

**Mental Health Parity and Addiction Equity Act      February 2010**  
**Interim Final Regulations Issued**

On January 29, 2010, regulations were issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). The regulations follow through on the intent of MHPAEA and take a mostly common sense approach to attaining parity by providing guidance on how to compare limitations imposed on medical/surgical benefits to mental health/substance use disorder benefits in order to test the level of compliance.

The regulations also highlight the following:

- Unless required by State law, (i) plans are not required to offer mental health/substance use benefits; (ii) plans that offer mental health benefits are not required to offer substance use disorder benefits. While California does require fully insured plans to provide coverage for certain mental illnesses, it does not require coverage for substance use disorder benefits.
- Unless required by State law, conditions and disorders may be permanently excluded from coverage without being considered a treatment limitation.
- Plans may not require participants to exhaust EAP resources prior to seeking mental health/substance use disorder benefits.
- Separate but equal deductibles and out-of-pocket maximums for medical/surgical benefits and mental health/substance use disorder benefits violate MHPAEA.
- A group health plan with a separate behavioral health carve out arrangement is considered to be one plan.
- Differences between general practitioners and mental health specialists are not taken into account when evaluating financial requirements.
- Claims administrators who have discretion to approve benefits based on medical necessity should be careful to apply criteria in the same manner to mental health/substance use disorder benefits unless clinically appropriate standards of care permit differences.
- Multi-tiered prescription drug plans remain generally intact if they operate without regard to whether drugs are prescribed for mental health/substance use disorders.
- The regulations do not address the scope of services available for treatment for mental health/substance use disorders and leave unanswered questions regarding the availability of residential treatment centers, for example. Comments have been invited on whether and to what extent MHPAEA addresses the scope of services or continuum of care.

- The cost exemption for compliance with MHPAEA may only be claimed for alternating years, which raises question about the usefulness of this exemption.
- Any plan amendment made pursuant to a collective bargaining agreement solely to conform to MHPAEA is not treated as a termination of the agreement.

## **MENTAL HEALTH CARVE OUTS**

The preamble to the regulations addresses the potential benefits that behavioral health carve out arrangements may provide. These benefits are detailed extensively in studies that illustrate that spending on private insurance may be reduced while rates of utilization of mental health care rises. The number of people receiving inpatient psychiatric care typically declines, as does the average number of outpatient visits decline, per episode when services are provided under behavioral health carve out arrangements. Plan sponsors should evaluate the benefits of behavioral health carve out arrangements in terms of their potential enhanced efficiency, cost savings and flexibility of offerings to better align mental health/substance use disorder benefits to medical/surgical benefits offered within a plan for purposes of parity.

## **THE GENERAL PARITY RULE**

The regulations provide that group health plans and group health insurers may not apply any type of financial requirement or treatment limitation to mental health or substance use disorder benefits in any “classification” that is more restrictive than the predominant type that applies to substantially all medical/surgical benefits in that classification. Classifications are based on plan design or State insurance law. There are six classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drug. Additionally, the regulations provide that a group health plan that provides any benefits for a mental health/substance use disorder condition in any classification must provide benefits for that condition or disorder in each classification that medical/surgical benefits are offered.

## **APPLICATION OF THE GENERAL PARITY RULE**

Initially, compliance with MHPAEA will be quite demanding because group health plans are required to apply the general parity rule by classification, coverage unit, type and level within each “benefits package option” or “tier” that an employee may elect for a plan year. However, these terms have been folded into the definition of “combination” to avoid abuse by plan sponsors who attempt to avoid parity by making mental health coverage a separate election. Comparisons must be made on a category-by-category basis. For example:

- Classification-- Inpatient, in-network limitations for medical/surgical benefits may only be compared to inpatient, in-network limitations for mental health/substance use disorder benefits.
- Copayments for medical/surgical benefits may only be compared to copayments for mental health/substance use disorder benefits.
- Coverage Unit-- Family coverage is compared to family coverage and single coverage is compared to single coverage.

The regulations describe further the types of financial requirements and treatment limitations that plan sponsors should identify as restrictions that may be impacted.

