Compliance Advisory: Final Rules for Mental Health Parity and Substance Addiction Coverage

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Group health plans will now need to ascertain if their efforts to equalize benefits for mental health and substance abuse treatment with the benefits provided for medical and surgical care comply with the Government's new regulations. The Interim Final Rules require plans to adjust their benefits and achieve parity in very short order.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act") became effective for group health plans with plan years beginning after October 3, 2009. The law prohibits group health plans from imposing different financial requirements or treatment limitations on mental health and substance abuse disorder benefits (hereafter collectively referred to as "mental health benefits") than those applicable to medical and surgical benefits. For calendar year plans, the Act became effective on January 1, 2010.

Interim Final Regulations (the "Final Rules") were published by the Departments of the Treasury, Labor and Health and Human Services (the "Departments") in the Federal Register on February 2, 2010. The Final Rules address a number of issues that were left unclear by the Act. For example, the Departments have closed the door on the possibility of the establishment of "separate but equal" financial requirements or treatment limitations for mental health benefits. It also clarified that treatment limitations include so-called "non-quantitative" limitations that may be imposed by medical management programs and formulary designs for prescription drug benefits.

Like the Act, the Final Rules do not require plans to offer mental health or substance abuse benefits (although state laws may mandate insured group health plans to provide certain mental health benefits).

> The Final Rules address a number of issues that were left unclear by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Effective and Applicability Date: While the Final Rules are effective on April 4, 2010, they are not generally applicable to group health plans and group health insurer issuers for plan years beginning on or after July 1, 2010. For collective bargaining agreements ratified before October 3, 2008, the Final Rules do not apply for plan years beginning before the later of either the date on which the last of the collective bargaining agreement relating to the plan terminates or July 1, 2010.

Because the Act became effective October 3, 2009, the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the Act with respect to a violation that occurs before the applicable date of the Final Rules. However, this does not prevent participants or beneficiaries from bringing a private action after the Final Rules' effective date.

The Final Rules amend the regulations issued pursuant to the Mental Health Parity Act of 1996 and include the following changes:

Rules Now Applicable to Annual or Lifetime "Dollar" Limits

The Mental Health Parity Act of 1996 prohibited group health plans from placing annual or lifetime limits on mental health benefits that were lower than annual or lifetime limits for medical and surgical benefits provided under the plan. These requirements will continue, however, the Final Rules are not based on "Aggregate Lifetime Limits." Rather, the Final Rules are based on "Aggregate **Dollar** Lifetime

Limits" and Annual **Dollar** Limits thereby eliminating the possibility of expressing lifetime and annual limits in terms of days or visits. (Emphasis added)

Exceptions

The Final Rules do not apply to (1) plans with no limits or limits on less than one-third of all medical/surgical benefits; (2) plans with a limit on at least two-thirds of all medical surgical benefits if it applies either (a) the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical benefits and mental health benefits or (b) not include an aggregate lifetime or annual dollar limit on mental health benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits; and (3) plans of small employers with not more than 50 employees and (4) plans qualifying for the cost exemption described in further detail below.

It is also important to keep in mind that the Final Rules, just like the Act, do not apply to individual health insurance policies. The Final Rules only apply to ERISA and certain other group health plans.

Rules Requiring Parity in Financial Requirements and Treatment Limits

The Act prohibits group health plans from applying financial requirements or treatment limits for mental health and substance abuse benefits that are more restrictive than the predominant financial requirements and treatment limits that are applicable to substantially all medical and surgical benefits.

The law defines "financial requirements" to include deductibles, copayments, coinsurance and out-of-pocket expenses. The Final Rules also clarify that there can be no separate cumulative financial requirements or cumulative quantitative treatment limitations applied to mental health benefits thereby preventing the implementation of "separate but equal" coinsurance and deductibles applicable to mental health benefits distinct from medical surgical benefits. Cumulative financial requirements include out of pocket maximums.

The prohibition on differing treatment limitations include limits on the frequency of treatment, number of visits, days of coverage, or other limits on the scope or duration of treatment also referred to as quantitative treatment limits. However, the Final Rules clarify that the prohibitions on differing treatment limitations also include non-quantitative treatment limitations. Non-quantitative treatment limitations include medical management standards that limit or exclude benefits based on medical necessity, medical appropriateness, or whether the treatment is experimental or investigative; or based on formulary design. Additional examples are set forth in the Final Rules. The Departments have also included detailed examples of the applicability of non-quantitative treatment limitations including those applicable to multi-tiered prescription drug benefits.

The Final Rules also provide that "substantially all medical/surgical benefits" refers to at least two-thirds of all medical surgical benefits in a "classification of benefits". The regulations specify six classifications of benefits: (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. The Final Rules provide that the parity requirements for financial requirements and treatment limitations are generally applied on a classification-by classification basis and these are the only classifications that may be used for purpose of stratifying the benefits. The classification system essentially prevents circumvention of the rules that could occur if a plan creates a multiple number of benefit classifications in order to "water" down parity.

In addition, a "predominant" level is considered the level that applies to more than one-half of medical/surgical benefits in the classification of benefits that represent the same classification of "substantial benefits." The Final Rules provide detailed descriptions as to the application of these terms.

The Act also requires plans to allow out-of-network mental health or substance abuse benefits if the plan offers out-of-network medical and surgical benefits. The Final Rules also provide that mental health benefits in any classification of out-of-network benefits be in parity with any out-of-network medical and surgical classifications.

The Act imposes two new disclosure requirements on plans that offer mental health benefits. Plans must disclose, upon request, the criteria for medical necessity determinations. Further, the reason for the denial of coverage or reimbursement of such benefits must be given to the participant or beneficiary in accordance with regulations. The Final Rules clarify that, in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to comply with the Final Rules, disclosures must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations. These regulations require (among other things) that such disclosures must be provided automatically and free of charge.

The Act contains a cost exemption if the parity requirements result in an increase of the total plan costs by 2% in the first plan year or 1% in the succeeding years. Exemption determinations of increases on actual costs need to be made and certified by a licensed actuary. The Final Rules clarify that the cost exemption will not apply until a plan has complied with the parity requirements for one full year. The cost exemption is for one plan year increments and the calculations for the exemption are based on the prior year's figures. Thus, the exemption lasts for one year and the increased cost exemption may only be claimed for alternating plan years. It is not clear from the Final Rules if it would be practical for a plan to apply for an exemption given the administrative costs associated with the application process and plan administration.

Request for Comments

Because the Act became effective prior to the issuance of the Final Rule, the Departments have the authority to issue the regulations in a final form, but on an "interim" basis. The Departments are still required to request comments from the public. Comments are due on or before May 3, 2010.

If you have any questions, please contact:

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