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Fact Sheet

Mental Health Parity and Addiction Equity Act of 2008 Final Regulations and Federal Guidance

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Background

Mental health conditions are common in the United States with roughly twenty percent of the population diagnosed with one or more mental health disorders in any given year and about four percent, or roughly 9 million people, considered to have a severe mental illness.[1] Only about sixty percent of individuals with a severe mental health disorder access mental health services and only forty percent of individuals with any mental health diagnosis access services.[2] Of the estimated 19 million adults with a substance use disorder in the United States, an estimated 6.8 million adults are diagnosed with both a substance use and mental health disorder.[3]

For children and adolescents, one in five has, or will have, a seriously debilitating mental disorder at some point during their life. About half of those children with a mental health diagnosis will receive treatment.[4] Substance use by children continues to rise.[5] The prevalence of mental health conditions and substance use disorders and their lack

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[1] Substance Abuse & Mental Health Services Admin., *The NSDUH Report: Revised Estimates of Mental Illness from the National Survey on Drug Use and Health* (Nov. 19, 2013), http://www.samhsa.gov/data/2k13/NSDUH148/sr148-mental-illness-estimates.htm.
[2] *Id.*
[3] Substance Abuse & Mental Health Services Admin., *The NSDUH Report: Data Spotlight* (Nov. 19, 2013), http://www.samhsa.gov/data/spotlight/spot111-adults-mental-illness-substance-use-disorder.pdf.
[4] Nat'l Inst. of Mental Health, Use *of Mental Health Services and Treatment Among Children*, http://www.nimh.nih.gov/statistics/1NHANES.shtml.
[5] Nat'l Inst. on Drug Abuse, *DrugFacts: High School and Youth Trends* (Dec. 2012), http://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends; Nat'l Inst. on Drug Abuse, *Elevated Rates of Drug Abuse Continue for Second Year* (Jan. 1, 2012), http://www.drugabuse.gov/news-events/nida-notes/2012/06/elevated-rates-drug-abuse-continue-second-year.

of adequate treatment in the United States offer strong evidence of the significant need for mental health parity in health insurance coverage.

Mental Health Parity Act of 1996

On September 26, 1996, the Mental Health Parity Act (MHPA) was enacted.[6] The MHPA required that annual and lifetime dollar caps on mental health benefits in group health plans be no more restrictive than those on medical and surgical benefits. The provisions applied to employment-related group health plans or health insurance coverage offered in connection with such a plan and they were effective for plan years beginning on or after January 1, 1998. In states in which Medicaid mental health benefits were covered under contract with managed care organizations (MCOs),[7] MCOs were required to comply with MHPA requirements.[8]

While the MHPA required parity with regard to dollar limits on benefits, it did not mandate that group health plans and their insurance issuers add mental health benefits to their benefits packages. Rather, the mandate only applied to those plans that already covered mental health benefits. Furthermore, the parity requirement did not cover substance use disorder benefits. The MHPA applied only to group health plans with more than fifty employees and did not affect plans with fewer employees, nor did the law cover health insurance coverage in the individual market. Additionally, the statute allowed group health plans an exemption, if they could show that the provisions resulted in an increase of 1% in cost or coverage.

The MHPA also permitted group health plans to increase copayments, limit the number of visits for mental health benefits, maintain different cost sharing arrangements for mental health benefits than for medical and surgical benefits, and impose different limits on the number of mental health visits than on medical and surgical benefits. Such shortcomings necessitated additional federal legislation to ensure meaningful mental health parity.

Mental Health Parity and Addiction Equity Act

In the fall of 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which was signed into law on October 2, 2008.[9] The MHPAEA preserves the MHPA protections regarding parity of aggregate lifetime and annual caps in benefits. One of the most important changes made by MHPAEA is the expansion of parity requirements from MHPA to include substance use disorder benefits, including aggregate lifetime and annual dollar limit protections. MHPAEA also requires that the financial requirements and treatment

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[6] Pub. L. No. 104-204, 110 Stat. 2874.
[7] 42 U.S.C. § 1396b(m)(1)(A).
[8] The Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, 498 & 558, added sections 1932(b)(8) and 2103(f)(2) to apply pieces of MHPA to MCOs as defined in 42 U.S.C. § 1908(m)(1)(A) and CHIP.
[9] Pub. L. No. 110-343, 122 Stat. 3765 (2008) (codified in scattered sections U.S.C Titles 26, 29 and 42).

limitations that apply to mental health benefits or substance use disorder benefits can be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits if a group health plan includes medical/surgical benefits and mental health or substance use disorder benefits. In addition, mental health and substance use disorder benefits may not be subject to any cost sharing requirements or treatment limitations that apply to only those benefits. Like the MHPA, the MHPAEA does not require group health plans to include mental health and/or substance use disorder benefits in their benefits package nor does it mandate the terms and conditions relating to amount, duration or scope of mental health benefits.

