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NEW REGULATIONS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS: IT'S COMPLICATED!

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the "Act"). The Act extended prior provisions of the 1996 Mental Health Parity Act to substance use disorder benefits. In addition, the Act significantly expanded the law for group health plans (including health insurance coverage offered in connection with a group health plan) that offer mental health or substance use disorder benefits. Specifically, the new law requires parity between medical/surgical benefits and mental health or substance use disorder benefits with respect to "financial requirements" and "treatment limitations" under a plan.

The Act does not require a plan to provide mental health or substance use disorder benefits or mandate the mental health or substance use disorder benefits that must be covered. The law only requires parity if such mental health or substance use disorder benefits are offered under a plan. The Act does not apply to employers with fewer than 50 employees.

On February 2, 2010, the Departments of the Treasury, Labor, and Health and Human Services issued interim final rules implementing the Act. This *Commentary* addresses the new parity rules for financial requirements and treatment limitations as interpreted under these interim final rules.

WHAT THE REGULATIONS PROVIDE

Under the regulations, if a group health plan provides both medical/surgical benefits and mental health or substance use disorder benefits, the plan may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether or not a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all

medical/surgical benefits in a classification is determined separately for each type of financial requirement and treatment limitation.

Under the regulations, the parity requirements for financial requirements and treatment limitations apply separately to six "classifications" of benefits. The six classifications are:

- Inpatient, In-Network;
- Inpatient, Out-of-Network;
- Outpatient, In-Network;
- Outpatient, Out-of-Network;
- Emergency Care; and
- Prescription Drugs.

If a plan provides mental health or substance use disorder benefits in any of the classifications of benefits listed above, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided.

Under the regulations, a type of financial requirement (*e.g.*, deductibles, copayments, and coinsurance rates) or a quantitative treatment limitation (*e.g.*, a limitation on the number of visits or days of coverage) is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

> **Note**: If any type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, that type of financial requirement or treatment limitation cannot apply to any mental health or substance use disorder benefits in that classification.

If a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification, then the level of financial requirement or quantitative treatment limitation that is considered the predominant level must be determined. The predominant financial requirement or quantitative treatment limitation for any classification is the level that applies to more than one-half of the medical/surgical benefits in that classification.

If a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification but there is no single level that applies to more than one-half of the medical/surgical benefits in that classification, the plan may combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the financial requirement or treatment limitation in the classification. The least restrictive level within the combination of levels is considered the predominant level of that type of financial requirement or treatment limitation. For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

> **Note**: A designation of a provider as a "primary care physician" or as a "specialist physician" is disregarded in determining the predominant level of financial requirement that applies to substantially all medical/surgical benefits.

For purposes of applying the substantially all and predominant standards described above, the determination of the portion of medical/surgical benefits in a classification of benefits is based on the dollar amount of all plan payments for medical/surgical benefits in the classification that are expected to be paid under the plan for the plan year. Any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits in a classification.

> **Note**: The requirement for a plan to determine the dollar amount of benefits expected to be paid under each classification of benefits for each year will be a new requirement for most employer plans.

For health plans that apply different levels of financial requirements or quantitative treatment limitations to different coverage units (*e.g.*, self-only, family, and employee-plus-spouse), the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

In addition, a group health plan may not accumulate any financial requirement or quantitative treatment limitation for mental health or substance use disorder benefits in a classification separately from the accumulation of any financial requirement or treatment limitation established for medical/surgical benefits in the same classification.

> **Note**: The rule that financial requirements (such as deductibles) and treatment limitations (such as number of visits permitted) may not be accumulated separately from medical/surgical benefits may require changes in many plan designs.

The regulations' parity requirements also apply to nonquantitative treatment limitations (*e.g.*, medical management standards excluding or limiting benefits based on their medical appropriateness or on whether the treatment is experimental or investigational, or methods of determining usual, customary, and reasonable charges). Such nonquantitative treatment limitations may not be imposed on mental health or substance use disorder benefits in any classification unless, *under the terms of the plan as written and in operation*, any factors used in applying such limitations to mental health or substance use disorder benefits in the classification are comparable to, and apply no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the classification (except where a difference would be permitted by recognized clinically appropriate standards of care).

In addition to prescribing parity in financial requirements, the regulations mandate certain disclosures with respect to mental health or substance use disorder benefits, including the criteria for medical necessity determinations under a group health plan, which must be made available on request to any current or potential participant, beneficiary, or contracting provider.

EFFECTIVE DATES

The changes made by the Act generally are effective for plan years beginning after October 3, 2009. The interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010 (a special effective date applies to certain collectively bargained plans). The agencies with enforcement authority will take into account a plan sponsor's good-faith efforts to comply with the Act prior to the effective date of the regulations. However, this will not prevent plan participants from bringing a private action if they believe their rights have been violated.

CONCLUSION

These complex regulations may make compliance difficult for all but the most sophisticated employer plans. As the examples below show, plans that offer mental health or substance use disorder benefits will have to estimate the dollar amount that will be spent during each plan year on all medical/surgical benefits in order to apply the substantially all and predominant requirements. All plans should be carefully evaluated for compliance with the new regulations.

EXAMPLES

The following examples were taken directly from the regulations.

Example 1. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

Coinsurance Rate	0%	10%	15%	20%	30%	Total
Projected Payments	$200x	$100x	$450x	$100x	$150x	$1,000x
% of Total Plan Costs	20%	10%	45%	10%	15%	
% Subject to Coinsurance	N/A	12.5% (100x/800)	56.25% (450x/800)	12.5% (100x/800)	18.75% (150x/800)	

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

Conclusion. In this Example 1, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment Amount	$0	$10	$15	$20	$50	Total
Projected Payments	$200x	$200x	$200x	$300x	$100x	$1,000x
% of Total Plan Costs	20%	20%	20%	30%	10%	
% Subject to Coinsurance	N/A	25% (200x/800)	25% (200x/800)	37.5% (300x/800)	12.5% (100x/800)	

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x +$300x + $100x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

Conclusion. In this Example 2, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25 percent; for the $15 copayment, 25 percent; for the $20 copayment, 37.5 percent; and for the $50 copayment, 12.5 percent). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels—the $50 copayment and the $20 copayment—are not

more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($300x + $100x = $400x; $400x/$800x = 50%). The combined projected payments for the three highest copayment levels—the $50 copayment, the $20 copayment, and the $15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

Example 3. A group health plan imposes a combined annual $500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

Conclusion. In this Example 3, the combined annual deductible complies with the requirements of the regulations with respect to cumulative financial requirements.

Example 4. A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all mental health and substance use disorder benefits.

Conclusion. In this Example 4, the separate annual deductible on mental health and substance use disorder benefits violates the regulations because the separate deductibles are not cumulative.

Example 5. A plan imposes an annual $300 deductible on all medical/surgical benefits and a separate annual $100 deductible on all mental health or substance use disorder benefits.

Conclusion. In this Example 5, the separate annual deductible on mental health and substance use disorder benefits violates the regulations because the separate deductibles are not cumulative.

Example 6. A plan generally imposes a combined annual $500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

Classification	Benefits Subject to Deductible	Total Benefits	Percent Subject to Deductible
Inpatient, In-Network	$1,800x	$2,000x	90%
Inpatient, Out-of-Network	$1,000x	$1,000x	100%
Outpatient, In-Network	$1,400x	$2,000x	70%
Outpatient, Out-of-Network	$1,880x	$2,000x	94%
Emergency Room	$300x	$500x	60%

Conclusion. In this Example 6, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications, at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

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