

HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

At Long Last: The Rules Implementing The Mental Health Parity Act

March 24, 2010

On January 29, 2010, the Departments of Health and Human Services, Labor and the Treasury jointly announced implementing regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act")¹ in the form of interim final rules (the "Regulations").² The Regulations will be applicable to plan years beginning on or after July 1, 2010.³ Since most plan years coincide with the calendar year, the effective date of the Regulations for most plans will be January 1, 2011.

The agencies received over four hundred comments regarding the implementation of the Act, and the issuing agencies are seeking further comments regarding, among other topics, scope and duration of covered benefits, how covered drugs are determined, the coverage of step therapies, and issues surrounding the continuum of care. However, although some open issues remain, the Regulations answer several critical questions that have emerged since the passage of the Act.

Classification of Benefits

Health plans typically categorize benefits with more specificity than simply types of treatment, using factors such as the network status of providers (in-network vs. out of the health plan's contracted network) and the acute nature of the treatment (outpatient, inpatient or emergency). Recognizing that in order to assess parity of benefits, similar categories are necessary, the Regulations set forth six classifications to be used to determine whether parity is met under the Act. These classifications are 1) in-patient, in-network, 2) in-patient, out-of-network, 3) outpatient, in-network, 4) outpatient, out-of-network, 5) emergency care and 6) prescription drugs.⁴ Within each classification, the

¹ The Act was part of the Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (October 3, 2008). The Act requires group health plans providing mental health and substance abuse treatment benefits to ensure that coverage of these benefits is equal to the plans' coverage of medical and surgical benefits. In order to effectuate this requirement, the Act amended the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and the Internal Revenue Code. For a full description of the Act itself, see our earlier Health Law Update, "The New Mental Health Parity Act: What It Does and Doesn't Do," January 7, 2009, available at <http://www.bassberry.com>

² These regulations were subsequently published in the Federal Register on February 2, 2010 at 5410.

³ For plans maintained pursuant to a collective bargaining agreement, the Act set the effective date as the later of 1) the date on which the last collective bargaining agreement relating to the group health plan terminates (without regard to any extension made to the agreement after October 3, 2008) or 2) July 1, 2010.

⁴ *Id.* The terms "in-patient," "out-patient" and "emergency" are not defined by the Act or the Regulations but rather are determined by the definitions used in the health plan's benefit design plan and/or by state insurance laws.

standard to establish parity is whether the financial requirement or treatment limit for the mental health or substance abuse treatment benefit is equal to or less restrictive than the "predominant" financial requirement or treatment limit that is applied to "substantially all" of the medical and surgical benefits within the same classification. The "predominant" financial requirements or treatment levels are defined as elements applying to more than one-half of the medical/surgical benefits in the classification, whereas "substantially all" is quantified as at least two-thirds. For example, a health plan will violate the Act if the in-patient/in-network treatment limits for the mental health benefits of a plan are more restrictive than more than half of the in-patient/in-network treatment limits applied to at least two-thirds of the in-patient/in-network medical and surgical benefits of that plan.

Cumulative (Not Separate) Deductibles

The Act did not address how to calculate deductible amounts. Specifically the statute left as an open question whether a health plan member's deductible for mental health and substance abuse treatment benefits could be calculated separately from the deductible for medical and surgical treatments (as long as the deductible amounts are the same) or if all of the benefits had to be calculated under one combined deductible. While acknowledging the comments from both sides of the issue, the Regulations require one cumulative deductible for mental health and substance abuse treatments and medical and surgical benefits. Prohibiting a health plan from imposing separate deductibles "is more consistent with the policy goals that led to the enactment of" the Act, according to the Regulations.⁵

"Nonquantitative" Treatment Limitations

Both the Act and the Regulations require parity in all treatment limitations, including those difficult to quantify, such as medical management and utilization review, formulary design for prescription drugs, methods of determining usual, customary, and reasonable charges, and standards for network providers. For example, a health plan may not require concurrent review of medical necessity for mental health services for those services to be covered by the plan while allowing for retroactive review for the same classification of medical and surgical benefits. Similarly, if a plan does not cover out-patient, in-network benefits for substance abuse treatments until it can be shown that the less expensive alternative is not effective (commonly known as step-therapy protocols) but the same step-therapy requirement for medical and surgical services is not in place, then the plan would violate the Act. For these nonquantitative treatment limitations, parity requires the processes and evidentiary guidelines used to determine mental health benefits to be equivalent to and not more stringent than the comparable processes and guidelines for medical and surgical benefits. However, if after following the process for determining appropriate medical standards of care, the medical necessity determination results in differing limitations based on clinical condition, this difference does not violate the Act.

While the Act and implementing rules have been lauded as helping assure that health plan benefits thoroughly include mental health and substance abuse disorder treatment benefits, the law does not mandate minimum coverage amounts for mental health benefits. Rather it only requires plans that offer mental health and substance abuse disorder benefits to do so in parity with the benefits offered for medical and surgical benefits. Potential unintended consequences of this Act include plans cutting mental health benefits altogether (in which case the law would not apply to the plan) or reducing medical coverage to satisfy the Regulations. If you have any questions on this Health Law Update, please contact any of the attorneys in our Healthcare Practice Group listed below.

⁵ 75 Fed. Reg. 5410, 5415.

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