The MHPAEA originally only impacted large health plans (with more than fifty employees and group plans), but not plans in the individual market. Other laws have since incorporated provisions of the MHPAEA and expanded the reach of its protections. The mental health and substance use disorder parity requirements of MHPAEA apply to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans.[10] In addition, effective March 23, 2010, the Affordable Care Act (ACA)[11] expanded the MHPAEA to apply to Medicaid non-managed care alternative benefit plans (ABPs) and required ABPs to include mental health and substance abuse disorder benefits as a basic service.[12]

After enactment of the MHPAEA, the Departments of Treasury, Labor and Health and Human Services published a request for information (RFI) soliciting comments on the requirements of MHPAEA on April 28, 2009. After considering the comments received in response to the RFI, the Departments released the interim final rules on the MHPAEA on February 2, 2010.[13] The Departments issued final rules on November 13, 2013 that were not substantially different from the interim rules. The final rules are effective as of January 13, 2014, but some plans will not be affected by the final rules until the new plan year.[14]

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[10] In 2009, section 502 of CHIPRA amended the Act and incorporated, by reference, provisions added to section 2705 of the Public Health Service Act (PHSA) by MHPAEA. Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, § 502, 123 Stat. 8, 89 (2009) (codified at 42 U.S.C. § 1397cc(c)(6)).

[11] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (collectively the "Affordable Care Act")

[12] 42 U.S.C. § 1396u-7(b)(6); *see infra* pp. 12-13 for more discussion of the ACA and parity, including ABPs.

[13] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 75 Fed. Reg. 5410 (interim final rules Feb. 2, 2010) [hereinafter MHPAEA Interim Final Rules].

[14] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (Nov. 13, 2013) (to be codified at 26 C.F.R. pt. 54, 26 C.F.R. pt. 2590, and 45 C.F.R. pts. 146-47) [hereinafter MHPAEA Final Rules]. The final rules apply to group health plans and health insurance issuers for plan years (or policy years in the individual market) beginning on or after July 1, 2014. The interim rules covered plan years beginning on or after July 1, 2010. *Id.*

Determining Parity—Important Terms

The MHPAEA requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations. The definitions of mental health benefits, substance use disorder benefits, financial requirements and treatment limitations are particularly important in understanding how parity is analyzed.[15]

The regulations describe the term "mental health benefits" as:

> benefits with respect to items or services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD [International Classification of Diseases], or State guidelines).[16]

Substance use disorder benefits are described as:

> benefits with respect to items or services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM [Diagnostic and Statistical Manual of Mental Disorders], the most current version of the ICD [International Classification of Diseases], or State guidelines).[17]

These meanings seem to offer plans a great deal of flexibility to define "mental health conditions" and "substance use disorders." Additionally, they raise questions about where to draw the line for treatment of certain conditions, such as smoking cessation or autism, for which the benefits may fall into more than one category. What is critical is the requirement that the definitions of conditions or disorders must be consistent with independent standards recognized in the medical community. This provision goes a step beyond the statutory language, which simply requires that the benefits are "in

[15] In addition to these terms, the rules define the terms aggregate lifetime dollar limit, annual dollar limit, coverage unit, cumulative financial requirements, cumulative quantitative treatment limitations, medical/surgical benefits, and treatment limitations. *Id.* at 68286-87.

[16] *Id.* The final rules added the "items or" to the definitions in the interim rules so that it was more clear that it included benefits for items as well as services. *Id.* at 68242.

[17] *Id.* at 68287.

accordance with applicable Federal and State law" and ensures that plans do not misclassify benefits in order to avoid complying with the parity mandates.[18]

Financial requirements include deductibles, copayments, coinsurance or out-of-pocket maximums, but not aggregate lifetime or annual dollar limits.[19] Treatment limitations "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."[20] There are two types of treatment limitations: quantitative (expressed numerically, such as 50 outpatient visits per year) and, nonquantitative, those that otherwise, limit the scope or duration of benefits for treatment under a plan or coverage.[21] Nonquantitative treatment limitations (NQTLs) include restrictions regarding prescriptions not on the plan's approved drug formulary or requirements that certain medications be tried before other medications. The rules do not consider a permanent exclusion of all benefits for a particular condition or disorder to be a treatment limitation.[22] Quantitative treatment limitations are relatively easy to compare and determine whether or not parity exists., but nonquantitative treatment limits are more difficult to analyze for parity.

Nonquantitative Treatment Limitations

The regulations offer an illustrative list of NQTLs, which include the following:

- Medical management standards limiting or excluding benefits based upon medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Prescription drug formularies
- Network tier design for plans with multiple network tiers, such as plans with preferred providers
- Plan methods for determining usual, customary, and reasonable charges
- Fail first policies or step therapy protocols
- Provider admission standards for participation in a network
- Exclusions based upon failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services.[23]

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[18] *Compare* MHPAEA Final Rules, *supra* note 14, at 68286-87 *with* Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a(e)(4).
[19] MHPAEA Final Rules, *supra* note 14, at 68286.
[20] *Id.* at 68287.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 68246, 68292. In response to comments to the interim rules, the final rules added two additional examples of NQTLs to the illustrative list: 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. *Compare id.* at 68292 *with* MHPAEA Interim Final Rules, *supra* note 13, at 5449.

