

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XVII) AND MENTAL HEALTH PARITY IMPLEMENTATION

November 8, 2013

Set out below are additional Frequently Asked Questions (FAQs) regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act. These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at <http://www.dol.gov/ebsa/healthreform/> and <http://www.cms.gov/ccio/resources/fact-sheets-and-faqs/index.html>), these FAQs answer questions from stakeholders to help people understand the law and benefit from it, as intended.

The Mental Health Parity and Addiction Equity Act of 2008

MHPAEA¹ amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code) to provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. In general, MHPAEA requires that the financial requirements (such as coinsurance) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.² Today, the Departments issued final rules on MHPAEA, which contain some clarifications regarding the statute's protections.

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

MHPAEA's statutory provisions generally became effective for plan years beginning after October 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.³

¹ MHPAEA amended and supplemented the Mental Health Parity Act of 1996.

² 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.

³ 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 (January 16, 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>.

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

The Affordable Care Act amended the PHS Act to apply MHPAEA to health insurance issuers offering individual health insurance coverage (both through the Health Insurance Marketplaces, also known as Exchanges, and outside the Marketplaces). These changes are effective for policy years beginning on or after January 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 nonquantitative 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 nonquantitative 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 nonquantitative 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 nonquantitative 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 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 to ensure compliance and issue guidance to address frequently asked questions from stakeholders. Compliance assistance is a high priority and the Departments’ 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 <http://www.dol.gov/ebsa/mentalhealthparity/> and http://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.⁴ Nevertheless, under HHS final rules governing the Affordable Care Act 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.⁵

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.⁶ Finally, MHPAEA does not apply to retiree-only plans.

⁴ A small employer is generally defined as one that has 50 or fewer employees under ERISA and the Code, and one with 100 or fewer employees under the PHS Act.

⁵ 45 CFR 156.115.

⁶ The procedure for plans to file a MHPAEA opt-out election with CMS is explained at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html>. If you are an employee of a State or local government and would like to know if your employment-based plan has elected to opt out, see the public list of non-Federal governmental employers that have opted out of MHPAEA at <http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa-nfgp-list-7-9-2013.pdf>.

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 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

Or via facsimile to 301-492-4462 or via e-mail to marketreform@cms.hhs.gov.

- 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.

Furthermore, under the internal appeals and external review requirements added by the Affordable Care Act, 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 Department of Labor claims procedure regulation.⁷ 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 nonquantitative 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 nonquantitative treatment limitation, are instruments under which the plan is established or operated, and copies must be furnished to a participant⁸ within 30 days of request.⁹

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

⁷ See 29 CFR 2560.503-1 and 2590.715-2719; 45 CFR 147.136. See also www.dol.gov/ebsa/healthreform and <https://www.healthcare.gov/how-does-the-health-care-law-protect-me/#part=11> for consumer information on internal claims and appeals, external review of health plan decisions, and grandfathered health plans under the Affordable Care Act.

⁸ ERISA section 3(7) 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 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.

⁹ See 29 U.S.C. §§ 1024(b)(4), 1132(c)(1) and 29 CFR 2520.104b-1.

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 Department of Labor's MHPAEA webpage at www.dol.gov/ebsa/mentalhealthparity and the Department of Health and Human Services' webpage at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

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 you may contact a benefit advisor in one of the Department of Labor'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 January 8, 2014 to E-OHPSCA-FAQ.ebsa@dol.gov.