



## **HIGHLIGHTS OF THE NEW FEDERAL PARITY REGULATIONS**

### **Background and Purpose of the Parity Regulations:**

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became Public Law 110-343 in October 2008
- The MHPAEA prohibits group health plans that currently offer coverage for drug and alcohol addiction and mental illness from providing those benefits in a more restrictive way than other medical and surgical procedures covered by the plan
- The MHPAEA rule and accompanying guidance, issued by the Departments of Health and Human Services, Labor and Treasury (the Departments), is intended to provide greater clarity and guide implementation of the MHPAEA
- In addition to the specific language of the rule, the Departments released guidance including a preamble discussion that defines certain terms and explains how the rule was formulated; the rule also includes numerous specific examples of practices that would and would not meet the requirements of the MHPAEA statute and regulations
- The Departments state that they expect the MHPAEA to affect approximately:
  - 111 million participants in 446,400 ERISA-covered group health plans
  - 29 million participants in the estimated 20,300 public, non-federal employer group health plans sponsored by State and local governments
  - 460 health insurance issuers providing substance use disorder (SUD) or mental health (MH) benefits in the group health insurance market
  - 120 Managed Behavioral Healthcare Organizations (MBHOs) providing SUD or MH benefits to group health plans

### **Status of and Process for the MHPAEA Rule:**

- The MHPAEA rule will be published in the Federal Register Tuesday, February 2<sup>nd</sup>
- The rule will be issued as “interim final”; this includes 90-day public comment period which closes May 3<sup>rd</sup>; the Departments identify specific areas they would like public comment on (listed below)
- Despite being issued as “interim final,” the rule will become effective April 5<sup>th</sup>. The regulatory guidance states that, until they go into effect, group health plans/issuers must make good-faith efforts to comply with the regulatory requirements
- Group health plans and issuers with plan years beginning on or after July 1, 2010 will be required to comply with the MHPAEA and accompanying regulations
- The rule does not address every area of the MHPAEA and the accompanying guidance makes clear that additional rules will be issued on specific topics; for example, while acknowledging that Medicaid managed care plans offering SUD or MH services must comply with the MHPAEA, the Departments state that this rule does not apply to those plans and that additional guidance will later be given by the Centers for Medicare and Medicaid Services (CMS)
- The citations for the MHPAEA regulations are:
  - 26 CFR Part 54 (Department of Treasury’s Internal Revenue Service regulations)

- 29 CFR Part 2590 (Department of Labor’s Employee Benefits Security Administration regulations)
- 45 CFR Part 146 (Department of Health and Human Services Center for Medicare and Medicaid Services regulatory code)

**Discussion of the Intersection of State Laws with the MHPAEA:**

- The regulations affirm that the MHPAEA does not preempt any State laws except those that would prevent the application of the MHPAEA
- The guidance states that the Departments have tried to “balance the States’ interests in regulating health insurance issuers, and Congress’ intent to provide uniform minimum protections to consumers in every State.”
- The regulations also state that, “State insurance laws that are more stringent than the federal requirements are unlikely to ‘prevent the application of the MHPAEA,’ and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.”

**Scope of Services/Categories of Care Not Defined by the Regulations:**

- The regulations do not define a scope of services or continuum of care for SUD or MH benefits; the regulations state that group health plans can define which services are covered in MH and SUD benefit packages; those definitions must be consistent with “generally recognized independent standards of current medical practice” which include the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases, and State guidelines
- The regulations do not define what constitutes inpatient, outpatient or emergency care but leave it up to health plans and State health insurance laws to define those terms; the regulations do require group health plans to apply these terms uniformly for medical/surgical benefits and SUD and/or MH benefits

**Rule Defines How to Determine whether Financial Requirements and Treatment Limitations Imposed on SUD or MH Benefits Comply with the MHPAEA:**

- The MHPAEA statute prohibits group health plans/health insurers offering SUD or MH benefits from applying financial requirements or treatment limitations to SUD or MH benefits that are more restrictive than the *predominant* financial requirements or treatment limitations applied to *substantially all* medical/surgical benefits
- The rule defines the terms “*predominant*” and “*substantially all*” and gives guidance about how to determine whether financial requirements and treatment limitations imposed on SUD or MH benefits comply with the MHPAEA

**Classifications of Benefits are Defined; Parity Analysis Must Compare Financial Requirements/Treatment Limitations Imposed on SUD or MH Benefits with Same Type Imposed on Medical/Surgical Benefits in the Same Classification:**

- The rule first identifies six categories of classification of benefits. These six classifications are:
  - Inpatient, in-network
  - Inpatient, out-of-network

- Outpatient, in-network
  - Outpatient, out-of-network
  - Emergency care
  - Prescription drugs
- The rule specifies that, when examining whether SUD or MH benefits are being offered at parity with other medical/surgical benefits, a financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within the same classification
  - This review must take place separately (i.e. copayments must be compared with copayments, annual visit limits with annual visit limits) within each above-listed classification
    - Example: The copayment amount charged for an outpatient session of care provided by an in-network SUD service provider must be compared with copayment amounts for sessions of outpatient care provided by other medical/surgical in-network providers
  - The rule establishes standards to measure plan benefits so that medical/surgical benefits can be compared with SUD or MH benefits