The regulations make clear that health plans may not impose such limitations unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits are comparable to and no more stringently applied than those for medical surgical benefits in the classification.[24] In being comparable, the factors cannot be specifically designed to restrict access to mental health or substance use disorder benefits.[25] The final rules recognize that plans and issuers do not have to use the same NQTLs for both mental health and substance use disorder benefits and for medical/surgical benefits, but do need to use comparable processes, strategies, evidentiary standards and other factors to determine whether and to what extent a benefit is subject to an NQTL.[26]

It is important to understand that NQTLs may comply with the parity requirements and still create disparate results.[27] For example, a plan could determine whether a treatment is medically appropriate (such as the number of visits) based on recommendations by panels of experts with appropriate training and experience in the fields of medicine involved. This may result in different numbers of visits and this does not necessarily violate parity.[28] Unlike the quantitative parity requirements in the rule, there is no mathematical analysis for NQTLs because of the non-quantitative nature of the limitations.[29] The final rules provide eleven examples that help illustrate how parity is determined for NQTLs.[30]

Advocates should monitor for problems with medical management, which plans have historically used to limit or impair access to mental health and substance use disorder

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[24] *See* MHPAEA Final Rules, *supra* note 14, at 68292. The interim rules allowed plans to use and apply processes and standards differently "to the extent that recognized clinically appropriate standards of care may permit a difference." MHPAEA Interim Final Rules, *supra* note 14, at 5449. The final rules specifically remove this exception because many commenters raised concerns it could be subject to abuse. MHPAEA Final Rules, *supra* note 14, at 68245.

[25] *Id.* at 68246.

[26] *Id.* at 68245.

[27] *Id.*; *see also* Dep't of Labor, *FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation* (Nov. 17, 2011), http://www.dol.gov/ebsa/pdf/faq-aca7.pdf. One of the examples of a possible disparate result of NQTLs that is more quantifiable is provider reimbursement rates. A wide array of factors may be considered in determining reimbursement rates and these factors are considered just like any other NQTL factors and must be done in a way for mental health and substance use disorder benefits that is comparable to and no more stringently applied than for medical/surgical benefits. MHPAEA Final Rules, *supra* note 14, at 68246.

[28] *Id.* at 68292.

[29] *Id.* at 68245.

[30] *Id.* at 68292. One example of a plan that violates the rules is a plan that requires prior approval but the ramifications for failing to get prior approval are different, e.g., for mental health and substance use disorders there would be no benefits paid, but for medical/surgical benefits there is only a twenty-five percent reduction in the benefits the plan would otherwise pay. An example of a comparable plan that does not violate parity is a plan that applies a concurrent review standard to inpatient care where there are high levels of variation in the length of stay. If in practice the application of the evidentiary standard affects 60 percent of mental health conditions and substance use disorders and only 30 percent of medical/surgical conditions, the practice does not violate parity even though it has a disparate effect as long as the standard is applied no more stringently for mental health and substance abuse disorders than for medical/surgical benefits. *Id.*

benefits. The rules allow for the use of medical management techniques such as looking at cost of treatment, high cost growth, clinical efficacy of any proposed treatment or service, and claim types with a high percentage of fraud, as long as the factors are applied in a comparable fashion. Although a plan or issuer documents the evidence, such as medical literature and professional standards, and how the medical management techniques were developed, this may allow for more subjectivity and historical bias or limited access and may affect the basis for the medical management.

Advocates should also watch for reductions in coverage or assessment of penalties when there is failure to obtain prior authorization for mental health benefits, but not for medical/surgical benefits. Similarly, advocates must watch out for extremely low fee schedules or restrictions in provider admission into a plan network which are applied more stringently to mental health or substance use disorder providers than to medical/surgical care providers.

Cumulative Financial and Quantitative Treatment Limitations

The MHAEPA regulations defined "cumulative financial requirements" and "cumulative quantitative treatment limitations." *Cumulative financial requirements* "determine whether or to what extent benefits are provided based on accumulated amounts" incurred or paid by the insured; they include deductibles and out-of-pocket maximums, but not aggregate or annual dollar limits.[31] *Cumulative quantitative treatment limitations* are "limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits."[32]

Beyond clarification of the terms, the regulations prohibit plans from imposing separate cumulative financial and quantitative treatment limitation for mental health or substance use disorder benefits, even if they are comparable to limitations for medical/surgical benefits.[33] Instead, plans must integrate deductibles and copayments and, also, any visit or episode limits so that all financial requirements, as well as all treatment limitations on medical/surgical benefits and mental health and substance use disorder benefits are cumulative. This is significant because historically, health plans have required insured individuals to pay higher deductibles or out-of-pocket costs for mental health care than for physical health care and have placed lower annual limits on visits for mental health-related services than for physical health-related services. It is precisely these disparities that the law and regulations seek to address.[34]

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[31] *Id.* at 68286.

[32] *Id.*

[33] MHPAEA Final Rules, *supra* note 14, at 68286.

[34] In the preamble to the final rules, the Departments cite that a study sponsored by the U.S. Department of Health and Human Services found that nearly all plans had eliminated the use of separate deductibles for mental health and substance use disorder benefits by 2011 and in 2010 only a very small percentage of plans were using separate deductibles. *Id.* at 68255-56.

