WINSTEAD

Expanded Final Mental Health Parity and Addiction Equity Act Regulations Require Plan Sponsor Consideration Early in 2014 for 2015 Plan Year & Limited Small Plan ACA Relief

11.14.13

Mental Health Parity and Addiction Equity Act Final Regulations

The final Mental Health Parity and Addiction Equity Act regulations ("MHPAEA Regs") were released late last week and apply to the first plan year beginning on or after July 1, 2014 (for calendar year plans on January 1, 2015). While this is not immediately effective, the MHPAEA Regs require careful consideration because some of the changes need to be considered as you start to contract with your health plan's vendors for the first plan year subject to the new rules and this will impact your timeline for the first plan year they are in effect. While we are not actuaries, some of the revisions appear likely to result in cost increases and plan sponsors may need to consider the impact of these changes on plan costs in their overall planning to avoid the Cadillac tax under health reform which applies in 2018.

While many of the concepts in the original Mental Health Parity and Addiction Equity Act Interim Final Regulations remain virtually unchanged in the final rules, such as testing parity based upon the six categories of services (inpatient in-network; inpatient out-of-network; Outpatient in-network; Outpatient out-of-network; Emergency care; and prescription drugs). The final regulations permit the use of some sub-categories for testing within outpatient such as for office visits and also address concerns related to the interaction of the preventive care mandates under the Patient Protection and Affordable Care Act ("ACA") and the determination of whether a financial restriction applies to "substantially all" or is a "predominant" restriction on medical and surgical benefits ("Med/Surg"), thus permitting it to be applied to the plan's mental health and substance abuse benefits ("MHSA"). The final regulations retain testing for parity considering financial restriction and quantitative restrictions much as they existed before (the number tests) based on projected or expected expenditures.

One of the big changes came in what the regulations refer to as the non-quantitative or qualitative restrictions (the "Nonnumeric Limitations"), which cover medical necessity or medical appropriateness determinations and coverage of different treatment settings. These are the changes that plan sponsors should consider as they review their contracts with vendors administering claims or selecting the provider network for their health plan for the first plan year under the MHPAEA Regs. These changes may require coverage of treatments at facilities the plan's terms had historically excluded from coverage or an elimination of coverage of the comparable facilities on the Med/Surg side.

The final regulations eliminated a specific broad exception in the proposed regulations for non-quantitative treatment limitations (or as I am referring to them Nonnumeric Limitations) for recognized clinically appropriate standards of care. ***This means that the Nonnumeric Limitations must be evaluated to see if they satisfy the parity requirements under the MHPAEA Regs.*** Examples of the Nonnumeric Limitations include: medical management standards limiting or excluding benefits based on medical necessity or appropriateness, experimental or investigational status, formulary design for prescriptions, if there are multiple network tiers, the standards for the network tier design, standards for provider admission to the network and the determination of reimbursement rates, how the plan determines usual, customary and reasonable charges (or the limit the plan applies to charges by any other name), a plan's refusal to pay for higher-cost therapies until the lower cost therapy is shown not to work (first fail requirements or step therapy), exclusions based on a failure to complete a course of therapy, restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope of duration of benefits or services. ***The evaluation of these types of***

treatment limitations is a new evaluation that will require plan sponsors to make new inquiries into the operations of the plan's vendors and into the terms of their plans to ensure compliance.

This change will require plan sponsors to further investigate how their plan's vendors select network providers and determine medically appropriate and similar criteria and to evaluate exclusions of certain categories of providers from their plan and the credentialing of different types of providers in the network selected for the plan. The plan still may have some limited flexibility in imposing Nonnumeric Limitations if such standards consider clinically appropriate standards of care in applying the Nonnumeric Limitations for both Med/Surg and MHSA. The Nonnumeric Limitations include the standards, processes, evidentiary standards and other factors used to determine such Nonnumeric Limitations provided the application of such factors does not result in disparate results when applied to MHSA as compared to their application to Med/Surg. Nonnumeric Limitations are permissible if the plan as written and in operation does not impose on the MHSA any process, strategy, evidentiary standard or other factor in applying the Nonnumeric Limitation that is not comparable to and is not applied more stringently than it is applied to the Med/Surg benefits in the same classification.

