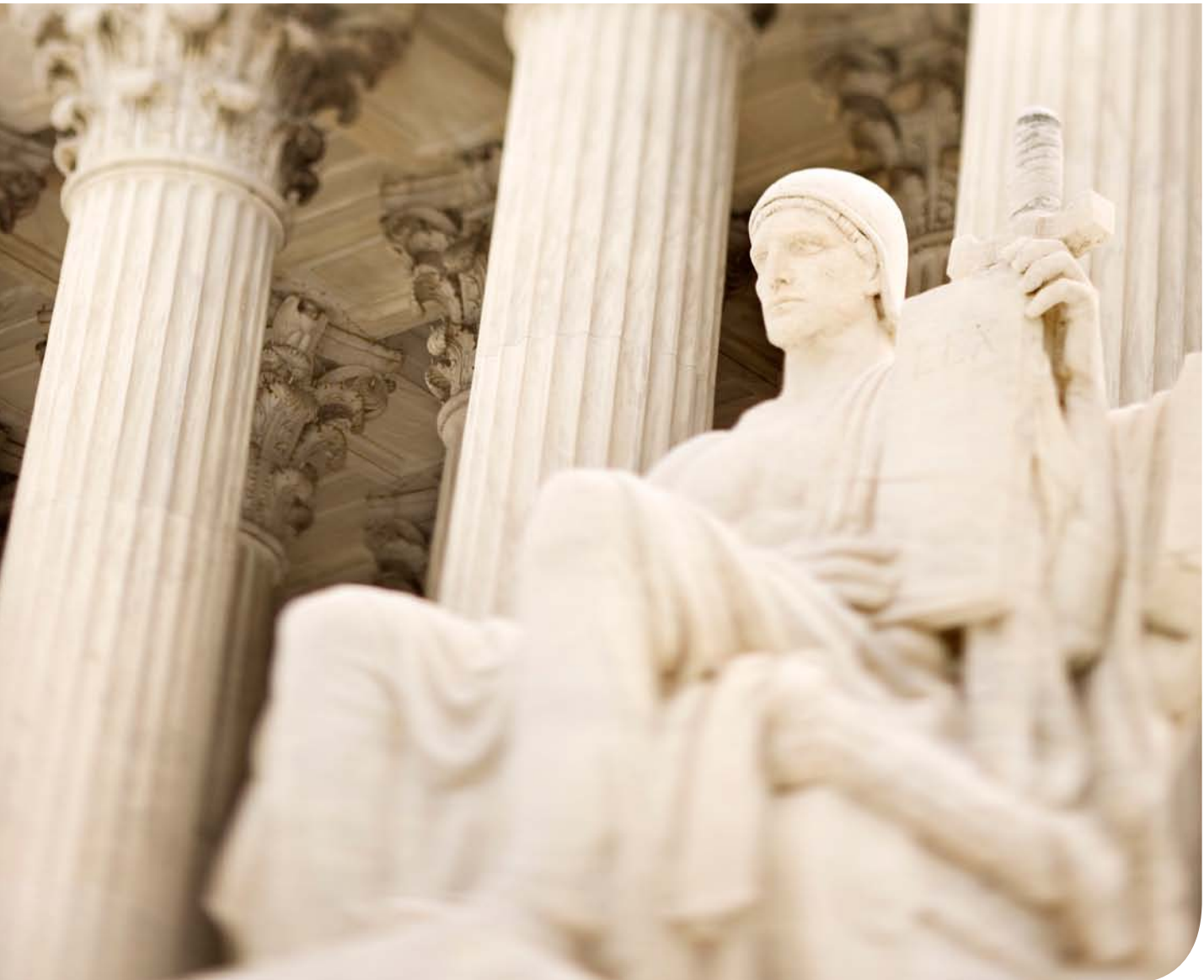


# Federal Mental Health Parity

A Summary of the Interim Final Rules:  
What You Need to Know



**This requirement will take effect for plans on the first day of their plan year which begins or renews on or after July 1, 2010.**

# Interim Final Rules

## Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

### What is it?

The MHPAEA was signed into law on October 3, 2008 and required three federal agencies — the Treasury (IRS), Labor, and Health and Human Services — to draft and publish implementing regulations. The regulations were published in the Federal Register on February 2, 2010 at 75 FR 5410. A copy of the regulations can also be obtained online at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>.

The regulations were published as an “Interim Final Rule” (the “Rule”). This means that, while these rules are official binding regulations (not proposed ones) and must be complied with by plans, the agencies may consider additional comments and information regarding these regulations, and later revise and re-issue them in a Final Rule. Comments on the Rule may be submitted to any one of the three regulatory agencies mentioned above until May 3, 2010 (instructions for submitting comments can be found in the comments section of the published Rule). There is no specified timetable for when the Final Rule will be issued.

### When does it take effect?

The effective date of these regulations (except for plans which are subject to a collective bargaining agreement) is the first day of the plan year which starts on or after July 1, 2010. For example, if the plan year runs on a calendar-year basis, the effective date would be January 1, 2011.

