



NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

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Governor

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Superintendent

**Insurance Circular Letter No. 5 (2014)
June 4, 2014**

TO: All Insurers Authorized to Write Accident and Health Insurance in New York State, Article 43 Corporations, and Health Maintenance Organizations (“HMOs”) (collectively, “issuers”)

RE: Impact of Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), Affordable Care Act (“ACA”), and the MHPAEA Final Rule on Mental Health and Substance Use Disorder Benefits in New York’s Health Insurance Market.

STATUTORY AND REGULATORY REFERENCES: 42 U.S.C. 300gg-1, et al.; 42 U.S.C. 18001, et al.; 45 C.F.R. Parts 146 and 147; and N.Y. Ins. Law §§ 3103, 3201, 3221, 4303, and 4308 and Article 49

The purpose of this circular letter is to provide guidance to issuers about the impact of the federal MHPAEA on New York’s health insurance market in light of the ACA and the issuance of the final rule implementing MHPAEA, which applies to group health plans and health insurance issuers for plan or policy years beginning on or after July 1, 2014.

This circular letter supersedes Circular Letter No. 20 (2009) and Supplement No. 1 to Circular Letter No. 20 (2009), both of which are hereby withdrawn.

I. Background

When enacted in 2008, MHPAEA applied to any group health plan, and any health insurance coverage offered in conjunction with such a plan, that had more than 50 total employees (“large group health plan”), and applied to plan years beginning on or after October 3, 2009. While MHPAEA did not require plans to cover treatment for mental health conditions (“MH”) or substance use disorders (“SUD”), it provided that if such conditions or disorders were covered, then they had to be covered at the same level as coverage under the plan for surgical and medical conditions.

On February 2, 2010, the United States Departments of Treasury, Labor, and Health and Human Services published an interim final rule further explaining and clarifying MHPAEA. On November 13, 2013, those Departments published a final rule, 45 C.F.R. Parts 146 and 147, following consideration of comments received in response to the interim final rule.

On March 23, 2010, President Barack Obama signed the ACA into law. The ACA requires individual and small group health insurance policies and contracts (collectively, “policies”) to provide

essential health benefits (“EHB”), including MH/SUD benefits. Additionally, as part of the ACA, Congress amended MHPAEA to extend its applicability to individual health insurance policies.

II. Impact of ACA and MHPAEA on Coverage in New York

A. ACA

Although MHPAEA continues to exempt from its requirements group health insurance policies issued to small employers, 45 C.F.R. § 146.136(f) clarifies that an issuer offering non-grandfathered health insurance coverage in the individual or small group market providing MH/SUD benefits as part of EHB must comply with MHPAEA to satisfy the ACA’s requirement to provide EHB. Thus, any individual or small group health insurance coverage delivered or issued for delivery in New York that is required to include EHB also must comply with the requirements of MHPAEA.

B. MHPAEA and 45 C.F.R. Part 146

1. Benefit Classifications

MHPAEA requires benefits for MH/SUD coverage to be placed in one of six classifications: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency care; and prescription drugs. See 45 C.F.R. § 146.136(c)(1)(i). In addition, 45 C.F.R. § 146.136(c)(3)(iii)(C) permits the outpatient classification to be separated into two sub-classifications, office visits and all other outpatient services. Determining whether specific MH/SUD benefits are in compliance with MHPAEA involves analyzing them in comparison to the medical/surgical benefits in the same classification. Thus, inpatient MH/SUD benefits are to be compared to inpatient medical/surgical benefits; prescription drugs to treat MH/SUD are to be compared to the prescription drug benefit to treat medical/surgical conditions; and so forth.

Furthermore, 45 C.F.R. § 146.136(c)(3)(iii)(B) recognizes sub-classifications based on tiered networks. It permits policies with multi-tiered provider networks to divide their benefits furnished on an in-network basis into sub-classifications that reflect the network tiers, if the tiering is: (1) based on reasonable factors (such as quality, performance, and market standards); and (2) done without regard to whether the provider is providing medical/surgical services or MH/SUD services.

2. Financial Requirements and Quantitative Treatment Limitations

Issuers that provide medical/surgical benefits and MH/SUD benefits must ensure that the financial requirements and quantitative treatment limitations applicable to MH/SUD are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the policy. See 45 C.F.R. § 146.136(c)(2)(i). Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See 45 C.F.R. § 146.136(a).

A type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. See 45 C.F.R. § 146.136(c)(3)(i)(A). If the type of financial requirement or quantitative treatment limitation does not meet the two-thirds threshold, then the policy may not impose that particular type of financial requirement or quantitative treatment limitation on MH/SUD benefits. See id. For instance, a policy that imposes copayments on only one-half of the inpatient in-

network medical/surgical benefits may not impose copayments on inpatient in-network MH/SUD benefits.

If the policy imposes a type of financial requirement or quantitative treatment limitation on at least two-thirds of the medical/surgical benefits in a classification, then the issuer must determine the predominant level of that type of financial requirement or quantitative treatment limitation for the medical/surgical benefits in that classification. See 45 C.F.R. § 146.136(c)(3)(i)(B)(1). The predominant level of the financial requirement or quantitative treatment limitation is the level that applies to more than one-half of the medical/surgical benefits in that classification. See id. For instance, assuming that copayments apply to substantially all medical/surgical benefits, if a policy imposes a \$50 copayment on one-quarter of the outpatient in-network medical/surgical benefits and a \$25 copayment on three-quarters of the outpatient in-network medical/surgical benefits, then the issuer only may impose a \$25 copayment on outpatient in-network MH/SUD benefits.

