The final rules for the Mental Health Parity and Addiction Equity Act of 2008

Comply with the rules or go beyond them?

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The U.S. Departments of the Treasury, Labor, and Health and Human Services issued final regulations on November 8, 2013, implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Although interim final rules (IFR) had been in effect since 2010, the industry has been awaiting these final rules in order to gain clarity on how to comply with certain provisions of MHPAEA.

Although initially applicable only to fully insured or self-funded health plans offered by large employers (over 50 employees), as a result of provisions in the Patient Protection and Affordable Care Act (ACA), MHPAEA and the IFR will also apply to the individual and fully insured small group markets, for policy years beginning on or after January 1, 2014. The new final rules, which are effective for plan years starting on or after July 1, 2014, will therefore affect almost all commercially insured lives in the country. The rules do not apply to Medicare or to Medicaid managed care plans, although the latter are covered by MHPAEA (but still without specific implementing regulations, five years after enactment of the law).

The new rules clarify or revise some aspects of the IFR that had created unusual consequences for employers and health plans. They also make several important changes to the rules regarding nonquantitative treatment limitations (NQTLs), but stop short of laying out a mathematical compliance test for NQTLs. The 2010 IFR was silent on the question of what scope of behavioral healthcare services must be provided to be compliant; the new regulations address the question but still leave some ambiguity. A number of important elements of the IFR, such as the basic framework for testing compliance on financial requirements and quantitative treatment limitations, were left unchanged.

This briefing paper presents the key changes to the regulations codified in the final rules and discusses the implications for employers and health plans. For an overview of the 2010 IFR, see the Milliman healthcare reform briefing paper, "Implementing Parity: Investing in Behavioral Health."[1]

OFFICE VISIT SAFE HARBOR

The original rules lay out six benefit classifications in which mental health (MH) and substance use disorder (SUD) benefits, referred herein also as behavioral healthcare benefits, must be compared to medical/surgical benefits to determine whether they are compliant with parity rules. Two of the benefit classifications are Outpatient In-Network and Outpatient Out-of-Network. On July 1, 2010, the effective date for the IFR, the federal departments announced a compliance safe harbor after considering a significant concern expressed by health plans and employers: Plans could choose to subdivide either or both of these two classifications into two subclasses, Office Visits and All Other Outpatient. As long as behavioral healthcare benefits were compliant within each subclass, the plan would be considered compliant.

This issue arose because many plan designs require predominantly copays for office visits and predominantly deductibles and coinsurance for other outpatient services. When considered together, no cost-sharing feature reached the "substantially all" threshold, and, therefore, no cost sharing of any kind could be imposed for outpatient behavioral healthcare services for these types of plan designs. Separating the benefits into subclasses allowed many plans to be able to impose cost sharing for outpatient behavioral healthcare services.

This safe harbor is now formally a part of the final regulations. Importantly, it remains optional. Plans are free to continue combining office visits and other outpatient services into a single classification for testing purposes. In the nearly four years since the IFR was issued, we have observed many cases where it is not advantageous to use the safe harbor, so having it remain optional will make it easier to comply with the regulations than if its use became mandatory.

1 Melek, S. (January 1, 2010). Implementing parity: Investing in behavioral health. Milliman healthcare reform briefing paper. Retrieved from http://www.milliman.com/insight/healthreform/Implementing-parity-Investing-in-behavioral-health/.

TIERED NETWORKS

Some health plans divide their in-network benefits into two or more "tiers." Typically, there will be a "preferred" network tier with lower member cost sharing, and a "non-preferred" network tier with higher member cost sharing than the preferred tier, but still lower than for out-of-network providers. Under the IFR, technically it was not permissible to subdivide the in-network classifications into tiers; they all had to be combined for testing purposes. This in-network classification normally passed the "substantially all" test for financial requirements, yet frequently the "preferred" tier had the predominant cost-sharing level, meaning that all behavioral services had to be offered with that lower level of in-network member cost sharing from the preferred tier.

The new regulations allow plans with tiered network designs to treat each tier separately for parity testing purposes. This change will make compliance more straightforward for many plans with tiered networks.

THE "COVER ONE, COVER ALL" RULE

Under the IFR, plans that cover an MH or SUD in any of the treatment classifications must cover it in all classifications where medical/surgical benefits are offered. Examples of noncompliant designs would include covering smoking cessation outpatient therapies but excluding coverage for prescription drugs used to treat nicotine addiction, covering outpatient psychotherapy for depression and antidepressants but not covering inpatient hospitalizations, or covering behavioral conditions only provided by in-network providers while out-of-network benefits exists for medical/surgical conditions. Plans either have to cover a behavioral condition in all classifications in which medical/surgical conditions were provided, or not at all (i.e., in no benefit classifications).

