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Does Your Health Plan Violate the New Mental Health Parity Rules?

by Stephanie Smithey, Ellen Foody and Tim Stanton

New regulations are giving employers their first glimpse of the mental health and substance abuse benefit changes that may be needed by 2011 to ensure that their health plans do not violate the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("New Mental Health Parity Act").

Published in the February 2 *Federal Register* and jointly issued by the IRS, the Department of Labor and the Department of Health and Human Services, the interim final regulations will require employers to consider – or, in many cases, reconsider – issues such as:

- Separate deductibles for mental health/substance abuse and standard medical/surgical benefits.
- Medical management standards, prescription drug formulary design and other "nonquantitative" treatment limitations that plans set for mental health and substance abuse benefits.
- Operational differences between how mental health and substance abuse benefits are administered and how medical benefits are administered.
- How the general parity rule applies to a multi-tiered prescription drug program.
- Specialist copays that could apply to nearly all mental health or substance use claims, but only a fraction of medical claims.

Though these regulations withdraw prior rules that date to 1997, they do not answer all employer questions about the New Mental Health Parity Act – such as questions concerning the exemption from the requirements for plans that experience certain cost increases from compliance. The regulators are seeking comments generally and on several specific questions through May 3, 2010.

Original Law

Congress first mandated parity for mental health benefits provided through employer health plans in 1996. Under the Mental Health Parity Act, plans could not place different lifetime or annual dollar limits on mental health benefits than they placed on medical benefits. This restriction was quickly circumvented, however, with other restrictions including different deductibles and co-payments and treatment limits based upon the number of days or visits a plan would cover in a year.

New Mental Health Parity Act

The New Mental Health Parity Act not only closes that loophole from the old law, but it expands the mandated parity requirements to benefits for addictions and substance abuse (referred to in the regulations as "substance use disorder benefits"). The resulting legislation is broad, yielding complex, comprehensive regulations that will require most employers to amend their group health plans. The new law does not mandate that a group health plan provide mental health or substance use disorder benefits. In addition, it does not change the plan's terms relating to the amount, duration or scope of mental health or substance use disorder benefits. Instead, the new law focuses on those plans that provide both medical/surgical and either mental health or substance use disorder benefits, imposing parity by precluding disparate limitations that are more restrictive for mental health and substance use disorder benefits.

The new regulations also close one other potential loophole. Plan administrators may have considered defining plan terms in ways that would have certain treatments or services characterized as medical, rather than mental health benefits, and therefore would not be subject to these protections. Under the new regulations, mental health and substance use disorder benefits must be defined by plans in ways that are consistent with generally recognized independent standards of current medical practice.

General Rules for Lifetime and Annual Dollar Limits

If a group health plan does provide both medical/surgical benefits and either mental health or substance use disorder benefits, then it must comply with one of three general rules with regard to lifetime and annual dollar limits:

(1) If the plan does not contain a lifetime or annual dollar limit on medical or surgical benefits, or if the plan includes a lifetime or annual limit that applies to less than one-third of all medical or surgical benefits expected to be paid out in the year, then the plan may not impose a lifetime or annual limit on mental health or substance use disorder benefits.

(2) If the plan includes a lifetime or annual limit on at least two-thirds of all medical or surgical benefits expected to be paid out in the year, it must either (a) apply the lifetime or dollar limit to both the medical/surgical benefits and to the mental health or substance use disorder benefits in a manner that does not distinguish between the types of benefits (*i.e.*, on a combined level); or (b) not include a lifetime or annual limit on the mental health or substance use disorder benefits that is less than the lifetime or annual limit on the medical/surgical benefits.

(3) If the plan does not fit into the description of (1) or (2) above, then the plan must either impose no lifetime or annual limit on mental health or substance use disorder benefits, or must impose a lifetime or annual limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits, determined by taking into account the weighted

average of the lifetime or dollar limits that are applicable to the medical/surgical benefits.

General Rules for Financial Requirements and Treatment Limitations

At the core of the New Mental Health Parity Act is the restriction on applying financial requirements or treatment limitations to mental health and substance use disorder benefits that are more restrictive than those most commonly applied to medical benefits. The new regulations helpfully restate the general rule this way:

> A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any *financial requirement* or *treatment limitation* to mental health or substance use disorder benefits *in any classification* that is more restrictive than the *predominant* financial limitation or treatment requirement *of that type* applied to *substantially all* medical/surgical benefits *in the same classification*. [emphasis added]

The new regulations add detail to or define many of these highlighted concepts. For this purpose, the law permits the plan to distinguish between six classifications of benefits: inpatient, in-network; in-patient, out-of-network; outpatient, in-network; outpatient, out-of network; emergency care; and prescription drug. Limitations and requirements are applied by "type." For example, copayments are compared to copayments within a classification, and deductibles are compared to deductibles within a classification. "Substantially all" is interpreted to mean two-thirds of the benefits a plan expects to provide for the year.

Applying this general rule to a financial requirement or to many treatment limitations requires a two-step analysis, applied to the dollar amount of all plan payments for medical/surgical benefits in the applicable classification. This analysis first requires a determination of whether the limit applies to "substantially all" of the medical/surgical benefits in the classification, which means at least two-thirds of the benefits, in a certain classification, that the plan expects to provide in the relevant year. If so, the analysis next requires a determination of whether the limit is more restrictive than the predominant limit of the same type, which means the limit that applies to more than one-half of the medical/surgical benefits that the plan expects to pay out that year and that are subject to the same type of limit in a classification. If it is more restrictive, it violates the new law.