If no single level applies to more than one-half of the medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, then the issuer may combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. See 45 C.F.R. § 146.136(c)(3)(i)(B)(2). In such case, the least restrictive level within the combination is considered the predominant level of that type of classification. See id.

With respect to financial requirements, the determination of the portion of medical/surgical benefits in a classification subject to a financial requirement is based on the dollar amount of all plan payments for the medical/surgical benefits in the classification expected to be paid under the policy for the plan year. See 45 C.F.R. § 146.136(c)(3)(i)(E).

An issuer with a policy that subjects MH/SUD benefits to a specialty office visit copayment must provide written assurance to the Superintendent of Financial Services that the policy is in compliance with MHPAEA before the Superintendent will approve the policy.

3. Out-of-Network Coverage

Policies that provide coverage for out-of-network medical/surgical services must provide coverage for out-of-network MH/SUD services. See 45 C.F.R. § 146.136(c)(2)(ii)(B).

4. Nonquantitative Treatment Limitations

Issuers may not impose nonquantitative treatment limitations (“NQTs”) with respect to MH/SUD in any classification unless any processes, strategies, evidentiary standards, or other factors used in applying the limitations are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used in applying the limitations to the medical/surgical benefits in the classification. NQTs include medical management standards, medical necessity determinations, experimental or investigative treatment determinations, formulary designs for prescription drugs, network tier design for multiple tier networks, standards for provider admission to participate in a network (including reimbursement rates), step-therapy programs, and restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits. See 45 C.F.R. § 146.136(c)(4).

Issuers should be aware that final 45 C.F.R. Part 146 eliminated the exception that was in the interim final rule that allowed issuers to impose more stringent NQTs on MH/SUD benefits than on

medical/surgical benefits where “recognized clinically appropriate standards of care” permitted a difference. However, final 45 C.F.R. Part 146 also recognizes that disparate results between allowable limits on the two types of benefits do not, without more, mean that the NQTLs are violating the requirements of the rule.

Although final 45 C.F.R. Part 146 provides numerous examples that demonstrate compliance and noncompliance with the NQTL requirements, one example in particular is noteworthy. Example 10, which is set forth in 45 C.F.R. § 146.136(c)(4)(iii), makes clear that an issuer may not limit coverage for MH/SUD conditions to providers and/or facilities licensed in New York if the issuer does not similarly limit coverage for medical/surgical conditions.

5. Multi-Tiered Prescription Drug Benefits

An insurer may provide multi-tiered prescription drug benefits if they are based on reasonable factors and are without regard to whether a drug is prescribed with respect to medical/surgical benefits or MH/SUD benefits. See 45 C.F.R. § 146.136(c)(3)(iii)(A).

6. Disclosure Requirements

45 C.F.R. § 146.136(d) requires that: (1) the criteria used for medical necessity determinations for MH/SUD benefits be made available to any current or potential participant, beneficiary, or contracting provider upon request; and (2) the reason for any denial of reimbursement or payment for MH/SUD services be made available to the participant or beneficiary.

7. Provider Reimbursement

45 C.F.R. Part 146 clarifies that issuers may consider a wide array of factors in determining provider reimbursement rates for both medical/surgical services and MH/SUD services. These factors include: geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience, and licensure of providers. The NQTL rules require that an issuer apply these factors comparably to and no more stringently than the way that it applies the factors to medical/surgical services. A disparate outcome of applying the factors to the two types of benefits in and of itself does not mean that the issuer has failed to comply with the NQTL requirements. See 45 C.F.R. § 146.136(c)(4)(ii).

8. Intermediate Levels of Care

45 C.F.R. Part 146 addresses coverage for intermediate levels of care such as residential treatment, partial hospitalization, and intensive outpatient treatment. The supplementary information in 45 C.F.R. Part 146 indicates that it neither imposes a benefit mandate for coverage of intermediate levels of care nor permits issuers to exclude intermediate levels of care. Rather, under 45 C.F.R. Part 146, an issuer must assign the intermediate levels of care to the existing benefit classifications in the same way that it assigns comparable intermediate medical/surgical benefits to these classifications. The supplementary information in 45 C.F.R. § 146.136 gives the following examples: “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 use disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as

an outpatient benefit, than any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.”

Once the proper classification is made, an issuer may only impose financial requirements, quantitative treatment limitations, and NQTLs on those intermediate levels of MH/SUD care consistent with MHPAEA and 45 C.F.R. Part 146. For example, in New York, skilled nursing facilities for medical/surgical conditions are covered as an inpatient benefit. Thus, issuers should cover residential treatment facilities for MH/SUD conditions as an inpatient benefit. This means that an issuer may impose only financial requirements and quantitative treatment limitations on residential treatment facilities for MH/SUD conditions that are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered by the plan in the inpatient classification. Additionally, issuers are prohibited from imposing NQTLs on residential treatment facilities for MH/SUD conditions unless any processes, strategies, evidentiary standards, or other factors used in applying the limitations are comparable to and no more stringent than the processes, strategies, evidentiary standards, or other factors used in applying the limitations to the medical/surgical benefits in the inpatient classification.

III. Conclusion

The ACA, MHPAEA, and 45 C.F.R. Part 146 have had a significant impact on coverage requirements for MH/SUD benefits. This circular letter endeavors to inform issuers of the requirements under the foregoing, and to assist issuers with complying with them.

Please direct any questions regarding this circular letter to Thomas Fusco, Supervising Insurance Attorney, Health Bureau, New York State Department of Financial Services, Walter J. Mahoney Office Building, 65 Court Street, Room 7, Buffalo, New York 14202, or by e-mail at thomas.fusco@dfs.ny.gov.

Very truly yours,

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