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Interim Final Regulations Issued Implementing the Mental Health Parity and Addiction Equity Act of 2008

Last Friday, the U.S. Departments of Labor, Health and Human Services, and the Treasury issued interim final regulations implementing the Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008.[1] The MHPAEA, which expands the requirements of the Mental Health Parity Act ("MHPA") of 1996, generally requires private group health plans that provide mental health and/or substance use disorder benefits to do so on an equivalent basis with respect to any medical and surgical benefits. The regulations are expected to be formally published in the Federal Register on Tuesday, February 2nd.

As enacted in 1996, the MHPA mandated parity regarding certain lifetime and annual dollar limits for mental health benefits and medical surgical benefits. The MHPAEA expands the MHPA in two regards. First, the MHPAEA expands the parity requirements to include financial requirements (such as deductibles and copayments) and treatment limitations (such as the number of covered office visits and days of inpatient coverage). Second, the MHPAEA extends the parity requirements to include substance use disorder treatment.

The interim final regulations issued on Friday replace existing regulations issued in 1997 following the enactment of the MHPA. The interim final regulations generally are effective for plan years beginning on or after July 1, 2010. Plans maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, however, are subject to a delayed effective date; the regulations for such plans are effective for plan years beginning on or after the later of (i) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extensions), or (ii) July 1, 2010.

Significantly, the MHPAEA generally became effective on January 1, 2010 for calendar year plans. Thus, calendar year plans subject to the MHPAEA generally must already be in compliance with the statutory provisions of the MHPAEA. The preamble to the interim final regulations states that the agencies will take into account good-faith efforts by plans to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation

[1] The regulations may be viewed at: http://www.davis-harman.com/pub.aspx?ID=VFdwSk1RPT0=. The Department of Labor also released a brief fact sheet that may be viewed at: http://www.davis-harman.com/pub.aspx?ID=VFdwSk1BPT0=.

occurring prior to the effective date of the regulations. The preamble makes clear, however, that "this does not prevent participants or beneficiaries from bringing a private right of action."

Written comments are requested with respect to the new interim final regulations on or before May 3, 2010.

Highlights of the interim final regulations include:

- ***Parity requirements apply to a broader category of health plans.*** Like the 1997 MHPA regulations, the new interim final regulations apply to an issuer of health insurance coverage. The 1996 regulations, however, provided that the health insurance coverage at issue had to provide for both medical/surgical benefits and mental health benefits to be subject to the MHPA's parity requirements. The interim final regulations include a revised definition of health insurance coverage that likely will subject additional plans to the parity requirements. Specifically, the interim final regulations provide that the parity requirements apply to health insurance coverage that provides mental health or substance use disorder benefits, even where the coverage itself does not provide any medical/surgical benefits, if such coverage is offered in connection with a health plan that otherwise offers medical/surgical benefits. The preamble states that "[t]his new combined rule clearly prohibits what might have been formerly viewed as a potential evasion of the parity requirements by allocating mental health or substance use disorder benefits to a plan or benefit package without medical/surgical benefits (when medical/surgical benefits are otherwise available)."

- ***The general parity requirements are extended to financial requirements and quantitative treatment limitations.*** The MHPAEA generally mandates that financial requirements (e.g., deductibles, cost-sharing, out-of-pocket limits, annual and lifetime dollar limits) and treatment limitations (e.g., number of covered office visits, days of inpatient coverage) for mental health and substance use disorder benefits cannot be more restrictive than the "predominant" requirements/limitations applied to "substantially all" medical and surgical benefits under the plan. The regulations include express definitions of "predominant" (generally greater than one-half) and "substantially all" (generally at least two-thirds) that should help plans better understand how to apply the new parity requirements with respect to financial requirements and treatment limitations.

- ***Plans must use generally recognized standards in defining whether benefits are mental health or substance use disorder benefits.*** The regulations provide that plan terms defining whether benefits are mental health or substance use disorder benefits must be "consistent with generally recognized independent standards of current medical practice". Such standards need not be based on a national standard, and may be based on, for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), a "state guideline" or other applicable sources.

- ***Both quantitative and nonquantitative treatment limitations are subject to the parity requirements.*** The regulations apply the parity requirements not only to a plan's quantitative treatment limitations (such as an annual limit of 50 outpatient visits), but also to a plan's nonquantitative treatment limitations (such as medical management standards).