Prescription Drugs

The final regulations provide special rules for prescription drugs. The rule allows plans to place prescription drugs into tiers and to apply the parity requirements within each tier.[35] However, this is only permitted if such placement is based upon reasonable factors, such as cost, efficacy and brand name versus generic, and is without regard to whether the drug is generally prescribed for mental health conditions or substance use disorders.[36] Thus, mental health prescription drugs could not be placed on higher cost tiers because of the conditions that those drugs treat. Assuming the tiers are based upon reasonable factors, a plan satisfies the parity requirement if it imposes different levels of financial requirements on different tiers of prescription drugs. Advocates should be watchful of the application of the parity requirement to prescription drugs. In addition to the flexibility the regulations allow plans in terms of placement of drugs into tiers, plans continue to have a great deal of discretion in establishing and managing formularies.

Determining Parity—Comparing Financial Requirements and Treatment Limitations

The general regulation governing parity states:

> A group health plan…may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.[37]

The regulations create six types of benefits classifications:

> (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.[38]

Sub-classifications are permitted for office visits separate from all other outpatient services and for plans that use multiple tiers of in-network providers.[39] Parity is required

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[35] *Id.* at 68289.
[36] *Id.*
[37] *Id.* at 68268.
[38] *Id.*
[39] MHPAEA Final Rules, *supra* note 14, at 68289-90. After the interim rules were issued, several plans and issuers brought to the Departments' attention that, with respect to outpatient benefits, many plans require a copayment for office visits and coinsurance for all other outpatient services. In response, the Departments issued a FAQ that established a safe harbor under which the Departments would not take enforcement action against plans and issuers that divide benefits into two sub-classifications (office visits

within the benefit classification types.[40] This means comparisons of mental health or substance use disorder benefits with medical/surgical benefits should be done within classifications, judging, for example, an emergency care service involving mental health benefits against an emergency care service involving medical/surgical benefits. A plan must apply the same standards to mental health and substance use benefits as it does to medical/surgical benefits in determining the classification in which the particular benefit applies.[41] Moreover, if a health plan offers mental health or substance use disorder benefits in any of these classifications, benefits must be provided in every classification in which medical/surgical benefits are offered.

In applying the general parity requirement of the MHPAEA, the first step is to determine whether the financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. According to the regulations, a type of financial requirement or treatment limitation is considered to apply to *substantially all* medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification.[42]

If a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification, then it may be permissible for that requirement or limitation to apply to mental health or substance use disorder benefits. For instance, if a plan has co-pays, those co-pays should be the same within the same category type. If an individual has a $20 co-pay for an outpatient, in-network provider and a $50 co-pay for an outpatient, out-of-network provider of physical health services, they must also have a $20 co-pay for an outpatient, in-network provider and a $50 co-pay for an outpatient, out-of-network provider of mental health services.

If a single level of a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification, the level of financial requirement or quantitative treatment limitation that is considered the *predominant* level of that type in a classification.[43] The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on mental health or substance use disorder benefits in that classification.

An example of a predominant level would be if a $20 copay is the predominant level of copay that applies to substantially all inpatient, in-network medical/surgical benefits, then a $20 copay is the most restrictive copay that can apply to inpatient, in-network mental health or substance use disorder benefits. The analysis for predominant level can get very complicated, particularly when multiple levels are involved. The rules provide examples of how to analyze for substantial and predominant, but most of this

and all other outpatient items and services) for purposes of applying the financial requirement and treatment limitation rules under MHPAEA. The terms of this FAQ are incorporated into the final rules. *Id.* at 68242.

[40] *Id.* at 68288.

[41] *Id.*

[42] *Id.* at 68289.

[43] *Id.*

analysis will be performed by the insurance industry. Oversight of the accuracy of the analysis by the Departments or advocates will be difficult because although the plans and issuers have to provide information, this information may not make it easy to tell if the determinations of levels and classifications are appropriate. Along with the complaint mechanisms for enforcement, the required regular reports to Congress regarding implementation of MHPAEA should be a good way for advocates to track compliance efforts.[44]

Parity and Level of Care Determinations

One of the concerns after the interim rules were issued was how intermediate levels of care, such as non-hospital residential treatment, would be covered under MHPAEA. Some wanted to limit the scope of services to say that if benefits for a type of treatment, such as counseling, was not provided for medical/surgical conditions, then it was not required for mental health or substance use disorders. Others wanted MHPAEA to require plans and issuers to provide benefits for any evidence-based treatment. In the final rules, the Departments directed plans and issuers to assign benefits, including intermediate services provided, to the six benefit classifications in the same way they assign comparable intermediate medical/surgical benefits. The preamble to the final rules provided the example that 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 also be considered outpatient benefits.[45]

Parity for Separate Benefit Packages

While MHPA and MHPAEA held that the parity requirement would be applied separately for each benefit package maintained by an employer, the final regulations specified that the parity requirements apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits, apply separately with respect to any combination of medical/surgical benefits and mental health or substance use disorder benefits, and that all health care benefits are to be treated as a single group health plan.[46] This provision is significant in that it should close the loophole in the statute, which allowed plans to avoid the parity requirements by covering mental health and substance use disorder benefits through separate carve-outs. In the preamble to the final rules, the Departments make clear that if an employer or issuer contracts with one or more entities to provide or administer mental health or substance use disorder benefits, the responsibility for compliance with MHPAEA still rests on that group health plan and/or the health insurance issuer.[47]

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[44] For example of such a compliance report, see U.S. Dept. of Labor, 2012 Report to Congress: Compliance with the Mental Health Parity and Addiction Equity Act of 2008 (Jan. 1, 2012), http://www.dol.gov/ebsa/publications/mhpaeareporttocongress2012.html.