- **Financial Requirements.** These include deductibles, coinsurance, copayments and out-of-pocket maximums.
- **Quantitative Treatment Limitations.** These are numerical limitations based on amounts such as frequency of treatment, number of visits, days of coverage or days in a waiting period.
- **Nonquantitative Treatment Limitations.** These are not expressed numerically but otherwise limit the scope or duration of benefits for treatment such as medical management, formulary design, standards used for provider admission to participate in a network, methods used to determine usual, customary and reasonable charges, step therapy and exclusions based on failure to complete a course of treatment.

The rules are quite detailed and technical. Their application is different for financial requirements and quantitative treatment limitations as opposed to nonquantitative treatment limitations.

## FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Determining whether a classification contains a financial requirement or quantitative treatment limitation that is more restrictive than permitted in the regulations is a two-step process:

- The type of requirement or limitation must apply to at least two-thirds (substantially all) of all medical/surgical benefits within a classification. Otherwise, that type cannot be imposed on mental health/substance use disorder benefits in that classification.
- The level (i.e. amount) of that type must apply to more than one-half (predominant) of the medical/surgical benefits within the classification. Otherwise, that amount cannot be imposed on mental health/substance use disorder benefits in that classification.

For plans that have varying financial requirements (copayments, for example) or different quantitative treatment limitations for different services, the regulations provide a method for weighting the type and level of restriction by allowing plan sponsors to use any reasonable method to allocate an anticipated dollar amount expected to be paid for each benefit for each type and level of restriction. The dollar amount is then expressed as a percentage of all plan payments for medical/surgical benefits to evaluate whether the restriction applies to substantially all benefits and whether it is predominant. For example, a plan that has a \$10 copayment for routine office visits but a \$25 copayment for specialists will need to weight these copayments based on the cost of benefits for routine office visits as compared to specialist visits in order to determine whether these or any copayments may be applied to mental health/substance use disorder services.

## NONQUANTITATIVE TREATMENT LIMITATIONS

Whether a classification imposes an impermissible nonquantitative treatment limitation with respect to mental health/substance use disorder benefits is determined under the terms of the plan as written and in operation. Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health/substance use disorder benefits in a classification

must be comparable to, and applied no more stringently than, those used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care permit a difference.

## **DISCLOSURE**

Criteria for medical necessity determinations made under a plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participants, beneficiary, or contracting provider upon request.

The reason for any denial of reimbursement or payment for services for mental health/substance use disorder benefits must be made available by the plan administrator in accordance with the claims regulations under ERISA for plans subject to ERISA. For governmental plans and church plans, this requirement is satisfied if the reason for the claim denial is provided within a reasonable time and reasonable manner following the request.

## **EXEMPTIONS**

There are two main exemptions to MHPAEA compliance. These exemptions are for small employers and increased cost.

Generally MHPAEA does not apply to employers who employed an average of at least two but not more than 50 employees based on all business days during the preceding calendar year.

The increased cost exemption under MHPAEA has changed in several respects:

- The threshold for the exemption is raised from one percent to two percent for the first year for which a plan is subject to MHPAEA. Qualified and licensed actuaries who are members in good standing of the American Academy of Actuaries must certify to the increase in cost.
- Plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year.
- The increased cost exemption lasts for one year. Thus, the increased cost exemption may only be claimed for alternating years. From a practical standpoint, this means that an employer claiming a cost exemption would still be required to provide parity in alternating years. It is probably impractical, especially in a collectively bargained environment, to annually change plans so as to take advantage of this exemption.

## **EFFECTIVE DATE AND GOOD FAITH COMPLIANCE**

The regulations are effective for plan years beginning on or after July 1, 2010. For purposes of enforcement, good-faith compliance efforts to comply with a reasonable interpretation of MHPAEA requirements will be taken into account with respect to a violation that occurs before the regulations become applicable to a plan. However, participants and beneficiaries may still bring a private action.

For group health plans maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the regulations apply on the later of (i) July 1, 2010 and (ii) the date on which the last of the collective bargaining agreements relating to the plan terminates (without regard to any extension agreed to after October 3, 2008).

Keenan & Associates is not a law firm and no opinion, suggestion, or recommendation of the firm or its employees shall constitute legal advice. Clients are advised to consult with their own attorney for a determination of their legal rights, responsibilities and liabilities, including the interpretation of any statute or regulation, or its application to client's business activities.