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Interim Final Regulations on Mental Health Parity Law Are Released

The Departments of Treasury, Labor, and Health and Human Services have released interim final regulations interpreting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The regulations contain some complicated rules for determining parity and many employers will likely have to make significant changes in how they provide mental health and substance use disorder benefits to their employees.

Background

Under the Mental Health Parity Act of 1996 (MHPA), group health plans were prohibited from imposing lower annual or lifetime dollar limits on mental health benefits than they imposed on medical/surgical benefits. However, plans were permitted to impose other limits, such as on the number of outpatient visits or hospital stays, even if they did not impose such limits with respect to other medical conditions. MHPA contained an exemption for plans that would incur a cost increase of at least 1% by complying with the requirements. The 1996 parity rules did not apply to substance use disorder benefits.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), signed into law on October 3, 2008, amended the Internal Revenue Code, ERISA and the Public Health Service Act to expand the parity rules enacted under MHPA. MHPAEA prohibits group health plans (both self-funded and insured) from imposing financial requirements (e.g., deductibles) or treatment limitations (e.g., limits on number of visits) on mental health benefits that are more restrictive than the most common or frequent requirements and limitations imposed on medical and surgical benefits. (See our October 9, 2008 *For Your Information*.) It also extends the parity requirements to substance use disorder benefits, modifies the cost exemption and imposes new disclosure requirements.

Although MHPAEA was effective for plan years beginning on or after October 3, 2009, regulations were not issued until February 2, 2010. These interim final regulations provide much needed guidance, although some of it is not necessarily as favorable as had been hoped for, and could necessitate plan design changes.

Interim Final Regulations

The interim final regulations clarify how the new parity provisions apply to group health plans and issuers, and provide rules for making parity determinations and required disclosures. They do not address the increased cost

exemption, or the extent to which plans must cover all medically appropriate services relating to mental health conditions or substance use disorders.

BUCK COMMENT. *The agencies are soliciting comments about both the increased cost exemption and the scope of medically appropriate services. Comments are due by May 3, 2010.*

General Application of New Parity Requirements

MHPAEA does not require group health plans to provide mental health or substance use disorder benefits. However, if a group health plan provides both medical/surgical and mental health/substance use disorder benefits, it will be subject to the parity requirements. MHPAEA also does not require group health plans to cover any particular mental health condition or substance use disorder. But if a plan does, coverage of that condition or disorder will also be subject to the parity rules.

The new regulations were released after many plans were already required to comply with MHPAEA. Although plans must currently operate in good faith compliance, they will have a limited period of time to satisfy these new regulations.

Opt-out by Public Plans. Self-funded plans sponsored by state and local governments may opt out of compliance with MHPAEA. The election must occur before the first day of a plan year, and must be filed with CMS. Notice of the opt-out must also be provided to plan participants.

Definition of a Plan

The regulations clarify that the parity rules "apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive." Thus, even if the mental health benefit plan is separate from the medical/surgical plan, as long as both types of plans are offered, they are considered to be one plan for purposes of the parity rules.

BUCK COMMENT. *This definition prevents employers from avoiding the MHPAEA requirements by establishing separate carve-out plans for mental health and substance use disorder benefits. Employers who have "carved out" these benefits under a stand-alone specialty program will need to review their current delivery model to ensure it satisfies the MHPAEA requirements. Because each combination of medical/surgical and mental health plans will need to be tested for compliance separately, it will be more difficult to design and administer a stand-alone mental health program that can be combined with multiple medical plans.*

Definition of Mental Health Conditions and Substance Use Disorders

The regulations do not set out a list of mental health conditions or substance use disorders, but instead allow plans to define these terms "consistent with generally recognized independent standards of current medical practice." The regulations cite the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), or state guidelines as examples of independent standards.

> ***BUCK COMMENT.*** *One important decision for an employer will be which mental health conditions and substance use disorders to cover under the plan. As discussed below, any benefits provided for a mental health condition in one classification will have to be provided in all classifications.*

Specific Parity Rules

The regulations address the parity rules in three areas –

- aggregate lifetime and annual dollar limits
- financial requirements and quantitative treatment limitations
- nonquantitative treatment limitations.

Aggregate Lifetime and Annual Dollar Limits

Lower aggregate lifetime or annual dollar limits for mental health benefits were already prohibited by the Mental Health Parity Act of 1996. The MHPAEA regulations extend this prohibition to substance use disorder benefits, but do not otherwise substantively change the prior regulations on dollar limits.

Financial Requirements and Quantitative Treatment Limitations

The regulations provide that if a plan imposes any separate "type" of financial requirement or treatment limitation (or separate "levels" of a financial requirement or treatment limitation) for benefits in a "classification," the parity rules apply separately with respect to that classification for all financial requirements or treatment limitations.

Types of Financial Requirements and Quantitative Treatment Limitations. Financial requirements are plan requirements that affect the amount of benefits paid, such as deductibles, co-payments, coinsurance, or out-of-pocket maximums. Quantitative treatment limitations are plan limits that affect the scope or duration of benefits for treatment, such as annual, episode, and lifetime day and visit limits.