Under the ACA, preventive healthcare services with an "A" or "B" rating from the U.S. Preventive Services Task Force must be covered by health plans, and with no cost sharing. Some of these services pertain to behavioral health conditions. This raised the concern that a plan not intending to provide coverage for a behavioral health condition (for example, depression) would have to offer limited screening services under the ACA, and then would be required by the MHPAEA to cover that condition in all classifications. The final rules have clarified that if a behavioral health condition is covered only to the extent needed to comply with the ACA's preventive care mandate, the "cover one, cover all" principle does not apply.

NONQUANTITATIVE TREATMENT LIMITATIONS (NQTLS)

In the IFR, the general requirement with respect to NQTLs is that the "processes, strategies, and evidentiary standards" used in developing these processes or standards must be "comparable to and applied no more stringently than" those used for medical/surgical services. This standard remains in place in the final rule, with one important difference. The IFR had an exception for situations where "clinically appropriate standards of care" permitted a difference. That exception is not included in the final rules. It was determined to be confusing, unnecessary, and subject to potential abuse.

Plans will continue to retain a great deal of flexibility in applying NQTLs. The final rules do not require plans and issuers to apply the same NQTLs for MH/SUD benefits and medical/surgical benefits, nor do disparate results alone indicate that a plan is applying NQTLs in a disparate manner.

There is still no mathematical test to determine NQTL compliance. Thus, concepts such as "substantially all" and "predominant," which figure prominently in the rules with respect to financial requirements and quantitative treatment limitations, still do not apply to NQTLs.

SCOPE OF SERVICES

The IFR did not address what scope of services within a treatment classification must be provided in order to be compliant. Although it was clear that some coverage must be provided in each classification of benefits, it was not clear how much would be sufficient. In performing compliance testing under the IFR, we have observed a number of plans with limited inpatient benefits for behavioral healthcare services, covering only certain types of facilities. It is fairly common for plans to exclude coverage for behavioral healthcare services provided by residential treatment facilities (RTFs), while covering inpatient hospital services, even though the services provided by both types of 24-hour facilities are similar. Under the IFR, it was not clear whether such plans could be compliant. Our view, under the IFR, was that there was nothing requiring coverage of RTF services given that the regulations were silent on the scope-of-services question.

The final rules are still not completely clear on this question, but are less murky than the IFR. The final rules do apply parity requirements to benefits for intermediate levels of care for MH conditions and SUDs. The final rules require that plans and insurers first identify what is meant by an intermediate service for MH/SUD care and for medical/surgical care and then require that such intermediate-level services be treated comparably with one another within the structure of plan benefits. Restrictions based on "geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services" must comply with the general NQTL requirements. For example, it is not permissible to exclude coverage for inpatient out-of-network MH/SUD benefits obtained outside the state while covering such benefits without exclusion for medical/surgical conditions.

As discussed above, the process for ensuring compliance with NQTL rules is much more ambiguous than the process to assess compliance with other aspects of the final rules. However, this new class of NQTL will make it significantly harder for health plans to argue that they can exclude coverage for residential treatment for behavioral disorders.

For other services (including intermediate levels of care such as partial hospitalization), it will be important for plans to document the evidentiary standards that support any limitations on the scope of behavioral health services and how those same standards are applied to medical/surgical services.

QUANTITATIVE TESTING

The final rules state that, for the purposes of performing the "substantially all" and "predominant" tests, the dollar amount of medical/surgical plan benefits should be based on the amount that the plan allows (after provider contract discounts and before member cost sharing) rather than on the amount that the plan pays (after member cost sharing).

The final rules also clarify that parity testing is not required every year unless there are plan benefit changes, changes to cost sharing, or changes in plan costs for medical/surgical benefits that could affect the results of the "substantially all" and "predominant" tests.

WHAT DIDN'T CHANGE?

Most of the fundamental framework of the IFR was unchanged by the final rules. For example, the "cover one, cover all" principle still applies (with the exception outlined above), and the definitions and application of the "substantially all" and "predominant" tests to financial requirements and quantitative treatment limits have not changed. Other significant items that were not changed (but may have been clarified) include:

- The cost exemption: Under MHPAEA, plans that comply with the parity requirements for one full plan year and demonstrate that compliance increased costs at least 1% can be exempted from the parity requirements for the following plan year. The rules note that, to date, no plans have applied for an exemption, and the rules will still require that an exemption (if granted) only applies for one year, after which the plan must resume compliance. The federal departments have stated that they do not have statutory authority to alter this mechanism.