[45] *Id.* at 68247.

[46] MHPAEA Final Rules, *supra* note 14, at 68250, 68294.

[47] *Id.* at 68250.

Transparency-Medical Necessity and Reasons for Denial Disclosure

MHPAEA added two important disclosure provisions, requiring covered issuers and plans to make available their criteria for medical necessity determinations and their reasons for denial of reimbursement or payment involving mental health and substance use disorder benefits.[48] The rules mandate that plans make information about medical necessity criteria available to any current or potential participant, beneficiary or contracting provider upon request.[49] Such disclosures must be provided at no charge. Advocates acting on behalf of a beneficiary or potential beneficiary should be able to use this provision.

Despite access to this type of information, advocates expressed continuing concerns about transparency, particularly about the ability to access sufficient information to determine whether plans are applying medical necessity criteria and other factors comparably to medical/surgical benefits and mental health and substance use disorder benefits. There were also concerns about how advocates could try to determine whether a plan complies with the NQTL provisions and thus MHPAEA. In the final rules, the Departments incorporated a new paragraph (d)(3) which states that compliance with MHPAEA disclosure requirements does not mean that all federally required disclosure requirements have been met, e.g., there are disclosure requirements under both ERISA and the ACA.[50]

Parity and the Affordable Care Act

The ACA extended MHPAEA to apply to the individual health insurance market and to qualified health plans in the same manner and to the same extent as it applies to health insurance issuers and group health plans.[51] The U.S. Department of Health and Human Services final regulation regarding essential health benefits (EHB) requires health insurance issuers offering non-grandfathered health insurance coverage in the individual and small group markets, through or outside of an Exchange, to comply with the requirements of MHPAEA so as to satisfy the requirement to cover EHB.[52] While a

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[48] MHPAEA, § 512(a)(4), 122 Stat. at 3881-82.
[49] MHPAEA Final Rules, *supra* note 14, at 68247, 68295.
[50] *Id.* at 68247. The Departments also published several FAQs clarifying the disclosure requirements, including information on other relevant disclosure requirements. *See* U.S. Dept. of Labor-Employee Benefits Sec. Admin., *FAQs for Employees about the Mental Health Parity and Addiction Equity Act* (May 18, 2012), http://www.dol.gov/ebsa/faqs/faq-mhpaea2.html.
[51] 42 U.S.C. § 1396u-7(b)(6); *see also* Dep't of Labor, *FAQs About Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation* (Jan. 19, 2014), http://www.dol.gov/ebsa/faqs/faq-aca18.html (explaining that grandfathered coverage is coverage provided by a group health plan, or individual health insurance coverage in which an individual was enrolled on March 23, 2010, and has not made certain changes in coverage since that time (citing § 1251 of the ACA, 29 C.F.R. 2590-715-1251, 45 C.F.R. 147.140))(citing CMS-Center for Consumer Information and Insurance Oversight, Letter to Insurance Commissioners (Nov. 14, 2013), http://www.dol.gov/ebsa/faqs/faq-aca18.html).
[52] MHPAEA Final Rules, *supra* note 14, at 68240 (citing 26 C.F.R. 54.9815-1251T, 29 C.F.R. 2590.715-1251, and 45 C.F.R. 147.140). Grandfathered health plans are exempted only from certain ACA requirements in Subtitles A and C of Title I, but the provisions regarding MHPAEA requirements were not part of the exempted sections. *Id.* EHBs include the following ten benefits categories, some of which

group health plan or health insurance issuer offering coverage in connection with a group health plan must provide mental health and substance use disorder benefits to meet the EHB requirements, MHPAEA final rules make it clear that nothing in the regulations requires such a plan to provide additional mental health or substance use disorder benefits.[53]

All Medicaid Alternative Benefit Plans (ABPs) must meet the MHPAEA provisions, regardless of whether services are delivered under managed care or non-managed care systems.[54] This includes benchmark equivalent, Secretary-approved benchmark plans, and ABPs for individuals in the Medicaid expansion group effective January 1, 2014.[55] States with ABPs for children should already meet the requirements because of the inclusion of mental health and substance use disorder services as one of the essential health benefits and the required assurance from states that eligible children will receive full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.[56] States may meet the requirements of parity and (EPSDT) through ABPs, or some combination of ABPs and wrap-around services, whether managed care or not.[57] EPSDT mandates outreach, screening, and the provision of treatment for all health conditions discovered by the screening.[58] Retaining the protections and benefits of EPSDT for children is very important to advocates as EPSDT is an important tool for accessing medically necessary services for children and, thus, important in achieving true parity for children. It will be important, however, for advocates to monitor the extent to which states are ensuring the EPSDT wrap-around.

While the MHPAEA would allow for annual or lifetime dollar limits, the ACA prohibits such dollar limits on the ten EHBs, including mental health and substance use disorder

include more than one type of benefit: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. For more information and factsheets about EHBs, benchmark plans, and other aspects of the ACA, visit NHeLP's Healthcare Reform website at http://www.healthlaw.org/issues/health-care-reform/services. An example of an available factsheet is *Reviewing Your State's Essential Health Benefits (EHB) Benchmark Selection*, http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00Pd0000006BgrAEAS, which is guide to help state advocates and includes important considerations when reviewing benefits offered by EHB benchmark plans.