Levels of a Financial Requirement or Quantitative Treatment Limitation. Level refers to the magnitude or amount of the type of financial requirement or treatment limitation. The regulations include examples of levels of

coinsurance (20%, 30%), copayments ($15, $20), deductibles ($250, $500) and episode limits (21 inpatient days per episode).

Benefit Classifications. There are six benefit classifications –

- inpatient, in-network
- inpatient, out-of-network
- outpatient, in-network
- outpatient, out-of-network
- emergency care
- prescription drug.

The regulations do not define inpatient, outpatient and emergency care. These terms will depend on the plan design and their meanings may vary from plan to plan. However, a plan must apply these terms uniformly to medical/surgical benefits and mental health/substance use disorder benefits.

Applying the Rules. If a plan provides mental health/substance use disorder benefits in any classification, it must provide mental health/substance use disorder benefits in every classification in which it provides medical/surgical benefits. Thus, a plan cannot limit mental health/substance use disorder benefits to in-network coverage if it provides out-of-network medical/surgical benefits. Similarly, a plan that provides benefits for a specific mental health condition or substance use disorder in one classification must provide benefits for that condition or disorder in each classification for which any medical/surgical benefits are provided.

The regulations prohibit a plan from applying any financial requirement or treatment limitation on mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" financial requirement or treatment limitation that is imposed on "substantially all" medical and surgical benefits in the same classification. If a plan imposes any separate financial requirement or treatment limitation (or separate levels of a financial requirement or treatment limitation) for benefits in a classification, the parity rules apply separately in each classification.

For purposes of this rule, substantially all means at least two thirds. Thus, a plan can apply financial requirements or treatment limitations to a mental health or substance use disorder benefit in a classification only if at least two thirds of projected plan payments for all medical/surgical benefits in that classification are subject to the same financial requirements or treatment limitations. Any reasonable method can be used to determine the dollar amount of projected plan payments.

A financial requirement or treatment limitation is predominant if the level applies to more than one half of the medical/surgical benefits of that type in that classification. Thus, the dollar amount of the requirement or the quantitative treatment limitation applied to mental health or substance use disorder benefits in a classification

cannot be greater than the dollar amount or quantitative treatment limitation that applies to more than one half of the medical/surgical projected plan payments in that classification subject to the same requirement or limitation.

Example 1. For the outpatient, in-network classification, a plan applies copayments for office visits and coinsurance for lab tests. Using a reasonable method, the plan determines that 70% of projected plan payments for medical/surgical benefits in that classification are subject to copayments and 30% are subject to coinsurance. The two thirds threshold for substantially all is met for copayments, and copayments can be applied for mental health and substance use disorder services in the inpatient, in-network classification.

> ***BUCK COMMENT.*** *Because coinsurance does not meet the substantially all requirement, coinsurance cannot be applied to lab tests for mental health or substance use disorder services. Lab tests would either need to also be subject to copayments or have no type of cost sharing. This limitation will complicate the design and administration of plan benefits.*

Example 2. For the outpatient, in-network classification, a plan applies copayments for office visits and coinsurance for lab tests, and covers preventive services in full. Using a reasonable method, the plan determines that 60% of projected plan payments for medical/surgical benefits in the classification are subject to copayments, 30% are subject to coinsurance and 10% have no cost sharing. Because the two thirds threshold for substantially all is not met by any type of financial requirement, no cost sharing can be applied for any mental health and substance use disorder services in the inpatient, in-network classification.

> ***BUCK COMMENT.*** *Many plans use multiple types of financial requirements in a classification, but this approach could result in **no** type of financial requirement being allowed for mental health or substance use disorder benefits, even though some type of financial requirement applies to **all** medical/surgical services. This surprising result may require employers to redesign their benefit plans.*

Example 3. For the outpatient, in-network classification, copayments satisfy the substantially all requirement. The plan applies a $15 copayment for primary care office visits and a $30 copayment for specialist office visits. The plan determines that 75% of projected plan payments are for services subject to the $15 copayment, and 25% of projected plan payments are subject to the $30 copayment. Because the $15 copayment satisfies the predominant requirement, the plan cannot impose a copayment on mental health or substance use disorder services that exceeds $15.

> ***BUCK COMMENT.*** *Many plans currently apply the specialist copayment for mental health and substance use disorder services. However, under the regulations, the specialist copayment cannot be applied unless it satisfies the predominant requirement.*

If no single level of a financial requirement or treatment limitation applies to more than one half of projected plan payments for medical/surgical benefits in a classification, the plan can combine levels to satisfy the more than one half requirement. The least restrictive level in that combination would be considered the predominant level.

Example 4. For the outpatient, in-network classification, copayments satisfy the substantially all requirement. The plan applies a $10 copayment for preventive services, a $15 copayment for primary care office visits, and a $30 copayment for specialist office visits. The plan determines that 20% of projected plan payments are for services subject to the $10 copayment, 45% of projected plan payments are for services subject to the $15 copayment, and 35% of projected plan payments are for services subject to the $30 copayment. Because no single level of copayment exceeds one half of projected plan payments for services subject to copayments, the plan can combine copayment levels. In this case, the plan can combine the $15 and $30 copayment levels, which includes 80% of projected plan payments. The least restrictive level of copayment in this combination, $15, would be the predominant level.

