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Mental Health Parity FAQs

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical coverage. The MHPAEA amended and supplemented the Mental Health Parity Act of 1996.

The health care reform law, the Affordable Care Act (ACA), builds on the MHPAEA and requires some plans to cover MH/SUD services as one of ten essential health benefits categories. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services) as well as comply with the federal parity law requirements, beginning in 2014.

The MHPAEA does not mandate that plans and issuers cover mental health and substance use disorder benefits. It applies only if a plan or issuer provides those benefits.

On Nov. 8, 2013, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (the Departments) released the following **Frequently Asked Questions** (FAQs) regarding implementation of the MHPAEA, as amended by the ACA. These FAQs were released in conjunction with final rules on the MHPAEA, which contain some clarification regarding the law's protections.

Q1: When are the final rules effective for group coverage?

MHPAEA's statutory provisions generally became effective for plan years beginning after Oct. 3, 2009. Interim final rules under MHPAEA generally became applicable for plan years beginning on or after July 1, 2010.

The final rules generally apply to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after July 1, 2014. Until the applicability date of the final rules, plans and issuers subject to MHPAEA must continue to comply with the interim final rules.

Note: The final rules do not apply by their terms to Medicaid managed care organizations, alternative benefits plans or the Children's Health Insurance Program. However, MHPAEA requirements are incorporated by reference into statutory provisions that do apply to these entities. See Centers for Medicare & Medicaid Services State Health Official Letter (Jan. 16, 2013).

Q2: When do the final rules apply to individual health insurance coverage?

The ACA expanded the MHPAEA to apply to health insurance issuers offering individual health insurance coverage (both through the Exchanges and outside the Exchanges). These changes are effective for policy years beginning on or after Jan. 1, 2014. The final rules apply to individual health insurance coverage for policy years beginning on or after July 1, 2014 and apply to both grandfathered and non-grandfathered plans.

Q3: What new protections do the final rules provide for individuals?

The interim final rules contained an exception for differences in non-quantitative treatment limitations between medical/surgical benefits and mental health or substance use disorder benefits based on "clinically appropriate standards of care." This exception has been determined to be confusing, unnecessary and subject to potential abuse. The underlying requirements regarding non-quantitative treatment limitations (even without this exception) are

sufficiently flexible to allow plans and issuers to take into account clinical and other appropriate standards when applying non-quantitative treatment limitations such as medical management techniques to medical/surgical benefits and mental health or substance use disorder benefits. Thus, the final rules have eliminated this exception.

The final rules also apply parity requirements to benefits for intermediate levels of care for mental health conditions and substance use disorders. The final rules accomplish this by providing that plans and issuers first identify what is meant by an intermediate service for mental health and substance use disorder care and medical/surgical care and requiring that such intermediate level services be treated comparably within the structure of plan benefits. Under the final rules, parity requirements for non-quantitative treatment limitations also apply to restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate level services).

Finally, the final rules clarify the disclosure rights of plan participants with respect to both mental health and substance use disorder benefits and medical/surgical benefits. See Q8 regarding the type of information that individuals can receive from their plans and issuers under federal law.

Q4: What are the Departments doing to promote compliance?

The Departments have stated that they are working with plans, issuers and their service providers to help them understand and come into compliance with MHPAEA and to ensure that individuals receive the benefits they are entitled to under the law. The Departments also coordinate with state regulators both individually and through the National Association of Insurance Commissioners (NAIC) to ensure compliance and issue guidance to address frequently asked questions from stakeholders.

According to the Departments, compliance assistance is a high priority and their approach to implementation is marked by an emphasis on assisting plans and issuers that are working diligently and in good faith to comply with the requirements of the law. The Departments receive complaints from group health plan participants and beneficiaries, enrollees in individual market health coverage, providers and other stakeholders and work with these individuals and the regulated community to correct violations.

The Departments also engage in extensive outreach and compliance assistance activities throughout the year on MHPAEA. For a copy of MHPAEA outreach publications, and to get information on upcoming events, see www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

Q5: Do the final rules address multiple provider network tiers?

Yes. The final rules permit plans and issuers to use multiple provider network tiers, provided they are consistent with the parity requirements.

Q6: Are there plans that are exempt from MHPAEA?

Yes. MHPAEA applies to most employment-based group health coverage, but there are a few exceptions. MHPAEA contains an exemption for a group health plan of a small employer. (A small employer is generally defined as one that has 50 or fewer employees under ERISA and the Internal Revenue Code, and one with 100 or fewer employees under the Public Health Service Act.) Nevertheless, under HHS final rules governing the ACA requirement to provide essential health benefits (EHBs), non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including mental health and substance use disorder benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules.

MHPAEA also contains an increased cost exemption available to plans that meet the requirements for the exemption. The final rules establish standards and procedures for claiming an increased cost exemption under MHPAEA. Additionally, plans for state and local government employees that are self-insured may opt out of MHPAEA's requirements if certain administrative steps are taken. The procedure for plans to file a MHPAEA opt-out election with Centers for Medicare & Medicaid Services (CMS) is explained on the CMS website. For employees of a state or local

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government who would like to know if their employment-based plan has elected to opt out, see the public list of non-federal governmental employers that have opted out of MHPAEA.

