

Legislative Update

New Requirements for Mental Health and Substance Use Disorder Coverage

EXECUTIVE SUMMARY

On February 2, 2010, Interim Final Rules regarding coverage for treatment of mental health and substance use disorders were issued. The new Interim Final Rules implement the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and apply to employers with 50 or more workers who offer mental health or substance use disorder benefits in a group health plan.

Group health plans do not have to provide mental health or substance abuse benefits. But if they do, plans must:

- Offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits.
- Treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review used by the insurer for medical and surgical benefits.
- Contain a single combined deductible for mental health and medical/surgical coverage.
- Comply with the new rules for plan years that begin **on or after July 1, 2010**. Note that the MHPAEA has been effective since October 3, 2009 and employers should already be in good faith compliance.



This Chelko Consulting Group Legislative Brief provides an overview of the Interim Final Regulations. Please read below for more information and contact the Chelko Consulting Group with any questions.

OVERVIEW OF THE PARITY REQUIREMENTS

The Laws

The MHPAEA and the Mental Health Parity Act of 1996 (MHPA) together require parity between medical/surgical benefits and mental health or substance use disorder (MH/SUD) benefits with respect to aggregate lifetime and annual dollar limits, financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits). The MHPAEA and MHPA do not mandate that a plan provide MH/SUD benefits; however, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the laws' parity provisions.

The laws apply to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully-insured arrangements. The laws also apply to health insurance issuers who sell coverage to employers with more than 50 employees.

The Regulations – What's New?

Interim Final Rules which implement the MHPAEA were issued on February 2, 2010. Parity requirements may now apply to a broader category of health plans, because of new rules where combinations of medical/surgical benefits and MH/SUD benefits may be treated as a single plan.

What Are Some of the New Rules Plans Need to Consider?

- **Financial Requirements** – The general parity requirements are extended to financial requirements, such as co-pays and co-insurance.

Under the MHPAEA, a plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply a more restrictive financial requirement or treatment limitation to mental health or substance use disorder benefits of any type in a particular classification than the "predominant" financial requirement or treatment limitation of the same type applied to "substantially all" medical/surgical benefits in the same classification. The Interim Final Rules provide for six classifications for determining the "predominant" requirements and limits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

Under the Interim Final rules, a financial requirement or treatment limitation generally applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in the classification. A financial requirement or treatment limitation generally will be considered "predominant" if it applies to more than one-half of medical/surgical benefits subject to the financial requirement or treatment limitation in that classification. The Interim Final Rules clarify that the predominance test should be applied separately for each type of financial requirement or treatment limitation. This test requires calculations of the plan's projected claims payments for medical benefits in each of the six classification for the plan year.

Within any given classification, the requirements and limits imposed on mental health/substance abuse benefits may be no more restrictive than the predominant requirements and limits applicable to medical/surgical benefits. For example, a group health plan may apply a copayment to all in-network benefits and apply a separate, higher copayment to all out-of-network benefits, provided the mental health/substance use disorder and medical/surgical benefits are treated the same within each classification. Note that the Interim Final Rules do not permit plans to make distinctions on the basis of classifications other than those listed. For example, it would be problematic to impose a higher copayment for services from a mental health specialist than for a primary care provider (*e.g.*, an internist).

Generally, if a plan provides mental health or substance use disorder benefits in any of the six classifications of benefits, mental health or substance use disorder benefits must be provided in

every classification in which medical/surgical benefits are provided. For example, if a plan does not provide any out-of-network medical/surgical coverage, the plan would not have to provide out-of-network mental health/substance use disorder coverage.

The Interim final Rules provide additional guidance about applying these standards to specific situations and their application to particular plans may be complex.

- **Deductibles** - Combined deductibles are required for MH/SUD benefits and medical/surgical benefits. Separate deductibles are now prohibited. That is, a plan may not apply one deductible to MH/SUD benefits and another deductible to medical/surgical benefits.
- **MH/SUD Benefits** - So that benefits are not misclassified, plans must use generally recognized independent standards of current medical practice in defining whether benefits are MH/SUD benefits.
- **Treatment Limitations** - Both quantitative (e.g., visit limits) and nonquantitative (e.g., medical management standards) treatment limitations are subject to the parity requirements.
- **Coverage Units** - Plans must apply parity requirements for financial requirements and treatment limitations based on each "coverage unit" (e.g., self-only, family, and employee plus spouse).
- **Prescription Drugs** - Plans are permitted to divide prescription drug coverage into tiers and apply the parity requirements separately to each tier of drug coverage based upon reasonable factors such as cost, generic versus brand name, and mail order versus pharmacy pick up.
- **Disclosures** - Disclosures from ERISA plans can follow existing requirements. Plans not subject to ERISA must provide disclosures within a reasonable time and in a reasonable manner.
- **Exemptions** - If applicable, the increased cost exemption can only be claimed for alternating years.

Medical management standards - the Interim Final Rules will limit what plan sponsors can and cannot do in the area of the pre-certification of mental health or substance use disorder treatments. The Interim Final Rules describe this area of activities as "nonquantitative treatment limitations."

Plans impose a variety of limits affecting the scope or duration of benefits under the plan that are not expressed numerically. Nevertheless, these nonquantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan. The Interim Final Rules provide an illustrative list of nonquantitative treatment limitations, including medical management standards; prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary, and reasonable amounts; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment.

The Interim Final Rules generally prohibit the imposition of any nonquantitative treatment limitation to mental health or substance use disorder benefits unless certain requirements are met. Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical surgical/benefits in the classification. However, these requirements do allow variations to the extent that recognized clinically appropriate standards of care may permit a difference.

Steps to Take Now

Plan sponsors should become familiar with the Interim Final Rules and review their health plans. It is likely that additional plans may now be subject to the parity requirements. Plans will need to evaluate whether any substantive changes must be made to their plan designs, such as providing for a combined deductible. Plans will also need to review their administration of benefits in order to ensure that administrative procedures are in compliance by the regulatory deadline.

Stay Tuned ...

The MHPAEA Interim Final Rules are intended to address the most pressing issues that affect the ability of plans and issuers to comply in the near term. However, stay tuned for additional rules and further helpful examples. The Departments are soliciting public comments until May 3, 2010; on areas including "scope of services," "continuum of care" and the increased cost exemption.


For more information contact your Chelko Consulting Group representative at (440) 892-2600.

For a copy of the MHPAEA, see: www.govtrack.us/congress/bill.xpd?bill=h110-1424

For a copy of the Interim Final Regulations, see: edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

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