



Mental Health and Substance Use Disorder Parity Interim Final Regulations

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We will cover ...

- **Introduction**
- **Statutory requirements**
- **The Interim Final Rule**
 - Plan definitions and exclusions
 - Parity Requirements
 - What are Treatment Limitations and Financial Requirements?
 - Determining parity under the Rules
 - Classifications
 - “Substantially All” Test
 - “Predominant” Test
 - New Single Group Health Plan Rule
 - Exemptions
 - New Disclosure Requirements
- **Takeaways - What Should Plans Do Now?**



Mental Health Parity and Addiction Equity Act (the "Act")

- The Mental Health Parity Act of 1996 prohibited group health plans from placing lifetime or annual limits on mental health benefits that did not apply to substantially all medical/surgical benefits.
- The Act passed in 2008 was intended to provide fully parity.
 - The Act prohibits group health plans that provide mental health and/or substance use disorder benefits from applying "**financial requirements**" or "**treatment limits**" that are more restrictive than the "**predominant**" financial requirement or treatment limit that applies to "**substantially all**" medical/surgical benefits.
- The Act was effective January 1, 2010 for calendar year plans (prior to the issuance of regulations)
 - For union plans, the Act is effective for the first plan year following the termination of the last CBA that was in effect on October 3, 2008.



Mental Health Parity and Addiction Equity Act (the "Act")

- Additional provisions under the Act:
 - The Act also has an **out-of-network** mandate – if the plan offers out-of-network coverage for medical/surgical benefits, it must also offer out-of-network services for mental health/substance use disorder.
 - Parity not expressly required for **medical management**
 - **New Disclosure Requirements** – Plans must now disclose medical necessity criteria to participants and providers in addition to reasons for denial of reimbursement for services
 - **New Cost Exemption** – if parity requirements cause a health plan's total costs to increase by 2% in the first plan year and 1% in subsequent plan years, plans can apply for relief from parity requirements for one plan year (but will have to comply the following year)



The Interim Final Rule

- Interim final rule issued by IRS, CMS and DOL on February 2, 2010 – 4 months after the Act's effective date for calendar year plans.
- The rule is effective April 3, 2010.
- The agencies have requested comments by May 3, 2010.
- The rule is applicable for the first plan year beginning on or after July 1, 2010.
- There is a limited **non-enforcement period** until the applicability date for a plan, provided the plan has taken good faith steps to comply with the Act.



Plan Exclusions of Conditions or Disorders

- Plans are not required to offer mental health or substance use benefits at all.
 - Except for state mandates that may apply to insured plans.
- Plans may permanently exclude all benefits for a specific condition or disorder without violating the parity rules.
- Covering mental health benefits will not require plans to cover substance use disorder benefits.
- But – if a condition is covered, it must be offered in parity with medical/surgical benefits.
- If mental health or substance abuse benefits are provided in any classification (e.g., prescription drugs), benefits must be provided in ALL classifications (e.g., in-patient, out-of-network, etc.)



Plan Definitions of Conditions & Disorders

- Mental health and substance use disorder benefits are defined by the plan, but must be categorized consistent with generally recognized independent standards of current medical practice (e.g., DSM, International Classification of Diseases, or a state guideline).
 - For example, autism is defined by the DSM as a mental health benefit, so cannot be defined by a Plan as a medical benefit in order to apply cost containment limits.



Plan Exclusions of Treatments and Treatment Settings

- Definitions of inpatient, outpatient and emergency care are subject to plan design (and may be subject to state law mandates for insured plans).
 - The definitions must be applied uniformly for medical/surgical benefits and mental health/substance abuse benefits.
- Plans CAN exclude certain treatments and treatment settings under the interim final rule.
- But, the agencies have requested comments on scope of services and continuum of care issues and have said they will address this in the final rule.



Parity Requirements – What are Treatment Limitations?

- Parity requirements apply to quantitative and nonquantitative treatment limitations
 - **Quantitative treatment limitations** are expressed numerically
 - For example, annual limits of 50 outpatient visits. Other examples are episodic or lifetime day or visit limits.
 - Quantitative treatment limits cannot accumulate separately (e.g., cannot have an annual limit of 50 visits on outpatient mental health and a separate annual limit of 50 visits for outpatient medical/surgical).



Parity Requirements – What are Treatment Limitations?