Finally, MHPAEA does not apply to retiree-only plans.

Q7: For a plan or issuer claiming the increased cost exemption, where should the plan or issuer send its notice to the Departments?

The increased cost exemption is not effective until 30 days after notice has been sent to group health plan participants and beneficiaries, enrollees in individual market health coverage, and to the appropriate federal agency. For notice to the federal government:

- An ERISA plan, or a health insurance issuer offering coverage in connection with such plan, must notify the Department of Labor at:

  Office of Health Plan Standards and Compliance Assistance
  Employee Benefits Security Administration
  U.S. Department of Labor
  ATTN: Increased Cost Exemption for MHPAEA
  200 Constitution Avenue, N.W.
  Suite N-5653
  Washington, DC 20210

- A group health plan that is a non-federal governmental plan (or a health insurance issuer offering coverage in connection with such plan) or a health insurance issuer offering health insurance coverage in the individual market must notify HHS via facsimile to 301-492-4462 OR via email to marketreform@cms.hhs.gov OR at:

  Centers for Medicare & Medicaid Services (CMS)
  Center for Consumer Information and Insurance Oversight (CCIIO)
  ATTN: Increased Cost Exemption for MHPAEA
  200 Independence Avenue, SW
  Room 737F
  Washington, DC 20201

- A group health plan that is a church plan (as defined in section 414(e) of the Code), or a health insurance issuer offering coverage in connection with such plan, must notify the Department of the Treasury. Notice should be sent to:

  MHPAEA Increased Cost Exemption Notice
  Office of Division Counsel/Associate Chief Counsel (TEGE)
  CC: TEGE
  Room 4300
  1111 Constitution Avenue, NW
  Washington, DC 20224

Q8: My plan uses medical management techniques (such as preauthorization) to manage care for mental health and substance use disorder services, and my mental health benefits were denied. What information am I entitled to receive from my plan?

MHPAEA provides that the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary or contracting provider upon request. In addition, under MHPAEA, the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits must be made available to participants and beneficiaries.

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Furthermore, under the internal appeals and external review requirements added by the ACA, non-grandfathered group health plans and health insurance issuers must provide to an individual (or a provider or other individual acting as a patient's authorized representative), upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the individual's claim for benefits consistent with the DOL claims procedure regulation. (See 29 CFR 2560.503-1 and 2590.715-2719; 45 CFR 147.136. Consumer information is also available on internal claims and appeals, external review of health plan decisions and grandfathered health plans under the ACA.) This includes documents of a comparable nature 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 a non-quantitative treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan. In addition, the plan or issuer must provide the claimant with any new or additional evidence considered, relied upon or generated by the plan or issuer (or at the direction of the plan or issuer) in connection with a claim. If the plan or issuer is issuing an adverse benefit determination on review based on a new or additional rationale, the claimant must be provided, free of charge, with the rationale.

Additionally, under ERISA, documents with information on medical necessity criteria for both medical/surgical and mental health or substance use disorder benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply a non-quantitative treatment limitation, are instruments under which the plan is established or operated, and copies must be furnished to a participant within 30 days of request. (See 29 U.S.C. §§ 1024(b)(4), 1132(c)(1) and 29 CFR 2520.104b-1) (Note: ERISA defines the term "participant" to include any employee or former employee who is or may become eligible to receive a benefit of any type from an employee benefit plan or whose beneficiaries may become eligible to receive any such benefit. Accordingly, employees who are not enrolled but who are, for example, in a waiting period for coverage, or who are otherwise shopping amongst benefit package options at open season, generally are considered plan participants for this purpose.)

Q9: How can I obtain more information about my health plan benefits and MHPAEA?

As stated in Q8, the final rules clarify that participants and beneficiaries in ERISA group health plans are entitled to request certain specific information with respect to both mental health and substance use disorder benefits and medical/surgical benefits, which may be helpful in determining whether or not a plan is complying with MHPAEA. Additional information and FAQs regarding MHPAEA are available on the DOL's MHPAEA webpage and HHS' webpage.

If you have additional questions regarding compliance with MHPAEA, you may:

- Contact HHS by calling toll free at 1-877-267-2323 extension 6-1565 or emailing phig@cms.hhs.gov; or
- Contact a benefit advisor in one of the DOL's regional offices at www.askebsa.dol.gov or by calling toll free at 1-866-444-3272.

Regardless of which number you call, the federal Departments will work together and with the states, as appropriate, to ensure MHPAEA violations are addressed.

The Departments request comments on what additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees and providers, especially with respect to individual market insurance, non-federal governmental plans and church plans.

Please send comments by Jan. 8, 2014, to E-OHPSCA-FAQ.ebsa@dol.gov.

Source: The U.S. Departments of Labor, Health and Human Services and the Treasury

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