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Interim Final Regulations for the Mental Health Parity and Addiction Equity Act of 2008

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Introduction

On January 29, 2010, the Departments of Treasury, Labor and Health and Human Services (the "Departments") jointly issued interim final regulations (the "Regulations") under the Mental Health Parity and Addiction Equity Act of 2008 (the "Act" or "MHPAEA"). The Act requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage in connection with a group health plan. MHPAEA was enacted on October 3, 2008 and amends the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the Internal Revenue Code of 1986, as amended (the "Code") and the Public Health Service Act ("PHS Act"). The Regulations replace prior regulations, make conforming changes to reflect modifications MHPAEA made to the original Mental Health Parity Act of 1996 ("MHPA") and incorporate new parity standards.

MHPAEA applies to (i) group health plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements; and (ii) health insurance issuers who sell coverage to employers with more than 50 employees. Significantly, although MHPAEA provides substantial new protections to participants in group health plans, it does *not* mandate that a plan provide mental health or substance use disorder benefits. Rather, if a plan provides mental health/substance use disorder benefits along with medical/surgical benefits, it must comply with MHPAEA's parity provisions.

MHPAEA Expands The MHPA

As noted above, in 1996, Congress enacted MHPA, which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. However, MHPA did not apply to substance use disorder benefits. MHPAEA continued the MHPA parity rules as to limits for mental health benefits and amended them to extend to substance use disorder benefits.

MHPAEA Protections Relating To Financial Requirements And Treatment Limitations

The general parity requirement under the Regulations states that if a plan or issuer that offers medical/surgical and mental health/substance use disorder benefits imposes financial requirements[1] or quantitative treatment limitations[2], the financial requirements or treatment limitations applicable to mental health/substance use disorder benefits can be no more restrictive than the "predominant"[3] financial requirements or treatment limitations applied to "substantially all"[4] medical/surgical benefits. In light of the fact that plans often vary the financial requirements and treatment limitations imposed on benefits based on whether a treatment is provided on an inpatient, outpatient or emergency basis; whether a provider is a member of the plan's network or whether the benefit is specifically for a prescription drug, the Regulations provide that the "predominant/substantially all" test applies on a classification-by-classification basis based on six classifications of benefits: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency; and (vi) prescription drugs.

Parity is generally required within these classifications and within coverage tiers (*i.e.*, single coverage/family coverage) but not across them. For example, assume a group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes the following financial requirements: (i) $500 deductible for all benefits, (ii) coinsurance requirement for inpatient medical/surgical benefits, and (iii) co-payments for outpatient medical/surgical benefits. In this example, because the plan has no network of providers, all benefits providers are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the general parity requirements apply separately to each classification. If a plan does not offer benefits in a particular classification (*e.g.*, outpatient, out-of-network) for medical/surgical services, the plan is not required to provide benefits for mental health conditions or substance abuse disorders of the same classification (*i.e.,* on an outpatient, out-of-network basis).[5]

The Regulations do not permit classifications other than the six named above. The Preamble to the Regulations specifically states that MHPAEA does not allow the separate classification of generalists and specialists in determining the predominant requirement that applies to substantially all medical/surgical benefits. This will require changes for those plans that currently classify mental health providers as “specialists” and apply more restrictive financial requirements or treatment limitations to those specialists than those that are applied to generalists.

The Regulations also explain how the parity requirements apply to cumulative financial requirements and quantitative treatment limitations, including deductibles. While financial requirements such as co-payments and co-insurance generally apply separately to each covered expense, other financial requirements, such as deductibles, accumulate across covered expenses. The Regulations clarify that a plan cannot have deductibles accumulate separately for medical/surgical benefits on the one hand, and mental health/substance use disorder benefits on the other, even if the levels of the two deductibles are the same. Accordingly, expenses for both medical/surgical benefits and mental health/substance use disorder benefits must accumulate to satisfy a single combined deductible or similar cumulative financial requirement.