Plans that are subject to a collective bargaining agreement that was executed prior to October 3, 2008 have to comply with the regulations on either July 1, 2010 or on the day the last of the collective bargained agreements related to the plan expires, whichever is later.

### Who does it cover?

All plans that are subject to the MHPAEA are subject to the Rule *except* for Medicaid Managed Care Plans. Those plans will be subject to separate regulations from the Center for Medicare & Medicaid Services (CMS), which are forthcoming. No specific timetable has been announced for the release of those separate regulations.

Note: Medicare Advantage plans are not subject to the parity law or these regulations unless they are a group plan sponsored by an employer.

## The Interim Final Rule: Key Provisions

### General

- The Rule updates the prior 1996 federal mental health parity law — which applied to annual and lifetime dollar maximums for benefits for mental health disorders only — to now apply to *both* mental health and substance use disorder benefits.
- The Rule *does not mandate coverage* of any mental health and substance use disorder benefits. However, if a plan chooses to provide coverage for mental health and substance use disorder benefits, it must do so in compliance with the Rule. Plans may, subject to state law mandates for fully insured plans, define which conditions they will cover and which they will not.
- The Rule adds some additional terms and clarifies the meaning of existing terms contained in the law. We will discuss these terms in the context of the various provisions of the Rule in the following section.

## Parity Regulations For Financial Requirements and Treatment Limitations

### General Requirement

- As stated in the MHPAEA, *plans must ensure that the financial requirements and treatment limitations applied to mental health and substance use disorder benefits are no more restrictive than those applied to medical/surgical benefits.* The Rule amplifies and explains the basis for determining this parity.

### Key Terms

- **“Classification” of benefits:** The Rule establishes six classifications of benefits:
  - Inpatient, in-network (IIN)
  - Inpatient, out-of-network (ION)
  - Outpatient, in-network (OIN)
  - Outpatient, out-of-network (OON)
  - Prescription drugs
  - Emergency

*Parity must be determined on a classification-by-classification basis.*

This means parity is assessed for each requirement or limitation between medical/surgical benefits and mental health and substance use disorder benefits of the same classification. If a plan offers medical benefits in one classification, it must also provide mental health and substance use disorder benefits in that classification as well.

- **“Type” of financial requirements and treatment limitations:** This refers to a requirement or limitation of the same nature (e.g., copayments or annual day limits are different “types” of requirements/limitations).
- **“Level” of requirements/limitations:** The magnitude of a single type of requirement. For example, different levels of copayments (e.g., \$10 and \$25) within a single classification of benefits.

- **“Coverage Unit”:** The groupings of individuals covered by the plan (e.g., individual, individual-plus-spouse, family). Because requirements and limitations may vary by coverage unit, the Rule specifies that general parity be assessed separately for separate coverage units.

### Financial Requirements and Quantitative Treatment Limitations

The Rule clarifies how to apply the general parity requirement to financial requirements (copayments, coinsurance, deductibles) and quantitative treatment limitations (e.g., day limits, visit limits, number of episode limits, etc.). The method is as follows:

1. Determine whether a type of requirement or treatment limitation applies to “substantially all” medical/surgical benefits — meaning two-thirds or more of the medical/surgical benefits within the specific classification of benefits. *“Substantially all” is based on the dollar amount of plan payments for benefits as determined by any reasonable method of the plan’s choosing.*
2. If a type of financial requirement or treatment limitation does not apply to “substantially all” medical/surgical benefits in a classification of benefits, it cannot be applied to mental health or substance use disorder benefits in that classification.  
  
Example: If, for the outpatient, in-network classification, *less* than two-thirds of the benefits are subject to a copayment, then a copayment *cannot* be applied to the outpatient, in-network mental health and substance abuse benefits.
3. If a single level of a type of requirement or limitation applies to at least two-thirds of the benefits in a classification, then that is also considered the “predominant” requirement or limitation, which must be applied to mental health and substance use disorder benefits in the same classification.

Example: If the medical/surgical benefits have only one level of copayment for all outpatient, in-network services (say, \$20), then that is the “predominant” requirement and the outpatient, in-network copayment for mental health and substance use disorder services cannot be more restrictive than that “predominant” copayment (so the mental health and substance use disorder copayment would need to be, in this case, \$20 or less).

4. If there is more than one level of a type of a requirement or limitation, then further analysis must be done to determine which of the various levels is the “predominant” level. *The “predominant” level is the one which applies to more than half of all the benefits (again based on cost as noted under No. 1 above), which are subject to that type of requirement/limitation.*

Example: A plan’s medical/surgical benefits provide two levels of copayments for outpatient, in-network benefits: primary care at \$20 and specialty care at \$30. Upon analysis, the plan assesses that the \$20 copayment applies to more than half of the total plan payments for these benefits (and is considered the “predominant” copayment). Therefore, the copayment for outpatient, in-network mental health and substance use disorder benefits must be \$20 or less.

If no single level is considered to be “predominant,” then the Rule discusses combining levels until at least half of the benefits are subject to the requirement, and then the least restrictive level of those used to reach that one-half threshold is considered the “predominant” level.