- **Nonquantitative treatment limitations** are limitations that affect the scope or duration of benefits under the plan that is not expressed numerically.
 - **New Parity Rule:** Any **processes, strategies, evidentiary standards** or other factors used in applying the nonquantitative treatment limitation to mental health/substance abuse benefits must be **comparable to and applied no more stringently** than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the same “**classification**”.
 - Variation is allowed only to the extent that recognized clinically appropriate standards of care may permit a difference.



Parity Requirements – What are Treatment Limitations?

- **Nonquantitative treatment limitations parity rule** applies to –
 - Medical management
 - Prescription drug formulary design
 - Standards for determining provider admission to a network, including reimbursement rates
 - Determinations of usual and customary charges
 - Fail-first or step-therapy protocols
 - Conditioning benefits on completion of a course of treatment
- The agencies intend to add to this list
- An EAP cannot be the gatekeeper for mental health if no similar arrangement for medical/surgical



Parity Requirements – What are Financial Requirements?

- Financial requirements include deductibles, copayment, coinsurance and out-of-pocket maximums
 - Separately accumulating deductibles or out-of-pocket maximums are now prohibited
 - A plan may not (without passing the parity tests) treat all mental health/substance use disorder providers as specialists and automatically apply a higher copayment than for primary care physicians for medical/surgical.



Determining Parity – Classifications and Coverage Units

- Parity must be determined **classification-by-classification**
 - Specific classifications required by the rule are:
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drug
 - No other classifications are permitted
- Parity must be determined for each **coverage unit** (e.g., employee only, employee + one, family, etc.)



Determining Parity – The “Substantially All” Test

- A “**type**” of financial requirement (e.g., all copays) or quantitative treatment limitation applies to **substantially all** medical/surgical benefits within a classification if it applies to **at least 2/3** of all the benefits (based on projected plan cost) in that classification.
 - Any **reasonable method** may be used to determine the dollar amount expected to be paid under the plan.
 - Benefits at a zero level (e.g., \$0 copay for well baby visits or \$0 coinsurance for preventive care) are counted in the denominator (i.e., not subject to the financial requirement)



Determining Parity – The “Predominant” Test

- If the “**Substantially All**” Test is met for a type of requirement or limitation, then the plan must pass the “**Predominant**” Test for the specific “**level**” of requirement or limitation to be applied to mental health/substance abuse.
 - For a level of financial requirement or treatment limitation to be predominant, it must apply to **at least 50%** of all medical/surgical benefits within the classification.
 - If there is no single level that applies to 50%, complex aggregation rules apply.



New Single Group Health Plan Rule

- The parity rules apply separately with respect to each combination of medical/surgical and mental health/substance abuse coverage that any participant can **simultaneously receive** from an employer.
 - As a result, mental health/substance abuse **carve-outs** with limits are prohibited.
- All such combinations constitute a “**single group health plan**” for parity purposes.
 - For example, if an employer offers three packages plus one mental health plan, parity requirements (including nonquantitative treatment limitations) must be met with regard to each package when combined with the mental health plan.
 - If an **EAP** is overlaid on top of a plan with full parity, it will not be subject to the parity requirements.
 - Not clear how this will apply to **account based plans**.



Exemptions

- Small Employer Exemption
 - Parity rules apply to employers who employed an average of more than 50 employees on business days during the preceding calendar year.
 - Agencies intend to issue guidance clarifying how to count employees



Exemptions

- Cost Exemption
 - If parity requirements cause a health plan's total costs to increase by 2% in the first plan year and 1% in subsequent plan years, plans can apply for relief from parity requirements for one plan year (but will have to comply the following year)



New Disclosure Requirements

- Upon request by a current or potential participant, beneficiary or contracting provider, the plan administrator or health insurance issuer must provide the criteria for **medical necessity determinations** made under the plan with respect to mental health or substance abuse benefits.
- Plan administrator or health insurance issuer must also make available upon request or as otherwise required, the reason for any **denial** of reimbursement or payment for services with respect to mental health or substance use disorder benefits.
 - The interim final rule provides that compliance with ERISA's claims procedure rules as to denials constitutes compliance with this rule for both ERISA and non-ERISA plans (e.g., church plans).



Takeaways – What Should Plans Do Now?

- **Step 1** – Review plan for good faith compliance with the Act until the applicability date for the Plan (e.g., January 1, 2011 for calendar year plan).
- **Step 2** – Analyze Plan design under new parity tests for the upcoming plan year.
 - Document results of “Substantially All” and “Predominant” tests.
 - Need to document processes and strategies for nonquantitative treatment limitations for mental health/substance use disorder and medical/surgical for comparison purposes.
 - Prepare to make medical necessity and claims denial disclosures.



Questions
