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Client Notice Regarding the 2010 Interim Final Regulations on the Mental Health Parity and Addiction Equity Act of 2008

If you have questions regarding the information in this alert or would like to receive further information regarding our employee benefits department, please contact:

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On February 2, 2010, the departments of Health and Human Services, Labor, and the Treasury published interim final regulations (Regulations) implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Act). The Act prohibits group health plans from applying financial requirements or treatment limitations that are more restrictive than those applied to the group health plan's other benefits, including surgical and medical benefits.

The Regulations, effective April 5, 2010, apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2010. The Regulations generally apply to employers who have an average of more than 50 employees during the preceding calendar year.

The Regulations prohibit health insurance coverage from applying any financial requirement or treatment limit to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limit applied to substantially all medical or surgical benefits in the same classification. "Predominant" here means the requirement or limit applies to more than one-half of the benefits in a classification and "substantially all" means that they apply to at least two-thirds of them.

Benefit Classification

The Regulations specify six classifications of benefits:

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

Within each classification, if a plan provides mental health/substance use benefits, those benefits must be provided at parity with the medical/surgical benefits provided in that classification. Parity must exist for financial requirements and treatment limitations. There is a limited exception for the prescription drug classification to allow for tiered cost-sharing levels across all treatments.

Financial Requirements

The parity requirements under the Regulations apply to financial requirements, including deductibles, co-payments, co-insurance and out-of-pocket maximums. The parity requirement applies separately for each type of financial requirement or treatment limit. For example, co-pays are compared to co-pays and deductibles are compared to deductible.

Detroit

Treatment Limitations

The Regulations provide that the parity requirements apply to quantitative and non-quantitative treatment limits. A quantitative limit is expressed numerically, such as an annual number of office visits. The Regulations make clear that quantitative treatment limits may not accumulate separately. For example, a plan cannot have an annual limit of 50 office visits for medical/surgical benefits and a separate annual limit of 50 office visits for mental health/substance use disorder benefits. There must be one annual limit for both types of benefits.

A non-quantitative limit involves the scope or duration of benefits for treatment and includes:

- Medical management standards;
- Drug formulary design;
- Standards for provider admission to participate in a network;
- Determination of usual, customary and reasonable amounts;
- Requirements for using lower-cost therapies before the plan will cover more expensive therapies; and
- Conditioning benefits on completion of a course of treatment.

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The Regulations state that any processes, strategies, evidentiary standards or other factors used in applying the non-quantitative treatment limitations to mental health or substance use disorder benefits must be comparable to those used in applying limitations to medical/surgical benefits in the same classification.

Exemptions

The Regulations grant health insurance plans a one-year exemption from the parity requirements, if they experience total increased costs of two percent in the first year after implementation and one percent in subsequent years. The criteria for this exemption are not included in the Regulations, but further guidance is expected to be released in the near future.

There is a special rule for collectively bargained plans. For group health plans maintained pursuant to a collective bargaining agreement that was ratified before October 3, 2008, the Regulations do not apply for plan years beginning before the later of the termination date of the last collective bargaining agreement relating to the plan or July 1, 2010.

Plan documents and insurance policies should be reviewed to ensure that they comply with the Regulations. If you have any questions or need assistance in this matter, please contact any of the attorneys listed on this Employee Benefits Alert.

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