5. If a plan provides benefits for more than one coverage unit and applies different levels of a requirement/limitation based on coverage unit, then the “predominant” level is determined separately for each coverage unit.

In regards to benefits for prescription drugs, the Rule allows these benefits to be tiered based on “reasonable” factors (including cost, efficacy, generic vs. brand-name, and mail order vs. pick-up). Parity is to be assessed separately based on these tiers.

## Cumulative Financial Requirements and Cumulative Treatment Limitations

The Rule defines “cumulative financial requirements” and “cumulative treatment limitations” as ones that apply across covered expenses/treatments and which determine whether, and to what extent, benefits are provided. The most common examples are deductibles and out-of-pocket maximum limits.

The Rule expressly *prohibits the use of separate cumulative financial requirements and cumulative treatment limitations for mental health and substance use disorder benefits*. If a plan wishes to use such requirements and limitations, they must be applied in a combined fashion and applied to *both* medical/surgical benefits and mental health and substance use disorder benefits.

The only exceptions to this prohibition are for the annual and lifetime dollar limits on benefits. As stated in the earlier 1996 federal parity law, these may be maintained separately for mental health and substance use disorder benefits.

## Non-Quantitative Treatment Limitations

The Rule defines the category of “treatment limitations” from MHPAEA to include non-quantitative treatment limitations. The Rule specifically identifies six of these (though it notes that there may be others):

1. Medical management standards limiting or excluding benefits based on medical necessity or appropriateness, or based on whether the treatment is experimental or investigational
2. Formulary design for prescription drugs
3. Standards for provider admission to participate in a network, including reimbursement rates
4. Plan methods for determining usual, customary and reasonable charges

5. Exclusions or limitations on particular therapies or treatments, unless another alternative treatment is attempted as a pre-condition — known as “fail first” or “step therapy” protocols
6. Exclusions based on failure to complete a course of treatment

*The Rule requires these non-quantitative treatment limitations to be in parity.* Specifically, any processes, strategies, evidentiary standards, or other factors used in applying non-quantitative treatment limitations must be comparable for both medical/surgical benefits and mental health and substance abuse disorder benefits.

The “processes” used to apply medical management standards (No. 1 above) include elements such as pre-authorization, concurrent review, retrospective review, case management, and utilization review.

The Rule explicitly notes that EAP “gatekeeper” models — where a plan requires people to use all of their EAP visits before using the mental health and substance use disorder benefits — are a prohibited form of a “fail first” protocol (No. 5 above) because it has no equivalent on medical/surgical plans.

### Availability of Plan Information and Plan Denial Disclosure Requirements

The MHPAEA contained two requirements for disclosure by plans:

1. The plan must provide the criteria for medical necessity determinations to any current or potential participant, beneficiary, or contracting provider upon request.
2. The plan must provide the reason for any denial of reimbursement or payment for services with respect to benefits under the plan.

These requirements already exist under other federal and state laws, and OptumHealth is in compliance with these requirements. According to the Rule, plans that meet these requirements under existing federal and state laws will be deemed compliant with these requirements under MHPAEA to the same extent.

### Miscellaneous Provisions

- **Separate plans by an employer/ plan sponsor:** All medical care benefits provided by an employer or plan sponsor constitute a single group health plan for parity purposes. This means that an employer/plan sponsor cannot avoid parity requirements by establishing a separate group health plan just for mental health and substance use disorder benefits.
- **Applying parity to separate coverage plans:** Parity requirements for a single mental health and substance use disorder benefit package (e.g., a carve-out) and multiple medical/surgical coverage plans or benefit packages must be applied to *each* combination of medical/surgical and mental health and substance use disorder benefits.
- **Interaction with state laws:** State laws are only superseded or preempted if they prevent the application of the MHPAEA or the Rule. In most cases, this will not occur. However, state autism mandate laws in some cases specify benefit annual maximums. It appears these limits will conflict with MHPAEA and the Rule, and would thus be preempted.
- **Small employer exemption:** Employers with 50 or fewer employees are exempt from parity requirements.
- **Cost-based exemption:** Prior regulations applicable to the 1996 federal parity law are repealed and new rules will be issued shortly (no timeline specified) regarding qualification for a cost-based exemption from MHPAEA. In the meantime, the Rule does note that:
  - To qualify for a cost-based exemption, a plan must experience at least a 2% increase on total plan costs in the first plan year of parity.
  - A cost-based exemption is good for a single year only.
  - The cost-based exemption can only be claimed every other year.

## Some Requirements Remain Unclear

The Rule contains some language which remains ambiguous and open to interpretation. For example, the standards for determining that non-quantitative treatment limitations are in parity are unclear (e.g., how does a plan determine that its methodology for usual, reasonable and customary charges is in parity?). We expect further guidance will be forthcoming from the regulatory agencies through informational sessions and bulletins. We will provide timely updates of this guidance to you as they become available.



## OptumHealth<sup>SM</sup>

### Behavioral Solutions

OptumHealth Behavioral Solutions stands ready to help you with planning and preparation for the new federal parity law. Call your Account Management representative today.

This document is for informational purposes only. We recommend you seek advice of counsel in assessing the requirements of the law and the impact on your plan.

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