Special Rule For Prescription Drug Benefits

The Regulations recognize the potential complications of applying the general parity requirement to a prescription drug program that imposes different financial requirements for different tiers of drugs. Because the placement of a drug in a tier is generally based on factors unrelated to whether the drug is usually prescribed for the treatment of a medical/surgical condition or a mental health condition/substance use disorder, the Regulations establish a special rule for applying the general parity requirement to prescription drug benefits. Specifically, if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic versus brand name and mail order versus pharmacy pick-up), and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health/substance use disorder benefits, the plan already satisfies the parity requirements with respect to the prescription drug classification of benefits.

For example, if a plan characterizes prescription drugs across four tiers (*e.g.,*Tier 1 is generic drugs; Tier 2 is preferred brand name drugs; Tier 3 is non-preferred brand name drugs; and Tier 4 is specialty drugs) and the plan pays a different percentage of the cost of a prescription drug based on such drug's tier, the plan would meet the parity requirements of the Regulations so long as the percentage of the cost paid by the plan was based on the prescription drug's tier and not whether the drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health/substance use disorder benefits.

Additional MHPAEA Protections Relating To Nonquantitative Treatment Limitations

Because nonquantitative treatment limitations (such as medical management standards, formulary design and determination of usual/customary/reasonable amounts) are not expressed numerically, the Regulations include a separate parity requirement for such limitations. Specifically, any processes, strategies, evidentiary standards or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits within 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 with respect to medical/surgical benefits in the classification.

In addition, employee assistance programs (“EAP”) cannot serve as gatekeepers, restricting or directing mental health care or substance use disorder treatment, by requiring participants to exhaust the EAP benefits unless a similar exhaustion requirement exists for medical/surgical benefits.

MHPAEA Availability Of Plan Information Requirements

MHPAEA sets forth two new disclosure provisions that require plans to make certain information available with respect to mental health/substance use disorder benefits. First, the criteria for medical necessity determinations with respect to mental health/substance use disorder benefits must be made available to any current or potential participant, beneficiary or contracting provider upon request.

Second, MHPAEA provides that the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits must be made available, upon request or as otherwise required, to the participant or beneficiary. The Regulations clarify that for plans subject to ERISA to satisfy this requirement, disclosures must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations. In the case of non-Federal governmental plans and church plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, compliance with the form and manner of the ERISA claims procedure regulations for group health plans satisfies this disclosure requirement.

Increased Cost Exemption

MHPAEA also includes an increased cost exemption under which, if certain requirements are met, plans that incur increased costs above a certain threshold, as a result of the application of the parity requirements, can be exempt from the statutory parity requirements. The Departments intend to issue guidance implementing the new requirements for the increased cost exemption in the near future and invite comments on implementing the new statutory requirements for the exemption.

Effective Date

While the Regulations are being adopted on an interim final basis with a 90 day public comment period, the Regulations are effective as of April 3, 2010, and generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. There is a special effective date for certain collectively-bargained plans, which states that, in the case of group health plans maintained pursuant to one or more collective-bargaining agreements ratified prior to October 3, 2008, the Act does not apply to plan years beginning before the later of: (i) the date on which the last of the collective-bargaining agreements relating to the group health plan terminates; or (ii) July 1, 2010.

This Client Alert is only a brief summary of a significant guidance published by the Departments. Plan Sponsors and fiduciaries should review, with the assistance of counsel, their current plan provisions regarding mental health or substance use disorder benefits to determine the appropriate steps that must be to comply with the Regulations.

If you have any further questions regarding the Departments' guidance or require assistance in MHPAEA compliance, please contact any of the attorneys listed above.

[1] Examples of financial requirements include: deductibles, co-payments, co-insurance and out of pocket limitations.
[2] Since they are similar to financial requirements, quantitative treatment limitations are subject to the same general test as the financial requirements. Examples of quantitative treatment limitations include frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.
[3] The predominant level of a type of financial requirement or quantitative treatment limitation is the level that applies to more than one-half of medical/surgical benefits in the classification. If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or treatment limitation in a classification, plan payments for multiple levels of the same type of financial requirement or treatment limitation can be combined by the plan.
[4] Under the regulations, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification.

[5] If a plan or issuer that offers medical/surgical benefits on an out-of-network basis also offers mental health/substance use disorder benefits, it must offer the mental health/substance use disorder benefits on an out-of-network basis as well.

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