The Departments of Treasury, Labor and Health and Human Services issued a final rule on Friday November 8, 2013 governing the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). While further analysis is required to digest the complexities of the 200 page rule, below is a brief summary of key provisions.

Links to key materials:

- Final regulation, available at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf
- FAQs about ACA Implementation Part XVII and Mental Health Parity Implementation, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html
- U.S. Department of Health and Human Services' Study: 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, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf
- News release, available at http://www.dol.gov/ebsa/newsroom/2013/13-2158-NAT.html

Effective Date
In general, the final rule is effective for plan years beginning on or after July 1, 2014. In practice, the bulk of plan years end December 31 so the effective date for most insured will be January 1, 2015.

Request for Comments
In the FAQs released with the rule, the Departments requested 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."

Comments are due by January 8, 2014 to E-OHPSCA-FAQ.ebsa@dol.gov.

Scope of Service
The final rule clarified the scope of service issue by stating:

1. The 6 classification of benefits scheme (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential).
2. The language in the final rule on scope makes it clear that each classification and sub-classification has to meet all parity tests within each classification. And further states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers."

   This language, coupled with the new specific examples around intermediate levels of care, makes it clear that MH/SUD services have to be comparable to the range and types of treatments for medical/surgical within each class.
3. Although neither the Interim Final Rule (IFR) or final rule mandate specific services required to be offered by plans under the 6 classification scheme, the final rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assigned intermediate levels of services for medical/surgical conditions.

The final rule provides an example on page 27:

> For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, 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 be considered outpatient benefits as well.

The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor today) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

(See examples 9 & 10 on page 193 in the rule for additional detail on how this rule impacts residential SUD facilities)

Non-Quantitative Treatment Limitations (NQTLs)

- The final rule strikes the provision included in the IFR that permitted plans to apply discriminatory limits on mental health/substance use disorder (MH/SUD) treatment if there was a "clinically recognized standard of care that permitted a difference."
- Under the final rule, parity requirements for NQTLs are expanded to include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). The net effect of this is plans will no longer be able to require a patient to go to an MH/SUD facility in their own state if the plan allows plan members to go out of state for other medical services.
- The final rule does not include a new quantitative floor or formula on how plans may apply NQTLs to MH/SUD.
- The final rule maintains the "comparable and no more stringently" standard on NQTLs without defining the term and continues to require plans to disclose the "processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit it subject to an NQTL be comparable and applied no more stringently for MH/SUD than for medical/surgical."
- The improvement in the final rule is that plan participants or those acting on their behalf will now be able to request a copy of all relevant documents used by the health plan to determine whether a claim is paid (see disclosure section for more detail on what documents may be requested. Current or potential enrollees may request this information and plans are required to provide it within 30 days).
- **The final rule confirms that provider reimbursement rates are a form of NQTL**. The preamble clarifies that plans and issuers can look at an array of factors in determining provider payment rates such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience and licensure of providers. The final rule reconfirms that these factors must be applied comparably and no more stringently on MH/SUD providers. Additional comments will be solicited if questions persist with respect to provider reimbursement rates.

Disclosure and Transparency

MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. New disclosure requirements in the final rule will require plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits.

Under the final rule, regulations under the ACA and FAQs issued by the Department of Labor (DOL), today, plans and issuers must provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.

Enforcement
The final rule clarifies, as codified in federal and state law, states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of enforcing implementation of MHPAEA.

The Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply. The Department of Labor (DOL) has primary enforcement authority over self insured ERISA plans.

State Preemption
More consumer protective state laws are not preempted.

Medicaid Managed Care, CHIP and Alternative Benefit Plans
The final rule does not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The final rule states more guidance on this will be forthcoming. The PIC will be requesting this additional Medicaid guidance be issued within 180 days.

The CMS letter of January 2013 made it clear that sections of the IFR do apply to Medicaid managed care organizations (MCOs) - specifically they stated that NQTLs apply to Medicaid MCOs just as they do to commercial plans. The PIC will advocate for additional guidance that will require that all key consumer protection sections from the final rule will be applied to Medicaid MCOs.

Cost Exemption for Plans and Issuers
The final rule provides a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the law raise costs by at least 2% in the first year.

Tiered Networks
The final rule allows plans and issuers to use multiple provider network tiers but only if they are not imposing these tiered networks more stringently on MH/SUD subject to the general test provided for NQTLs.

Application to the Individual Market
The final rule applies to the individual market to both grandfathered and non-grandfathered plans for plan year beginning on or after July 1, 2014.

Non-Federal Governmental Plans
Local and state self-funded plans may continue to apply to CMS for an exemption from MHPAEA's requirements.

Multi-Tiered Prescription Drugs
A plan may have multi-tiered prescription drug programs (applies different levels of financial requirements to different tiers to prescription drugs in accordance with the NQTL rules). A plan may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.