- Medicaid managed care and the Children's Health Insurance Program (CHIP): These plans are still not covered by the final rules. The rules mention that additional guidance may still be issued.

- Employee Assistance Program (EAP) gatekeeping: Plans that require a member to exhaust EAP benefits before receiving coverage for behavioral healthcare benefits are still noncompliant. It was clarified that EAPs themselves are not subject to MHPAEA, as long as they do not furnish "significant benefits in the nature of medical care or treatment" (and this determination can be made using reason and good faith).

- Parity in dollar limits: It is still not permissible for a health plan to provide a separate annual or lifetime dollar limit on MH or SUD benefits as compared to medical/surgical benefits.

- Separate testing of cost-sharing types: There was no change to the requirement that each cost-sharing type be tested separately (e.g., coinsurance, copays, deductibles, etc.). In other words, it is not permitted to simply determine that some cost sharing applies to substantially all medical/surgical benefits, but rather it must be determined that a particular type of cost sharing applies to substantially all medical/surgical benefits before that type of cost sharing can be applied to behavioral healthcare benefits.

- Cost allocation: Under the final rules, plans may still use "any reasonable method" to apply the "substantially all" and "predominant" tests; this continues to allow plans some flexibility in assigning medical/surgical benefits to the treatment classifications.

- Criteria for medical necessity determinations: There was no change to the requirement that the criteria for medical necessity determinations with respect to MH or SUD 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.

WHAT'S NEXT FOR HEALTH PLANS AND EMPLOYERS?

For plans with tiered network benefit designs that altered behavioral health cost sharing when the 2010 IFR was issued, benefit designs can likely be revisited for renewals on or after July 1, 2014. For all plans, the changes to the NQTL rules should lead to a serious discussion about whether the behavioral health scope of services in each classification is compliant. We have, in general, seen plans focus much more on quantitative aspects of parity compliance than on NQTLs since the IFR was issued. Additional focus on NQTLs is likely needed, both because of the new rules and because of the much larger population subject to MHPAEA starting in 2014. The potential fines for noncompliance are significant, and the likelihood of a member objecting to an NQTL increases with higher membership.

There is also an interesting implication of the effective date of the rule of July 1, 2014, in the small group market. While the ACA requires individual market plans to be on a calendar-year basis starting in 2014 (meaning that the final rule will not take effect until the beginning of 2015), small group plans start and renew coverage throughout the year. However, there was a federal requirement that carriers may not submit new rate filings throughout 2014 for small group plans, even though ordinarily small group rates (and benefit designs) can be refiled. This restriction, which has its roots in technological limitations in a federal oversight system, means that carriers have already locked in their rates and plan designs for all small group renewals in 2014 (even those in the second half of the year, when the new rules will be applicable). It is not clear how the federal departments intend to enforce the final rule with respect to small group plans that were required to finalize rates and benefit designs prior to the issuance of the rule.

FIGURE 1: PER MEMBER PER MONTH (PMPM) HEALTHCARE COSTS (ALLOWED DOLLARS) BY PRESENSE OF BEHAVIORAL CONDITIONS - 2012

POPULATION	BEHAVIORAL HEALTH DIAGNOSIS	MEMBER MONTHS	MEDICAL	BEHAVIORAL	MEDICAL RX	BEHAVIORAL RX	TOTAL
COMMERCIAL	NO MH/SA	2,048,000,000	$280	$3	$53	$4	$340
	NON-SPMI MH	278,000,000	$661	$23	$145	$74	$903
	SPMI	47,000,000	$759	$128	$135	$175	$1,197
	SA	22,000,000	$830	$73	$102	$67	$1,072
	TOTAL	2,386,000,000	$335	$8	$66	$16	$425