[53] *Id.* at 68244.

[54] CMS, Dear State Medicaid Director (Jan. 16, 2013), http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf.

[55] MHPAEA, § 1937(b)(7) directs that approved section 1937 Medicaid non-managed care Alternative Benefit plans that provide both medical/surgical benefits and mental health or substance use disorder benefits comply with MHPAEA; *see also*, CMS, Dear State Medicaid Director (Nov. 20, 2012) describing ABPs under section 1937 as modified by the Affordable Care Act, http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf.

[56] States that enroll children in a Medicaid ABP are directed by 1937(a)(1)(A)(ii) of the ACA to assure that eligible children under age 21 receive full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits through an ABP or a combination of an ABP and wrap-around services. *Id*.

[57] CMS, Dear State Medicaid Director (Jan. 16, 2013), *supra* note 54.

[58] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B); 1396d(r).

treatment. The final rules make it clear the ACA disallows these dollar limits.[59] Other aspects of the ACA, such as pre-existing condition exclusions, limits on out-of-pocket expenses, prohibition from rescinding or cancelling once a beneficiary is enrolled (except in cases of fraud or abuse), and limitations on what basis a health insurance premium rate may vary, should benefit individuals with mental health or substance use disorder issues.

Parity and Children's Health Insurance Programs (CHIP)

When CHIP was reauthorized in 2009, it incorporated provisions of MHPAEA by reference.[60] In January 2013, CMS issued a Dear State Medicaid Director letter that stated that if a state provides full EPSDT benefits under its CHIP state plan, then MHPAEA are deemed to be met.[61] If a state does not provide full EPSDT benefits, the state must examine its state plan to ensure that treatment limitations on mental health and substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits.[62] Medical management techniques, financial requirements, availability of out-of-network providers, availability of information regarding criteria for medical necessity determinations, and denial reasons must also meet parity requirements.[63]

Parity and Medicaid Managed Care Organizations

The provisions of the MHPAEA are incorporated into Medicaid managed care programs in section 1932 of the Social Security Act.[64] Although the MHPAEA provisions are incorporated with regard to statutorily defined Medicaid managed care organization (MCO), this is limited by the Medicaid regulations that direct states to reimburse MCOs based only on state plan services. This means that MCOs are in compliance with MHPAEA provisions as long as the benefits offered by the MCO reflect the financial limitations, quantitative and non-quantitative treatment limitations, and disclosure requirements of the Medicaid state plan, and as specified in CMS approved contracts.

However, any additional or alternative treatment limitations imposed by the MCO must comply with parity requirements. For example, any benefits offered by the MCO beyond those in the Medicaid state plan must comply with parity. This is also true when out-of-network coverage is available for medical/surgical benefits. States are responsible for assessing MCO contracts to ensure MHPAEA compliance. CMS encourages states with Prepaid Inpatient Hospital Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) to apply the principles of parity across the managed care delivery system, even if in carve-out arrangements. CMS intends to issue additional guidance and

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[59] MHPAEA Final Rules, *supra* note 14, at 68240, 68244. The parity requirements regarding annual and lifetime limits only apply to the provision of mental health and substance use disorder benefits that are not EHB. *Id.*
[60] 42 U.S.C. § 1397cc(c)(6).
[61] CMS, Dear State Medicaid Director (Jan. 16, 2013), *supra* note 54.
[62] *Id.*
[63] *Id.*
[64] 42 U.S.C. § 1396u-2(b)(8).

provide technical guidance to states regarding strategies to implement MHPAEA for PIHPs and PAHPs.[65]

Limits to Parity

MHPAEA extended the reach of the MHPA and the ACA made the reach of MHPAEA even broader. However, there are still limitations. The rules for MHPAEA specifically create two exemptions, one for small employers and the other related to increased costs.[66] Prior to the ACA, the MHPAEA defined a small employer, in connection with a group health plan, as an employer who employed an average of not more than 50 employees on business days during the preceding calendar year, as compared to 100 or fewer employees under the ACA. This difference, combined with other interpretations for plans subject to ERISA or other scenarios make the small employer exemption a complicated analysis. The Departments created a FAQ about the ACA and the MHPAEA that provides information about when an employer may fit under the small employer exemption for purposes of the MHPAEA. [67] The final regulations on EHBs and the requirements to include mental health and substance use disorder benefits in compliance with MHPAEA ultimately requires that all insured, non-grandfathered, small group plans must cover EHB in compliance with MHPAEA regulations, regardless of the small employer exemption.

The increased cost exemption is available for plans and health insurance issuers that make changes to comply with the law and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent year. The test for an exemption is based on the estimated increase in actual costs incurred by the plan or issuer that is directly attributable to expansion of coverage.[68] The exemption lasts for one plan or policy year, thus it may only be claimed for alternating plan or policy year. An exempt plan or coverage does not have to use the exemption or may continue to provide benefits in such a way that is in compliance with some, all, or none of the parity requirements.[69] If a plan or issuer plans to claim an increased cost exemption, they must provide notice of the plan's exemption to participants and beneficiaries, the Departments, and appropriate State agencies. The plan or issuer must also make a summary of the information on which the exemption

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[65] *Id.*

[66] The exceptions do not apply to non-grandfathered plans in the individual and small group markets that are required by the ACA regulations to provide EHB that comply with the requirements of the MHPAEA regulations.