If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units (e.g., single coverage, participant plus one) in a classification, the predominant level for each coverage unit must be determined separately. This would typically apply for plans with different deductible and out-of-pocket limits for employee and dependent coverage.

Special Rule for Prescription Drug Benefits. The regulations contain a special rule for multi-tiered prescription drug benefits. A plan may have different levels of financial requirements for different tiers of prescription drug benefits if the differences are based on reasonable factors determined in accordance with the rules for nonquantitative treatment limitations and are applied regardless of whether the drug is generally prescribed for medical/surgical or mental health/substance use disorder conditions. For this purpose, reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Separate Cumulative Financial Requirements for Treatment Limitations. The regulations prohibit the application of cumulative financial requirements like deductibles, out-of-pocket maximums and visit limits that apply separately to mental health or substance use disorder benefits. The regulations include an example in which a $300 deductible is applied to medical/surgical benefits and a separate $150 deductible is applied to mental health or substance use disorder benefits. The regulations state that this separate deductible violates MHPAEA.

> ***BUCK COMMENT.*** *Some employers have carved out mental health and substance use disorder benefits and use a specialty vendor (rather than the medical vendor) to more effectively manage these benefits. In this case, it is common (often due to administrative limitations) to have separate deductibles or to not have mental health or substance use disorder deductibles and coinsurance credited toward the plan's overall out-of-pocket maximum. This approach is no longer allowed and employers will need to integrate administration with the medical plan.*

Nonquantitative Treatment Limitations

Nonquantitative treatment limitations are not expressed numerically but otherwise limit the scope or duration of benefits for treatment. Nonquantitative treatment limitations include standards for determining medical necessity,

preauthorization, formulary design, determination of usual, customary and reasonable charges, and network standards for provider admission or reimbursement.

The factors used in applying nonquantitative treatment limitations to mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, the factors used in applying the limitations to medical and surgical benefits in the same classification.

BUCK COMMENT. *The regulations include an example in which a participant is only eligible for mental health and substance use disorder benefits under the medical plan after exhausting the counseling sessions provided by an EAP. If no similar requirement applies to medical/surgical benefits, the plan violates MHPAEA. Employers that utilize EAPs to manage mental health conditions and substance use disorders will need to redesign their programs unless similar requirements apply to medical/surgical benefits.*

Disclosure Requirements

MHPAEA includes two disclosure requirements. First, the criteria for medical necessity determinations must be made available upon request to current and potential participants, beneficiaries and contracting providers. Second, the reason for any denial under a health plan must be made available to the participant or beneficiary. The regulations clarify that this disclosure must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations. For non-ERISA plans, compliance with the ERISA regulations will satisfy these requirements.

Increased Cost Exemption

A group health plan may elect to be exempt from the parity requirements if compliance causes its overall plan costs to increase by more than 2% in the first year of applicability and 1% in subsequent years. Importantly, the cost exemption is only available for alternating plan years. Regulatory guidance on the cost exemption will be issued in the future.

BUCK COMMENT. *The limited availability of the cost exemption to alternate years makes its use impractical for most employers.*

Interaction with State Laws

The regulations confirm that MHPAEA does not supersede any state health insurance law as long as it does not prevent the application of a MHPAEA requirement. Further, a state law that mandates "a minimum dollar amount of mental health or substance use disorder benefits does not prevent the application of MHPAEA." For example, in recent years, many states have passed laws requiring fully insured plans to cover up to a specified dollar limit

per year in autism benefits. To comply with MHPAEA, a plan may be required to provide benefits in excess of such state law minimums.

Effective Date

The regulations are effective for plan years beginning on or after July 1, 2010. Thus, for calendar year plans, the regulations will be effective January 1, 2011. There is a delayed effective date for plans maintained pursuant to one or more collectively bargained agreements ratified prior to October 3, 2008. For these plans, the regulations do not apply for plan years beginning before the later of July 1, 2010 or the date on which the last of the plan's collective bargaining agreements terminates.

> ***BUCK COMMENT.*** *The regulations do not define what percentage of employees covered by a plan need to be union employees for the plan to be considered maintained pursuant to a collective bargaining agreement.*

MHPAEA took effect for plan years beginning after October 3, 2009 (January 1, 2010 for calendar year plans). Prior to the applicability date of the regulations, the agencies will take into account good faith efforts to comply based on a reasonable interpretation of the statutory requirements. However, this does not prevent participants from bringing private actions.

Conclusion

Employers will need to review the mental health and substance use disorder provisions in their benefits programs to ensure compliance with these regulations. The regulations include complicated testing requirements and surprising results that will impact many employer plans. Employers with carve-out programs or who use EAPs to manage mental health programs will particularly need to review the design and administration of their programs. Buck's consultants are available to discuss these new requirements with you and assist in compliance.