITS**
  Because the Departments believe that group health plans have become familiar and experienced with implementing the numerical standards in the interim final regulations, they have retained them in the final regulations. Those standards are the two-thirds "substantially all" standard and the "predominant" standard which was quantified to mean more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation. The final regulations clarify, however, that a plan 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 sub-classification).

- **COORDINATION WITH THE AFFORDABLE CARE ACT**
  - **LIFETIME AND ANNUAL LIMITS.** The MHPAEA allows for lifetime and annual dollar limits on mental health and substance use disorder services. However, the ACA generally prohibits such limits with respect to essential health benefits. So, when mental health and substance use disorder services are provided as essential health benefits, they cannot be subject to those limits.

  - **PREVENTIVE SERVICES**. The interim final regulations provide that if a plan provides mental health or substance use disorder benefits in a classification, such benefits must be provided in every classification in which medical/surgical benefits are provided. Preventive services under the ACA, which must be provided under non-grandfathered plans, include a range of services such as depression and alcohol screenings. Many expressed concern to the Departments that complying with the ACA preventive service requirements would in effect require those plans to provide the full range of benefits for mental health or substance user disorder benefits under the MHPAEA. The Departments agreed and the final regulations provide that plans which provide mental health or substance use disorder benefits only to the extent required to meet the ACA requirements for preventive services, are not required to provide additional mental health or substance use disorder benefits in any classification.

- **DISCLOSURE REQUIREMENTS**
  The final regulations remind plans that compliance with the MHPAEA's disclosure requirements is not determinative of compliance with any other provision of applicable Federal or State law. For group health plans, it is critical that plan administrators make sure that they comply with the ERISA disclosure requirements. For example, a section of ERISA requires that, upon written request from a participant, a plan administrator must disclose the plan instruments under which the plan is established or operated. Those instruments 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. Note also that together with the final regulations, the Departments issued additional FAQs which, in part, seek comments on ensuring greater transparency and compliance.

- **EMPLOYEE ASSISTANCE PROGRAMS**
  Commenters questioned whether benefits under an employee assistance program (EAP) are considered to be excepted benefits and, therefore, not subject to the MHPAEA. The Departments intend to amend existing "excepted benefits" regulations to provide that benefits under an EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Such EAPs will not be subject to MHPAEA or the final regulations.

Compliance with the MHPAEA could begin as early as July 1, 2014, for plans with plan years beginning on that date. For calendar year plans, the compliance date is Jan. 1, 2015. Employers will need to start reviewing their plans ensure MHPAEA compliance, but must continue to comply with the interim final regulations until that time.

JACKSON LEWIS LLP