MENTAL HEALTH PARITY COMPLIANCE

Impact On Plan Products & Processes

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Agenda

- Background on Mental Health Parity (MHP)
- Interim Final MHP Rule
  - Aggregate Dollar Limits
  - Financial Limitations and Quantitative Treatment Limitations
  - Nonquantitative Treatment Limitations
- Legal Challenge to MHP Rule
- Interaction with State MHP Laws

Background on MHP

Background

Mental Health Parity Act of 1996

Prohibited more restrictive aggregate lifetime or annual limits	Allowed other differences such as cost sharing, visit limits, utilization management

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Prohibits more restrictive financial requirements or treatment limits	Includes substance abuse treatment with mental health benefits

Interim Final MHPAEA Rule February 2, 2010

Requires extensive financial analysis of quantitative limits and requirements	Includes prohibition of nonquantitative treatment limitations

Structure of MHPAEA and Regulations

MHPAEA amends

- Employee Retirement Income Security Act (ERISA)
- Public Health Service Act
- Internal Revenue Code

Interim Final Rule Published on February 2 by

- DOL, Employee Benefits Security Administration
- DHHS, Centers for Medicare & Medicaid Services
- Treasury, Internal Revenue Service

Effective Dates

MHPAEA of 2008

- Generally effective one year after October 3, 2008 enactment, whether or not regulations published
- Limited extension for union plans

MHP Rule – February 2, 2010

- “Effective” April 5, 2010
- Applicable to plan years beginning on or after July 1, 2010

Mental Health and Substance Use Disorder Benefits

Presentation uses "mental health" to refer to mental health and substance use disorder benefits and "medical" to refer to medical and surgical benefits

Mental Health Benefits

- Services for mental health conditions defined by plan in accordance with law and consistent with generally recognized standards of medical practice (DSM, ICD, State guidelines)
- Not mandatory, but subject to rule if offered

Substance Use Disorder Benefits

- Services for substance use disorders defined by plan in accordance with law and consistent with generally recognized standards of medical practice (DSM, ICD, State guidelines)
- Not mandatory, but subject to rule if offered

Statute on Financial Requirements

Financial requirements include

- Deductibles
- Copayments
- Coinsurance
- Out-of-pocket expenses
- (Does not include aggregate or lifetime limits, addressed in MHPA1996)

Plans must ensure -

- Financial requirements are no more restrictive than the predominant (most common) financial requirements applied to substantially all covered medical benefits
- No separate cost sharing requirements apply only to mental health

Statute on Treatment Limitations

Treatment limitations include

- Limits on number of days covered
- Limits on treatment frequency
- Limits on days of coverage
- Medical necessity determinations
- Step therapy
- Provider admission to network

Plans must ensure –

- Treatment limitations are no more restrictive than predominant (most common) treatment limitations for substantially all medical benefits
- No separate treatment limitations apply only to mental health

Interim Final MHP Rule

Structure of MHP Rule

(b)
- Aggregate lifetime and annual dollar limits
- Revises 1997 regulations to include substance use disorder benefits

(c)
- Financial Requirements
- Treatment Limitations

(d)
- Availability of Plan Information

(e)
- Applicability – applies directly to group health plans and health insurance issuers

(f)
- Small employer exemption – 50 or fewer employees

Government Estimates $60 in Legal Costs Per Plan

"The Departments assume that the average burden per plan will be one-half hour of a legal professional's time at an hourly rate of $120 to conduct the compliance review and make the needed changes to the plan and related documents."

Preamble, 75 Fed. Reg. at 5426.

Interim Final MHP Rule

Aggregate Dollar Limits

Aggregate Lifetime and Annual Dollar Limits

Mechanics of subsection (b) on aggregate lifetime and dollar limits remain consistent with regulations under MHPA of 1996.

- Interim Final MHP Rule added "substance use disorder benefits" to aggregate lifetime and annual dollar limit requirements
- Added "dollar" before limits to clarify that limits in days or visits are covered under the treatment limitations provisions

Aggregate Lifetime and Annual Dollar Limits

No limit or limit on less than 1/3 medical benefits	• May not have limit on mental health benefits
Limit on at least 2/3 medical benefits	• Apply limit to both medical and mental health (combine) or • Mental health limit no less than medical
Limit on between 1/3 and 2/3 medical benefits	• No aggregate limit on mental health or • Mental health limit no less than "weighted average" of medical limit

Interim Final MHP Rule

Financial Limitations and Quantitative Treatment Limitations

Classifications of Benefits

The MHP Rule uses six **classifications of benefits** to compare financial restrictions and treatment limitations for mental health and medical benefits

1. Inpatient, in-network
2. Inpatient, out-of-network
3. Outpatient, in-network
4. Outpatient, out of network
5. Emergency care
6. Prescription drugs

Evaluating Financial Restrictions and Treatment Limitations

Types

- Financial restrictions (ex. deductibles, copayments, coinsurance, out-of-pocket maximums)
- Treatment limitations (ex. day and visit limits, nonquantitative)

Levels

- Magnitude of restriction or limitation
- $X copayment or deductible, X% coinsurance, number of days

Coverage Units

- How individuals are grouped for determining benefits or premiums
- Self-only, family, employee+spouse

Quantitative Treatment Limitations

Quantitative Treatment Limitations include limits on scope or duration, such as

- Frequency of treatment
- Number of visits
- Days of coverage
- Days in waiting period

Overview of Parity Analysis

Required

Classifications of Benefits

- **Must** offer mental health benefits in each classification of benefits for which medical benefits are offered

Permitted

Financial Restrictions and Treatment Limitations

- **May** apply FR/TL to mental health benefits if applied to *substantially all* medical, but only at *predominant* level

Parity 1: Classifications of Benefits

For each classification of benefits

- Does plan cover medical benefits?
- If so, covering mental health benefits *required*

Example:

- Medical benefits inpatient, out-of-network?
- If so, must cover inpatient, out-of-network mental health benefits

Parity 2: Type of Financial Restriction or Quantitative Treatment Limitation

Applies within each classification of benefits

Each **Type** of Mental Health restriction/limitation:

- Does it apply to **Substantially all** medical surgical benefits?

