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HEALTH LAW ALERT
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Federal Agencies Publish Mental Health Parity Rule

Rules Prohibit Separate Deductible for Mental Health Benefits

Today, the Centers for Medicare and Medicaid Services (CMS), the Internal Revenue Service, and the Employee Benefits Security Administration (collectively, the Federal Agencies) published interim final rules to implement the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Rules expand the "parity" that group health plans and their insurers must provide enrollees with respect to mental health benefits and require the same parity for substance use disorder benefits. Whereas the Mental Health Parity Act of 1996 required parity between mental health benefits and medical/surgical benefits for lifetime and annual limits, MHPAEA and these interim final Rules require parity with respect to all "financial requirements" (*e.g.*, deductibles and copayments) and all "treatment limitations" (*e.g.*, frequency of treatment or number of visits).

Under the Rules, group health plans (and insurers offering group coverage) are prohibited from using "separately accumulating financial restrictions." That means a health plan cannot require, for example, an enrollee to meet one deductible for mental health (or substance use disorder) benefits and a separate deductible for medical/surgical benefits, even if the deductibles are the same. The Rules also require parity between mental health, substance use disorder, and medical/surgical benefits in the application of medical management processes, such as case management, preauthorization, and utilization review.

The Rules, published at 75 *Federal Register* 5409, apply to large group health plans and group health insurance issued to large plans for plan years beginning on or after July 1, 2010. Small (50 or fewer employee) group health plans and individual insurance policies are not affected. The Rules clarify that the Federal law does not require group health plans (or their insurers) to offer mental health or substance use disorder benefits; the Rules only apply when group health plans or their insurers choose to offer such benefits (or are required to offer such benefits under state law).

The Federal Agencies ask for comments on the Rules no later than May 3, 2010. The Rules are codified in 26 C.F.R. Part 54 (Internal Revenue Service), 29 C.F.R. Part 2590 (Employee Benefits Security Administration), and 45 C.F.R. Part 146 (CMS).

The CMS version of the new rule is incorporated into my compilation of Selected Federal Health Insurance Provisions available here or at tbixbylaw.com (*see* the "Resources" page, under "Compiled Rules").

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Parity Requirements

The Rules prohibit group health plans (and health insurance coverage for health plans) from applying any "financial requirement" or "treatment limitation" to mental health or substance use disorder benefits that is more restrictive than "the predominant financial requirement or treatment limitation . . . applied to substantially all medical/surgical benefits." The Federal Agencies apply "parity" broadly to ensure the Rules accomplish legislative goals:

- **Classification of benefits**: Parity is required within each of six "classifications of benefits." The six classifications of benefits are:
    - Inpatient, in-network;
    - Inpatient, out-of-network;
    - Outpatient, in-network;
    - Outpatient, out-of-network;
    - Emergency care; and
    - Prescription drugs.

  Moreover, "if a plan provides any benefits for a mental health condition or substance use disorder, [those] benefits must be provided . . . in each classification for which any medical/surgical benefits are provided." Thus, a health plan that offers outpatient medical/surgical benefits through out-of-network providers must allow outpatient mental health benefits to be furnished by out-of-network providers to the extent the plan offers mental health benefits at all.

- **Type** of requirement or limitation: Parity is required with respect to each type of requirement or limitation, which includes financial limitations (*e.g.*, copayments, coinsurance, or deductibles) and treatment limitations (*e.g.*, annual visit limits, episode visits, or step-therapy protocols). Accordingly, step-protocols may not generally be required for substance use disorders, unless a similar step-protocol applies to "substantially all" medical/surgical benefits (limited exceptions apply).

- **Coverage unit**: Parity is required within each "coverage unit"—single participant, participant with spouse, and family coverage are each distinct coverage units. Hence, a group health plan (or its insurer) must provide "parity" with respect to family deductibles as well as individual deductibles, for example.

The Rules explain in considerable detail how health plans (and their insurers) are to determine "the predominant financial requirement or treatment limitation [that applies] to substantially all medical/surgical benefits." That determination is necessary to establish the requirements and limitations that are allowed to apply to mental health and substance use disorder benefits. In the simplest case, a copayment of $25 that applies to at least two-thirds of all medical/surgical benefits (measured by the dollar amount expected to be paid under the plan) is the maximum copayment the plan may apply to mental health and substance use disorder benefits. The Rules prohibit application of a higher copayment for mental health (or substance use disorder) specialists than for generalists, even if a higher copayment applies in the medical/surgical context.

Separately Accumulating Financial Restrictions and Treatment Limitations

The Rules prohibit health plans (and their insurers) from applying a "cumulative financial requirement" for mental health or substance use disorder benefits that is separate from a "cumulative financial requirement" that applies to medical/surgical benefits. "Cumulative financial requirements" include deductibles and out-of-pocket maximums, but do not include aggregate lifetime or annual limits. Thus, a health plan may not have separate annual deductibles (or out-of-pocket maximums) for mental health benefits and medical/surgical benefits; rather, the health plan must have a single deductible applicable to both types of benefits (or applicable only to medical/surgical benefits).

The same principle applies to "quantitative treatment limitations," such as limitations on the number of visits in a year or the frequency of treatments. The Federal Agencies acknowledge that this result is not required by the MHPAEA—though they argue it is permitted. The Federal Agencies believe "that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA" than allowing such financial restrictions.

Prescription Drugs

The Federal Agencies establish a "special rule" for prescription drug coverage. A health plan may establish multiple tiers of prescription drugs without the need to assess parity between mental health, substance use disorder, and medical/surgical coverage, provided that the tiers are based on reasonable factors "unrelated to whether the drug is usually prescribed for the treatment of a medical/surgical condition or a mental health condition or substance use disorder." Thus, the Rules allow a health plan to establish tiers of prescription drug coverage based on cost, efficacy, generic versus brand name, and mail-order versus retail (for examples), as long as the tiers do not take into account whether a drug is generally prescribed for medical/surgical, mental health, or substance use disorder purposes and the tiers do not otherwise discriminate against mental health or substance use disorder benefits.

Medical Management and Other "Nonquantitative Treatment Limitations"

The Federal Agencies stress that "nonquantitative" limitations on mental health or substance use disorder benefits are also subject to the parity requirements. Thus, group health plans (and their insurers) must ensure that "[a]ny processes, strategies, evidentiary standards, or other factors used in applying [a] limitation to mental health or substance use disorder benefits . . . must be comparable to, and applied no more stringently than" such methods when applied to medical/surgical benefits. Thus, medical management standards, such as preauthorization, concurrent review, retrospective review, case management, and utilization review, must be applied to mental health and substance use disorder benefits in a manner comparable to and no more strictly than they are applied to medical/surgical benefits.

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