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The Affordable Care Act—Countdown to Compliance for Employers, Week 35: ACA, Mental Health Parity, and (the Hazards of the) Final MHPAEA Regulations

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With so much attention focused on the particulars of the employer shared responsibility and, to a slightly lesser extent, reporting rules, it's easy to lose sight of other important changes—including final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which we addressed **here** and discuss further below.

The ACA expanded and amended the MHPAEA in certain particulars.

- By including mental-health and substance-use disorder (MH/SUD) benefits as one of the ten essential health benefits, the ACA effectively expanded the reach of MHPAEA to non-grandfathered health plans in the individual and small group markets.
- Before the ACA, MHPAEA applied to group health plans. The ACA extended MHPAEA's requirements to the individual market. As a result, non-grandfathered policies issued in the individual and small group market must provide MH/SUD benefits that comply with MHPAEA.

  NOTE: MHPAEA will not apply, however, to policies governed by the HHS 2013 transitional policy (establishing rules under which certain individual or small group market coverage will not be considered out-of-compliance with the ACA's market reform provisions).

- Although grandfathered individual market policies are not required to provide MH/SUD benefits, if they do cover these benefits, the coverage must comply with MHPAEA requirements.

The central challenge of MHPAEA is summed up succinctly in an **April 3, 2014 Health Policy Brief** issued by the Robert Woods Johnson Foundation:

> Traditionally, insurers and employers have covered treatment for mental health conditions differently than treatment for physical conditions. Coverage for mental health care had its own (usually higher) cost-sharing structure, more restrictive limits on the number of inpatient days and outpatient visits allowed, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care. Altogether, these coverage rules made mental health benefits substantially less generous than benefits for physical health conditions.

It is this tradition that the MHPAEA reverses. Disruptions are inevitable. The MHPAEA final rules establish the contours of that disruption, and they set out the operational standards for the new regime.

The ACA's expansion of MHPAEA to individual policies is of little or no concern to employers. But the final MHPAEA regulations are or at least should be of interest to employers, if only because of the host of practical problems that the final rules raise. On the "plus" side, the final MHPAEA regulations provide pretty clear rules for the content of plan documents. The rules are, however, complex, and they raise a host of practical problems. These include the following:

1. The final MHPAEA regulations adopt the classification-by-classification testing approach adopted in an earlier, interim final rule, and they also add some new sub-classifications for such things as multiple network tiers and separate sub-tiers for co-pays for office visits and other items and services. While the added sub-classifications are intended to provide flexibility in response to real-world clinical and treatment conditions, they make a complicated testing structure even more cumbersome.
2. Among other things, MHPAEA imposes parity limits on financial requirements and quantitative treatment limitations. While these limits are easy to understand conceptually, and while they pose little difficulty by way of plan drafting challenges, they are difficult to comply with in practice where an employer—as is often the case with MH/SUD carve-outs—uses one provider for medical and surgical benefits (M/S) and another for MH/SUD benefits. For example, where an employer uses different provider networks for M/S and MH/SUD benefits, are they using the same medical management techniques?
3. The final regulations eliminate an exception in the earlier, interim final rule that allowed for differences in medical/surgical benefits and MH/SUD benefits "to the extent that recognized clinically appropriate standards of care may permit a difference." This will make compliance with rules governing "non-quantitative treatment limitations" far more challenging. Under the final regulations, "parity" means "parity," despite that there are substantive differences between M/S, on the one hand, and MH/SUD benefits, on the other. Simply put, many treatments for M/S benefits do not have a MH/SUD equivalent. For example, intensive outpatient treatments for MH/SUD do not have an internal medicine analog.
4. The final regulations bar coverage restrictions based on geographic location. Thus, plans will not be able to restrict, say, outpatient MH/SUD benefits based on the locus of the treatment.
5. To what extent will small employers (under 50) seek to self-fund to avoid MHPAEA compliance? There are of course other reasons for small employers to self-fund (the minimum loss ratio rules don't apply, the penalties for non-discrimination are more manageable, etc.). There is evidence that this is in fact happening. The final MHPAEA regulations may accelerate this nascent trend.

As a consequence of the final MHPAEA regulations, the focus will be less on getting plan documents to comply and more on operational compliance.

Authors