Substantially all calculation

Calculate for each **type** of mental health restriction/limitation

Applies to two-thirds of medical/surgical dollar amount

- Do not include “zero level” benefits
- Calculate irrespective of “level”

Any “reasonable method”

- By group health plan or whole book of business?
- Account for different levels of member responsibility

Separate calculation by <u>coverage unit</u>

Substantially all calculation

Special Rule for deductibles

- Separately accumulating deductibles prohibited

Same rule applies to other "cumulative financial requirements"

- Out-of-pocket maximums
- But **not** lifetime or annual dollar limits
  - Different analysis (subsection (b) instead of (c))
  - Separately accumulating lifetime or annual limits are allowed

Substantially all for Rx

Special rule for prescription drugs - no calculation necessary for multi-tiered benefits, provided that:

- Prescriptions covered without regard to whether for medical/surgical or mental health benefits
- Drugs assigned to tiers by reasonable factors:
  - Cost
  - Efficacy
  - Generic vs. brand or
  - Mail-order vs. retail
- Factors comply with Nonquantitative Treatment limitation requirements

Level of Financial Restriction or Quantitative Treatment Limitation

Level of Mental Health restriction/limitation must be:

- Equal to or less restrictive than:
- **Predominant** level applied to medical/surgical benefits

Predominant level determination

Make determination when restriction/limitation:

- Is applied within classification of benefits to:
  - Mental Health benefits and
  - Substantially all medical benefits

May apply medical benefits predominant level to mental health benefits

Predominant level determination

Base determination on medical benefits subject to restriction/limitation

Predominant medical level may vary by:

- Classification of benefits
- Group health plan

Predominant level determination

Simple case:

- Level 1 of restriction/limitation applies to > 50% of benefits

  Predominant level

Multiple Levels

- Level 1 of restriction/limitation=30%
- Level 2 of restriction/limitation=30%

  Predominant level is least restrictive of combination

Predominant level determination

Determine using any "reasonable method"

- By group health plan or whole book of business?
- Account for different levels of member responsibility

Multiple levels of restrictions/limitations

- Application to specialist/PCP

Interim Final MHP Rule

Nonquantitative Treatment Limitations

Nonquantitative Treatment Limitations

Nonquantitative Treatment Limitations – Include limits on benefits such as

- Medical management, including review for medical necessity, investigational
- Formulary design
- Standards for provider network participation, including reimbursement rates
- Methods for determining usual, customary, and reasonable charges
- Step-therapy
- Exclusions based on failure to complete course of treatment

Nonquantitative Treatment Limitations

Evaluate within each classification of benefits

Evaluate for each treatment limitation:

- Processes
- Strategies
- Evidentiary standards
- Other factors

Used in applying the limitation to mental health benefits

Nonquantitative Treatment Limitations

Application of limitation to Mental Health benefits must be -

- Comparable to
- No more stringent than

Application of limitation to medical benefits

Exception for clinically appropriate standards of care permitting different treatment

Nonquantitative Treatment Limitations

- Applies to
  - Medical necessity determinations
  - Provider admission to network (reimbursement rates?)
  - Step therapy
  - Failure to complete course of treatment
- Coordination with mental health carve-out vendors

Legal Challenge to MHP Rule

Legal Challenge to MHP Rule

- Filed March 31, 2010 by a group of managed behavioral health organizations
- Claims agencies violated Administrative Procedure Act due to failure to follow notice and comment process
- "Interim" final rule released four months past statutory deadline

Complaint’s Allegations

“[T]he Departments issued a vague, ill-informed, and boundless rule . . . .”

“so ambiguous and susceptible to so many different interpretations that it precludes uniform compliance. . .”

The nonquantitative treatment limitations “injected a wholly new concept . . . that exceeds Congress’ statutory grant.”

Status of Case

Emphasize to business leaders that implementa-tion has to proceed under the assumption that legal challenge to rule will not succeed.

- Motion for Preliminary Injunction denied April 1, 2010 by U.S. District Court for the District of Columbia
- Allowing rules to become "effective" April 5 does not cause "irreparable harm"
- Expedited briefing schedule on underlying challenge in light of July 1 implementation date

Interaction with State MHP Laws

Overlap of State Law

Forty-nine states have enacted some type of law addressing mental health coverage.

- Federal law sets the "floor," but states can build on requirements
- State laws vary widely
  - Parity laws
  - Minimum benefit mandates
  - Mandated offering laws

Example – Mandated Offering, Parity with a Twist

- Applies to groups of all sizes
- Mandates mental health coverage
- General parity requirement with exception for "durational limits"
- Mandates parity in durational limits for nine listed conditions (e.g. Major Depressive Disorder)

Adds Complexity to Product Mix

Self-insured customers want products without state mandates

Insured >50 group products must comply with two sets of requirements

Demand for less costly benefit designs for <50 groups

Costly to design, build, and administer

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