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Trustee Alert – Final Mental Health Parity Rules

The Mental Health Parity rules require group health plans that offer mental health and substance use disorder benefits to cover those benefits on terms that are no more restrictive than those applied to comparable medical and surgical benefits.

Recently issued final mental health parity rules will be effective for plan years beginning on or after July 1, 2014. The Trust should review its plan terms to ensure compliance with the final rules.

Financial and Quantitative Treatment Limits: Parity must be provided in each of the following six classifications: (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. A plan may not impose any financial requirement or quantitative treatment limitation on mental health benefits in any class that is more restrictive than that applied to substantially all medical/surgical benefits in the same class. The final rules clarify:

- Plans must assign intermediate mental health benefits (such as residential treatment) that do not clearly fall within a particular classification to a classification in the same manner as comparable medical/surgical benefits;
- Plans that provide in-network benefits through multiple tiers of providers may use sub-classifications that reflect those network tiers. If the plan does not have an equal number of tiers for medical/surgical benefits and mental health benefits, the plan must apply the most generous medical benefit tier to all mental health tiers in the same classification.

Nonquantitative Treatment Limits: The final rules also add some nuances to the interpretation of permitted nonquantitative treatment limitations. For instance, parity now applies to all plan standards, including geographic limits, facility-type limits and network adequacy.

Health Care Reform: The final rules address certain intersections of the parity requirements with health care reform requirements. Notably, if a plan covers mental health benefits only to the extent needed to comply with the Affordable Care Act preventive services mandate (such as screening for depression), then the plan is not required to cover additional mental health benefits in any classification.

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