FIGURE 2: IMPACT OF BEHAVIORAL COMORBIDITIES, COMMERCIAL POPULATION - 2012 PMPM COSTS

CONDITION	NO MH/SA	NON-SPMI	SPMI	SA
ARTHRITIS	$814	$1,586	$2,065	$1,827
ASTHMA	$569	$1,389	$1,851	$1,774
CANCER	$1,360	$2,338	$2,525	$2,668
CHRONIC KIDNEY DISEASE	$4,650	$6,232	$5,664	$6,901
CONGESTIVE HEART FAILURE	$1,274	$1,955	$2,649	$2,827
CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$992	$2,088	$2,719	$2,028
CHRONIC PAIN	$1,259	$1,780	$2,355	$2,387
BACK PAIN	$1,624	$2,395	$3,109	$2,705
HEADACHE	$1,659	$2,221	$3,311	$3,354
DIABETES (WITH COMPLICATIONS)	$1,821	$2,681	$3,366	$3,678
DIABETES (WITHOUT COMPLICATIONS)	$811	$1,353	$1,775	$1,848
HYPERCHOLESTEROLEMIA (WITH COMPLICATIONS)	$1,369	$2,061	$2,769	$2,349
HYPERCHOLESTEROLEMIA (WITHOUT COMPLICATIONS)	$649	$1,065	$1,498	$1,411
HYPERTENSION (WITH COMPLICATIONS)	$1,447	$2,220	$3,056	$2,621
HYPERTENSION (WITHOUT COMPLICATIONS)	$688	$1,157	$1,641	$1,494
ISCHEMIC HEART DISEASE	$1,443	$2,319	$3,006	$2,335
OSTEOPOROSIS	$874	$1,592	$2,312	$1,720
STROKE	$1,673	$2,590	$3,556	$2,554
NONE	$221	$528	$762	$615
ANY CONDITION	$695	$1,271	$1,690	$1,577
TOTAL	$340	$903	$1,197	$1,072

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AS A HEALTH PLAN OR EMPLOYER, WHAT'S BETTER: MORE OR LESS BEHAVIORAL HEALTHCARE?

Health plans and employers continue to face old and new healthcare opportunities and challenges: more commercially insured lives through healthcare exchanges, more competition from accountable care organizations (ACOs) and consumer operated and oriented plans (CO-OPs), higher prevalence rates of behavioral conditions, fewer behavioral healthcare providers, and continually increasing healthcare costs. Complying with the final rules described herein is necessary. But should health plans and employers stop there, or go beyond what is required? Consider the high cost of members that have an MH issue; serious and persistent mental illness (SPMI) such as schizophrenia, major depressive disorder, bipolar disorder, or obsessive compulsive disorder; or SUD as compared with those who do not. This comparison is shown in the table in Figure 1 on page 4, which presents results from a comprehensive analysis of the Truven MarketScan® Commercial Claims and Encounters database, a large database of healthcare claims from commercially insured large group business.

Note that members with behavioral conditions can cost 2.5 to 3.5 times higher (on average) than those without such conditions. And increased medical costs, not behavioral costs, are the biggest driver of these increases. When members have comorbid chronic medical conditions and behavioral disorders, costs increase dramatically as shown in the table in Figure 2 on page 4.

These healthcare cost differences between insured members with and without behavioral disorders, and with and without comorbid chronic medical conditions, suggest that there are significant opportunities available to health plans and employers who provide effective treatment of mental health and substance use disorders. If the most effective benefit designs and cost structures exceed the minimum required by the MHPAEA final rules, plan sponsors may want to review their plan benefits. For example, consider expanding the scope of behavioral services in your plan benefits. Consider reviewing your medical necessity criteria for behavioral benefits. Consider the adequacy of your behavioral healthcare provider network and your contracted rates for all types of behavioral services. Consider the psychotropic drugs you offer in your formulary and any step-therapy requirements. Consider how you incentivize primary care practices to pay attention to behavioral disorders that they may have previously avoided within their patient bases. Innovative solutions to providing effective treatments for these members may help health plans and employers achieve the triple aim of improving the patient's experience of care, improving the health of populations, and reducing the per capita cost of healthcare.

CAVEATS

We used the Truven MarketScan Commercial Claims and Encounters 2010 database and medical and behavioral condition identification criteria developed by the author to calculate the healthcare costs presented in the above tables. The MarketScan database represents the inpatient and outpatient healthcare service use of individuals in the United States who are covered by the benefit plans of large employers, health plans, and government and public organizations.

The MarketScan database links paid claims and encounter data to detailed patient information across sites and types of providers, and over time. The annual medical database includes private-sector health data from approximately 100 payors. Historically, more than 500 million claim records are available in the MarketScan database. The costs developed herein will likely not represent those of any particular plan. Actual per-member costs for patients with different medical and behavioral conditions will likely vary from those developed for this paper.

This briefing paper represents a summary of the MHPAEA final rules, based on the author's review, which does not represent legal advice. There is no substitute for reading the full set of rules and drawing your own conclusions and obtaining your own legal advice. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work.

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