Medical plan standards or exclusions that limit or exclude certain benefits based on medical necessity requirements in policies requiring the failure of lower cost therapies before higher cost therapy can be utilized if it is not imposed more stringently on MHSA benefits than on Med/Surg benefits. If a Nonnumeric Limitation operates to limit the scope or duration of treatment for MHSA through the processes, strategies, evidentiary standards or other factors used to apply the standard, those standards must be comparable to and must be applied no more stringently than the similar Nonnumeric Limitations applied to Med/Surg benefits for the provisions to be permissible. The plan standards such as in and out of network, geographic limits, limits on types of services, limitations of services by clinical social workers or by degree, experimental treatments must be applied on a nondiscriminatory manner that complies with the final regulations.

Any factors determining reimbursement rates for providers that are on non-quantitative treatment limitations must be applied comparably to those types of providers both between medical surgical providers and MHSA-treatment providers. In determining whether a non-quantitative treatment limitation is appropriate you can use outside standards such as the URAC as a comparable standard.

Nonnumeric Limitations on the scope of services are treated differently in the final regulations. Plans must assign intermediate MHSA treatments (e.g., treatment in a residential facility or use of a non-MD as a service provider) to one of the existing six benefits classifications in the same way they assign comparable intermediate Med/Surg benefits to these classifications. ***So if a skilled nursing facility or rehab hospital are covered for Med/Surg benefits under the in patient hospital classification, the plan must treat any residential treatment facilities for MHSA as an in-patient benefit in the same classification for testing parity. This change means many plans will need to review their exclusions from coverage to determine whether certain facilities previously excluded from coverage are required to be covered to satisfy MHPAEA parity requirements.*** Another example is if home health care coverage is covered for Med/Surg as an out-patient therapy classification, then partial days for MHSA must also be considered as covered in the out-patient therapy classification to evaluate MHPAEA Reg compliance. This requires a comparison of coverages in each of the classifications for Med/Surg to exclusions in the same classifications applicable to MHSA.

If your plan requires a medical necessity determination for substance abuse or mental health treatment, your plan must also comply with a new disclosure requirement. The MHPAEA regulations require your plan's administrator to make available to the participants or the participant's beneficiary or the contracting provider, upon request, the requirements for satisfying medical necessity for the particular treatment. This is a clarification or expansion of the disclosure requirements under ERISA sections 104 and 503. Thus, penalties of $110 per day for failure to produce will apply. Historically, many vendors have called these proprietary and not provided them. ***This means vendor contracts must be reviewed and amended to require the vendors to produce these standards for the plan administrator to be able to comply.*** For plan sponsors that have contracts that were not renewing for the first plan year subject to

MHPAEA Regs, they will need to allow time to renegotiate those agreements so that their contract will require the vendor to comply with the new requirements and so the plan sponsor can demonstrate that it made an appropriate review of the various vendors' compliance because many of the new requirements were not considered in prior vendor selection processes or in the vendor contracts.

The MHPAEA Regs retained the small employer exception for those under 100 employees and there is also the exemption based on historical costs if you have costs increases that were over 1%.

If you would like additional information on the MHPAEA Regs, please contact one of the individuals below. This is not a full explanation, but just the high points that need to be considered as you plan the tasks to be completed on your schedule for 2014.

Health Reform Guidance and Relief for Small Group Plans

Small group plans and individuals who found their insurer canceling their health insurance policies for 2014 may now be able to continue their insurance policies under the guidance released by the Center for Medicare and Medicaid Services today. The guidance in the form of a letter to the state insurance commissioners permits the state insurance commissioners to approve the issuance of small group and individual health insurance policies without the inclusion of all of the market reforms that were required to go into effect on January 1, 2014 provided certain requirements are satisfied. This is initially available for policies issued for policy years starting from January 1, 2014 through October 1, 2014. This change may permit some small employers and individuals to obtain policies at lower costs than were previously available.

Contacts:

Greta Cowar t | 214.745.5275 | gcowart@winstead.com
Tony Eppert | 713.650.2721 | aeppert@winstead.com
Nancy Furney | 214.745.5228 | nfurney@winstead.com
David Jackson | 281.681.5944 | djackson@winstead.com
Lori Oliphant | 214.745.5643 | loliphant@winstead.com