[67] Dep't of Labor, *FAQs About Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation* (Dec. 22, 2010), http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[68] MHPAEA Final Rules, *supra* note 14, at 68249. The increased costs must be directly related to the expansion of coverage and not due to trends in utilization and prices, a random change in claims experience that is unlikely to persist, or seasonal variation commonly experienced in claims submission and payment patterns. The final regulations set forth a formula for actual costs attributable to MHPAEA.

[69] *Id.* at 68248.

was based available to participants and beneficiaries (or their representatives) on request and at no charge.[70]

Parity also does not apply to some church-sponsored plans and self-insured plans sponsored by state and local governments.[71] In addition, parity does not apply to TriCare, retiree-only plans, and traditional, fee-for-service, non-managed care Medicaid. As discussed previously, although the final regulations for MHPAEA do not expressly apply to Medicaid MCOs, ABPs, or CHIP, MHPAEA requirements are incorporated by reference into statutory provisions that apply to these programs.[72] MHPAEA does not apply to Medicare, but Medicare has increased parity as of January 1, 2014. Previously, Medicare beneficiaries were required to pay up to 50 percent of the approved amount for outpatient mental health services but in 2014 Medicare will reimburse these services at parity with other Part B services so that Medicare beneficiaries will pay the standard twenty percent share.[73]

The Remaining Gaps in Mental Health and Substance Use Disorders Coverage

Although mental health and substance use disorder services must be covered on fair and equal terms with other medical care, there remain some gaps in full coverage of these services. The MHPAEA does not require plans to offer coverage for mental health or substance use disorders and does not require plans to offer coverage for specific treatments or services. The ACA extends the reach of MHPAEA through the requirements for small group and individual plans, as well as through coverage as part of EHBs, but this does not mean that all types of mental health and substance use disorder services will be available in a plan. Some plans may not cover all mental health conditions. Plans must generally cover outpatient, hospital, and emergency services as well as prescription drugs, but a plan may still be able to meet the requirements of parity and the ACA and not cover services an individual seeks, such as certain kinds of therapies or residential placements. Plans are required to cover a minimum number of mental health drugs, but they do not have to cover all of them. The habilitative and rehabilitative services for individuals with mental health and substance use disorders may also vary by state and by plan.

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[70] *Id.* at 68250.

[71] Church plans are not affected by MHPAEA's ERISA related requirements because of their ERISA exemption. However, a church plan would be covered if the church purchases a covered product, unless the church is otherwise exempt. MHPAEA does not apply to non-Federal governmental plans that have 100 or fewer employees or large, self-funded non-Federal governmental employers that opt-out of MHPAEA requirements. If the employer opts out, the enrollee must be issued a notice of opt-out on an annual basis. The Departments are also beginning rulemaking regarding Employee Assistance Programs, but until that is finalized, the Departments will consider an EAP to constitute excepted benefits only if the EAP does not provide significant benefits in the nature of medical care or treatment based on the employers reasonable, good faith interpretation. *Id.* at 682151.

[72] 42 U.S.C. § 1396u-2(b)(8); 42 U.S.C. § 1396u-7(b)(6); 42 U.S.C. § 1397cc(c)(6); and *see generally* CMS, Dear State Medicaid Director (Jan. 16, 2013), *supra* note 54.

[73] Under the Medicare Improvements for Patients and Providers Act (MIPPA) (2008), CMS implemented a phase-out of the mental health treatment limitation over a five-year period from 2010 to 2014.

While MHPAEA and the ACA certainly helped achieve greater parity in healthcare, as compared to general health services, that equity extends to existing problems with insures not covering all services. There are still gaps in coverage for all mental health services and individuals may not be able to access the services they need. Some states have state parity laws that will help fill these gaps, but some state parity laws are less comprehensive than the MHPAEA. Initial concerns predicted plans would just drop mental health services from their plans so they would not have to increase coverage to have parity, but this has not really happened.[74] To compound the insurance coverage issues, there is still the ongoing problem regarding a lack of providers for mental health and substance use disorders in many areas of the country.

Who Enforces Parity?

Enforcement of parity varies based on the type of insurance plan. Individual and employer-funded plans with less than fifty-one insured, as well as fully-insured large group plans, are initially overseen by state insurance commissioners, but if the U.S. Department of Health and Human Services makes a finding that the State has failed to "substantially enforce" the federal law, it can exercise enforcement authority.[75] The Department of Labor and the IRS generally enforce self-insured private sector employment-based plans subject to ERISA. Self-funded, non-federal government plans are enforced directly by U.S. DHHS.

