Employee Benefits and Executive Compensation Advisory: New Rules Expand Mental Health and Substance Use Disorder Parity Requirements

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On February 2, 2010, the Internal Revenue Service, U.S. Department of Labor, and U.S. Department of Health and Human Services issued interim final regulations interpreting the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Regulation").

Background

The Mental Health Parity Act of 1996 (MHPA) requires that medical plans offering both medical benefits and mental health benefits apply equivalent annual and lifetime benefit limitations to both types of benefits.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Wellstone Act) expands the MHPA in two key ways:

- In addition to mental health benefits, parity is now required with respect to substance use disorder benefits.
- In addition to annual and lifetime limits, parity is now required with respect to a broad array of "financial requirements," such as deductibles and copayments, and "treatment limitations," such as limits on days of treatment or number of office visits.

The Wellstone Act is already in effect for most plans, as it applies to plan years beginning on or after October 4, 2009. The Regulation, which is effective for plan years beginning on or after July 1, 2010, provides additional guidance on the Wellstone Act's requirements.

General Rule

Under the Regulation, a plan may not apply more restrictive **financial requirements** or **treatment limitations** to mental health or substance use disorder benefits **in any classification** than the **predominant** limitations applied to **substantially all** of the medical and surgical benefits **in any classification**.

The Regulation further provides that mental health and substance abuse disorder benefits must be provided in each classification for which medical/surgical benefits are provided.

Classifications

Each classification of mental health or substance use disorder benefits must be separately compared to each classification of medical/surgical benefits. The Regulation sets forth six classifications which are to be compared:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs.

Financial Requirements and Treatment Limitations

Within each classification, the predominant financial requirements and/or treatment limitations applying to "substantially all" of the medical/surgical benefits must be identified, and the mental health or substance use disorder benefits compared to the medical/surgical benefits:

- Financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums.
- Quantitative treatment limitations include annual, episode, and lifetime day and visit limits.

"Substantially All"

A financial requirement or quantitative treatment limitation is considered to apply to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. If a financial requirement and/or treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that requirement/limitation cannot apply to **any** mental health or substance use disorder benefits in that classification.

"Predominant"

If a financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification, the predominant level is the one that applies to at least one-half of the medical/surgical benefits in that classification. If no single level applies to at least one-half of the medical/surgical benefits, a plan may combine levels until the combination applies to at least one-half of the benefits subject to the financial requirement or quantitative treatment limitation, but the plan may then impose only the least restrictive requirement or limitation in the combination on the mental health or substance use disorder benefits.

Non-Quantitative Treatment Limitations

Generally, a group health plan may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the non-quantitative treatments to the mental health or substance use disorder benefits in the classification are comparable to, and applied no more stringently than, those used with respect to medical/surgical care in the classification, unless recognized, clinically appropriate standards of care may permit a difference.

Non-quantitative treatment limitations include:

- Medical necessity standards
- Formulary designs for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher-cost therapies until it can be shown that lower cost therapy is not effective
- Exclusions based on failure to complete a course of treatment.

Annual and Lifetime Requirements

Like existing regulations promulgated under the MHPA, the Regulation contains certain rules that apply when a plan applies annual or lifetime limits for some, but not all, of the medical/surgical benefits.

Additional Rules

- Plans may not impose separate cumulative deductibles for medical/surgical and mental health or substance use disorder benefits.
- The criteria for medical necessity determinations made under a plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request.
- The reason for any denial under a plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits must be made available by the plan administrator to participants and beneficiaries in a form and manner consistent with ERISA claims procedures (with respect to ERISA plans) or within a reasonable time and reasonable manner.
- “Mental health benefits” and “substance use disorder benefits” are not comprehensively defined in the Regulation. Rather, these are benefits for “mental health conditions” and “substance use disorder conditions” as defined under the terms of a plan in accordance with applicable state and federal law. Similarly, “medical/surgical benefits” are benefits for medical/surgical services, as defined under the plan, other than mental health or substance use disorder benefits. All conditions, whether identified as medical/surgical,

mental health or substance use disorder, must be consistent with generally recognized standards of current medical practice.

Exceptions

- **Small Employer Exemption.** The mental health/substance use disorder parity provisions do not apply to an employer who employed an average of at least two (or one, in the case of an employer residing in a state that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year, determined on a controlled group basis.
- **Increased Cost Exemption.** If a plan incurs costs over a certain threshold (2% for the first plan year in which the Wellstone Act applies, and 1% for plan years thereafter) due to the application of the parity rules, the parity rules will not apply to the following plan year. The Wellstone Act contains rules regarding certification, duration and filing requirements with respect to the increased cost exemption. The Regulation does not address this exemption; however, the preamble to the Regulation clarifies that the exemption may only be claimed in alternating years.
- Nothing in the MHPA, the Wellstone Act or the Regulation requires a plan to offer either mental health or substance use disorder benefits. If a plan does not offer these benefits, the rules do not apply.

Effective Date

The Regulation applies for plan years beginning on or after July 1, 2010. Thus, for calendar year plans, the Regulation is effective January 1, 2011.

For assistance in this area please contact one of the attorneys listed below or any member of your Mintz Levin client service team.

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