To better help plan sponsors understand what aspects of their plan may constitute a nonquantitative treatment limitation for purposes of the regulations, the interim final regulations include a nonexhaustive list of such limitations. This list includes: prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary, and reasonable charges; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment. Please note that this list is not exhaustive and thus plan sponsors should be mindful to look beyond those limitations included in this list to identify all nonquantitative treatment limitations for purposes of applying the parity requirements.

- ***Plans are only permitted to compare medical/surgical and mental health benefits for purposes of applying the parity requirements by using six specified categories.*** The regulations generally provide that, in determining whether a plan has satisfied the parity requirements, a plan is only permitted to compare medical/surgical benefits and mental health benefits based on the following six categories: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs. Significantly, the regulations do not define the terms "inpatient", "outpatient", and "emergency care". The preamble states that this was intentional because "[t]hese terms are subject to plan design and their meanings may differ from plan to plan." The preamble goes on to state that "[a] plan must apply these terms uniformly for both medical/surgical benefits and mental health or substance use disorder benefits," but that "the manner in which they apply may differ from plan to plan".

- ***Plans must apply parity requirements based on each "coverage unit".*** The regulations also require that the parity requirements be applied only with respect to a plan's given coverage unit (such as self-only or family coverage). Accordingly, plan sponsors should be careful to ensure that they are properly classifying benefit restrictions into the six specified categories and that they do so only with respect to a specified "coverage unit".

- ***Special parity rule applies to prescription drug programs.*** The final interim regulations provide a special rule for applying the parity requirements to a prescription drug program that imposes different financial limitations for different tiers of drugs. Because the placement of a drug into a given tier is based on factors (such as cost and efficacy) that are generally unrelated to whether such drug is prescribed for medical/surgical benefits or for mental health or substance use disorder benefits, the preamble acknowledges that it could be very burdensome for plans to undertake a full parity analysis of their prescription drug programs. Moreover, the preamble acknowledges that doing so would not "ensur[e] any greater parity for mental health and substance use disorder benefits." Accordingly, the regulations provide that a plan satisfies the parity requirements with respect to its prescription drug program if such plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus store pick-up), and that such financial requirements are determined (i) in accordance with the requirements for nonquantitative treatment limitations, and (ii) without regard to whether a drug is generally prescribed for medical/surgical benefits or mental health and substance use disorder benefits.

- ***Combined deductibles are required for mental health/substance use disorder benefits and medical/surgical benefits – separate deductibles are prohibited.*** The interim final regulations state that a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and a separate deductible for medical/surgical benefits. The preamble states that although the statutory language of the MHPAEA could be read to permit the use of separate deductibles, the agencies' view is that requiring combined deductibles is more consistent with the policy goals of the statute. Many plans may currently use separate deductibles for mental health/substance use disorder benefits and medical/surgical benefits. Accordingly, these plans will need to be modified to provide for a combined deductible in order to comply with the final interim regulations.

- ***Clarifies how the new disclosure rule regarding denial of mental health benefits applies to ERISA plans.*** The MHPAEA provides that plans must make available, upon request, to participants and beneficiaries the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits. Prior to the issuance of the interim final regulations, there had been some question as to how this requirement applied to ERISA plans that are otherwise subject to ERISA claims procedure regulations. In what is likely welcome news to many ERISA plan sponsors, the interim final regulations make clear that ERISA plans are only required to make disclosures in a form and manner consistent with the existing ERISA claims procedure regulations.

- ***Addresses changes to the increased cost exemption, including that the exemption may only be claimed for alternating years.*** Both the MHPA and the MHPAEA include an increased cost exemption under which, if certain requirements are met, plans that incur increased costs above a certain threshold as a result of the application of the parity requirements can be exempt from the statutory parity requirements. The MHPAEA changed the MHPA increased cost exemption in several regards, including: (1) raising the threshold for qualification from one percent to two percent for the first year for which the plan is subject to the MHPAEA parity requirements; (2) requiring certification by qualified and licensed actuaries who are members in good standing of the American Academy of Actuaries; and (3) revising the notice requirements. Significantly, the regulations make clear that under the MHPAEA, plans may only qualify for the increased cost exemption in alternating plans years. This is because "plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year."

- ***Small employers generally are exempt from MHPAEA's requirements.*** The regulations make clear that the MHPAEA's requirements do not apply to a group health plan of a small employer. For purposes of the MHPAEA, a small employer means, "in connection with a group health plan . . . 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 no more than 50 employees on business days during the preceding calendar year."

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