Conclusion & Advocacy Opportunities

The mechanism created by the Departments in the interim final regulations for evaluating whether financial requirements and quantitative treatment limitations on medical/surgical benefits achieve parity with those on mental health and substance use disorder benefits is complex and unwieldy. Given the various types and levels of types of financial requirements and quantitative treatment limitations, as well as classifications of benefits, the analysis necessary to determine whether the plan has violated the parity mandate is unlikely to be done by few outside a small community of health economists and will depend on the ability of regulators to obtain the information needed to adequately assess parity. One suspects that it will be difficult for advocates, much less actual group plan participants, to determine whether a plan has violated the parity mandates in denying certain mental health or substance use disorder benefits.

Despite the complexity of the analysis to determine parity, the core principle of mental health parity -- that requirements or limitations shall not be more restrictive on mental health and substance abuse disorder benefits than those on medical/surgical benefits in

[74] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-63, MENTAL HEALTH AND SUBSTANCE ABUSE: EMPLOYERS' INSURANCE COVERAGE MAINTAINED OR ENHANCED SINCE PARITY ACT, BUT EFFECT OF COVERAGE ON ENROLLEES VARIED 9 (2011).
[75] For contact information for State insurance commissioners, National Association of Insurance Commissioners, http://www.naic.org/state_web_map.htm. For questions about US HHS enforcement or self-funded State/local plans and church plans, the US HHS/CMS Health Insurance Helpline is 1-877-267-2323 ext. 6-1565 or phiq@cms.hhs.gov.

the same classification -- is relatively simple and advocates play a significant role in enforcement. Advocates can also work to ensure that:

- children are getting wrap-around EPSDT services where necessary,[76]
- intermediate levels of care are provided consistent with parity,[77]
- issuers are not trying to skirt parity requirements through the use of carve-outs and separate benefit packages,[78]
- plans are complying with transparency requirements,[79]
- Medicaid MCOs are not imposing additional or alternative treatment limitations that do not comply with parity,[80]
- medical management is not being used to limit or impair access to mental health and substance use disorder benefits[81]
- there are no reductions in coverage or assessment of penalties where there is failure to obtain prior authorization for mental health benefits, but not for medical/surgical benefits[82]
- mental health or substance use providers are not subjected to extremely low fee schedules or restrictions in provider admission into a plan network as compared to medical/surgical care providers.[83]
- plans do not abuse the flexibility allowed in terms of placement of drugs into tiers[84]
- issuers and plans are making their criteria for medical necessity determinations and their reasons for denial of reimbursement or payment regarding mental health or substance use disorder benefits available upon request, at no charge, by any current or potential participant[85]

Because parity does not yet extend to all areas of healthcare that are expected, such as Medicaid PIHPs and PAHPs, advocates may have a role in additional guidance issued. How parity functions in practice is evolving and there is certainly a role for advocates to ensure enforcement mechanisms are in place, identify potential violations, and participate in future development of rules or guidance.

Summary Chart

As discussed in this factsheet, although the MHPAEA directly applies to most employment-based group health coverage, its requirements have been incorporated into other health coverage plans, such as most of Medicaid and CHIP. The following is a

[76] *See supra* p. 13.
[77] *See supra* p. 10.
[78] *See supra* p. 14.
[79] *See supra* p. 11.
[80] *See supra* p.14.
[81] *See supra* p.5, 7.
[82] *See supra* p.7.
[83] *Id.*
[84] *See supra* p. 8.
[85] *See supra* p.11.

chart that simplifies what types of plans are required to meet mental health parity, even if not directly by MHPAEA. Because there are sometimes exceptions or limitations to how mental health parity applies, please use this chart only as a starting point.[86]

Mental Health Parity Applies To:	Mental Health Parity Does NOT Apply To:
• Employment-based group health coverage (non-small employer)[87] • Medicaid Managed Care Organizations (as defined in 42 U.S.C. § 1396(m)(1)(A) • CHIP • Medicaid ABPs • Medicare[88]	• Small employer[89] • Self-insured plans for State and local government employees that have properly opted out[90] • Church-sponsored exempt from ERISA[91] • Retiree-only plans • Traditional, fee-for-service, non-managed care Medicaid • Medicaid in a PIHP or PAHP delivery system[92] • Plans using the increased cost exemption • TriCare

[86] This factsheet provides general information about when mental health parity applies. For more specific information and FAQs, *see generally* Dep't of Labor, Mental Health Parity, http://www.dol.gov/ebsa/mentalhealthparity/.

[87] Parity indirectly applies to non-grandfathered health insurance coverage in the individual and small group markets, which must provide parity in coverage so as to satisfy EHB requirements.

[88] There is increased parity in Medicare as of January 1, 2014, but MHPAEA requirements do not apply.

[89] The Departments created a FAQ about small employers and when that exemption may apply, *see* Dep't of Labor, *FAQs About Affordable Care Act Implementation (Part V) and Mental Health Parity Implementation* (Dec. 22, 2010), http://www.dol.gov/ebsa/faqs/faq-aca5.html.

[90] For a public list of non-Federal governmental employers that have opted out of MHPAEA, see http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa-nfgp-list-7-9-2013.pdf

[91] A church plan that is exempt from ERISA requirements would also be exempt from the related MHPAEA requirements, but a church plan would be covered if the church purchases a covered product. U.S. DEP'T OF HEALTH & HUMAN SERVS., CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 4 (Nov. 2013), http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.pdf.

[92] CMS encourages states to apply the principles of parity in these systems and intends to issue additional guidance.