Cumulative Limits

Separately, this rule precludes a plan from applying any cumulative financial requirements or cumulative treatment limits for mental health or substance use disorder benefits if the limit accumulates separately from a limit for medical/surgical benefits in the same classification. For example, a plan may not apply one cumulative deductible to mental health and substance abuse benefits and another cumulative deductible to medical/surgical benefits, even if those deductibles are the same amount. The same rule would apply to prohibit separate out-of-pocket maximum limits.

Nonquantitative Treatment Limits

The general rule of the New Mental Health Parity Act is applied differently to treatment limitations that are "nonquantitative," that is, limits that affect the scope or duration of plan benefits but are not expressed numerically. A plan generally cannot impose a nonquantitative treatment limit on mental health or substance use disorder benefits in any classification unless the plan terms used to apply such limits are *comparable*, and *not applied more stringently than*, the terms for medical/surgical benefits in the same classification, unless recognized clinically appropriate standards of care justify a difference.

For this purpose, nonquantitative treatment limits include, but are not limited to, medical management standards (including limits on non-medically necessary, experimental, or investigative treatments), prescription drug formulary designs, admissions for network participation, procedures for determining usual, customary, and reasonable charges, step therapy requirements, and exclusions based upon the failure to first complete a particular course of treatment.

For example, a claim administrator with discretion to approve benefits based upon medical necessity may not use that discretion to approve medical claims but to deny mental health claims, unless some recognized clinically appropriate standard justifies the difference. Ensuring parity in plan administration and use of discretion likely will be more challenging in plans that use different claims administrators for different types of benefits.

Another example of a plan design that could violate these rules would be any requirement that participants first exhaust benefits provided through an employee assistance program (EAP) before they will be eligible for the plan's mental health or substance use disorder benefits. This type of gate keeping would violate the law absent a similar requirement on medical/surgical benefits.

Special Rule for Prescription Drug Benefits

A special rule for prescription drug benefits permits plans 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, efficacy, generic versus band name, and mail order versus pharmacy pick-up).

What Must You Review to Avoid Violating the New Law?

The following is a non-exhaustive list of items you will want to review in your health plans for compliance with the New Mental Health Parity Law, in addition to your plan's administrative practices:

- Lifetime limits
- Annual limits
- Separate benefits for generalists and specialists
- Day limits
- Visit limits
- Frequency of treatment limits
- Medical management
- Formulary design
- Step therapy
- Deductibles
- Co-payments
- Co-insurance amounts
- Separately accumulating financial requirements
- Separately accumulating treatment limits
- Use of discretion to approve/deny claims
- Preauthorization
- Concurrent review
- Retrospective review
- Case management
- Utilization review
- Requiring exhaustion of EAP benefits

These rules apply to group health plans offering both medical/surgical and either mental health or substance use disorder benefits, and apply separately to any combination of those benefits that a participant may elect as a benefit option. All such options offered by an employer will be treated as a single plan for purposes of these rules, so that it is not possible to avoid the requirements of the rule by separating medical/surgical benefits into one plan and mental and/or substance use disorder benefits into another plan.

What Plans Are Exempt from the New Mental Health Parity Act?

Small group health plans provided by employers of an average of at least two but no more than 50 employees during business days during the prior calendar year are exempt from this law. In addition, under the terms of the New Mental Health Parity Act itself, there is a cost-based exemption if the employer can prove, with actuarial certification, that complying with the new rules raised its actual health benefit costs two percent or more in the first year and one percent or more in later years. That exemption would last only one year, so an employer would have to remove any inappropriate limitations at the end of that year, remain compliant with the law for at least six months and then rerun the calculations in order to qualify for another one year exemption. These regulations do not yet address how to meet that requirement, but more guidance is anticipated on that topic.

Availability of Plan Information

The New Mental Health Parity Act requirements include two new disclosure provisions for group health plans. First, plan administrators must make available upon request from any current or potential participant, beneficiary, or contracting provider the criteria for medical necessity determinations made under the group health plan with respect to mental health or substance use disorder benefits. Second, a plan administrator must provide to a participant or beneficiary the reason for any denial of a claim for reimbursement or payment for services with respect to mental health or substance use disorder benefits. The new regulations state that if the plan is subject to the Employee Retirement Income Security Act (ERISA), it must provide the reason in a form and manner consistent with ERISA's claims procedures for group health plans. Plans that are not subject to ERISA must provide the reason within a reasonable time and in a reasonable manner.

Interaction with State Insurance Laws

While the New Mental Health Parity Act requirements do not supersede any provision of state law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage, they do prohibit the sale of a non-compliant policy to a health plan subject to the New Mental Health Parity Act. For example, if a state mandates that an insurer offer minimum mental health or substance use disorder benefits and those mandated benefits do not comply with the New Mental Health Parity Act requirements, the insurer may need to provide additional mental health or substance use disorder benefits in order to sell that policy to plans covered by the New Mental Health Parity Act.

Effective Date

Generally, the new rules will apply for plan years beginning on or after July 1, 2010. Be aware, however, that the New Mental Health Parity Act became effective October 3, 2009, and the new interim final regulations will be effective 60 days after they are published, or April 5, 2010. Therefore, even though those regulations reflect a regulatory intent to honor good faith efforts to comply with the law, they warn that an individual could sue claiming a violation of the law that occurred after it took effect (*i.e.*, for plan years starting after October 3, 2009). As a result, plan documents that are in place this year but do not provide parity in mental health and substance abuse benefits as mandated by the statute may give

rise to exposure for an individual lawsuit, even if the plan is not yet required to comply with these new regulations.

Additional Information

To discuss these or other employee benefit issues, contact a member of the firm's Employee Benefits and Executive Compensation Practice Group, or the Client Services Department at 866-287-2576 or via e-mail at clientservices@ogletreedeakins.com.