**Rule Discusses Financial Requirements and Treatment Limitations, Including Medical Management Tools, and How They Must Comply with the Parity Requirements:**

- Financial requirements are defined as including deductibles, copayments, coinsurance and out-of-pocket maximum
- The rule makes the distinction between quantitative treatment limitations and non-quantitative treatment limitations
  - Quantitative treatment limitations include day or visit limits or frequency of treatment limits
  - Non-quantitative treatment limitations are medical management tools. The regulations include a non-exhaustive list of types of non-quantitative treatment limitations that includes:
    - Medical management standards
    - Prescription drug formulary design
    - Fail-first policies/step therapy protocols
    - Standards for provider admission to participate in a network
    - Determination of usual, customary and reasonable amounts
    - Conditioning benefits on completion of a course of treatment
- The regulations state that group health plans offering benefits for an SU or MH condition or disorder must provide those benefits in each classification for which any medical/surgical benefits are provided; if the plan provides medical/surgical benefits in one of the classifications but does not provide SUD or MH benefits in that classification, that would constitute a treatment limitation
- The regulations state that the processes, strategies, evidentiary standards and other factors used to apply non-quantitative treatment limitations to SUD or MH benefits in a classification have to be comparable to and applied no more stringently than the processes, strategies, evidentiary standards and other factors used to apply to medical/surgical benefits in the same classification. The regulations acknowledge that there may be different clinical standards used in making these determinations.

### **Rule Defines a “Predominant” Financial Requirement or Treatment Limitation for Purposes of Parity Analysis:**

- The rule states that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement
- A predominant level (amount) of a type of financial requirement or quantitative treatment limitation is defined as the level that applies to more than one-half of the medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification
- If there is no one level that applies to more than one-half of the medical/surgical benefits that are subject to financial requirements or quantitative treatment limitations in a certain classification, the regulations provide guidance about how this should be determined

### **Rule Defines What Constitutes “Substantially All” Medical/Surgical Benefits for Purposes of Parity Analysis:**

- The rule states that when a financial requirement or quantitative treatment limitation on a medical/surgical benefit applies to at least two-thirds of the benefits in that classification, this is considered to be “substantially all” of those benefits
  - Therefore, if a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of requirement or limitation cannot be applied to SUD or MH benefits in that same classification

### **Additional Regulatory Provisions Aimed at Providing Parity for SUD and MH Benefits:**

- The regulations restate the MHPAEA requirement that, for group health plans/issuers that offer SUD or MH benefits, where out-of-network benefits are provided for medical/surgical benefits they must also be provided for SUD and MH benefits
- The regulations prohibit separate cost-sharing requirements or treatment limitations that apply only to SUD or MH benefits
- The regulations provide guidance on the two MHPAEA disclosure provisions requiring:
  - Criteria for medical necessity determinations for SUD or MH benefits be made available to participants and beneficiaries, and
  - Reasons for denial of reimbursement or payment for SUD or MH services be made available to participants and beneficiaries
- The preamble to the rule acknowledges that some group health plans have lower co-payments for primary care providers than for specialists and that often SUD and MH providers are defined as specialists; the guidance makes clear that there cannot be a separate classification of generalists and specialists in determining whether certain financial requirements or treatment limitations meet the MHPAEA parity requirements
- The guidance prohibits insurers from setting up separate plans or benefit packages to try to avoid complying with the MHPAEA requirements; the guidance states that separately administered benefit packages should be considered as a single plan

- The rule prohibits plans from applying cumulative financial requirements (such as deductibles) or cumulative quantitative treatment limitations for SUD or MH benefits in a classification that accumulates separately from any cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification

### **Application of the Parity Requirements to Prescription Drugs:**

- The regulations state that the MHPAEA parity requirements apply to prescription drug benefits
- To determine whether a group health plan/issuer is imposing unfair financial requirements on certain drugs prescribed for SUD or MH conditions, the regulations state that financial requirements imposed on drugs prescribed for the treatment of an SUD or MH condition must be compared with those imposed on other prescription drugs in the same tier in which the prescription drug is classified
- The regulations state that if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on “reasonable factors” and without regard to whether a drug is generally prescribed for medical/surgical benefits or SUD or MH benefits, the parity requirement is satisfied

### **Areas Identified as Subject to Future Regulatory Action:**

- The regulations acknowledge that Medicaid managed care plans offering SUD or MH services must comply with the MHPAEA but state that these regulations do not apply to those plans and that additional guidance will be given by the Centers for Medicare and Medicaid Services (CMS)
- The regulations state that additional guidance will be issued “in the near future” concerning the provisions that allow group health plans that experience certain increased costs to be exempt from the MHPAEA requirements

### **Solicitation for Public Comments:**

- In addition to seeking general comments in response to the MHPAEA regulations, the Departments identify a number of areas where they would like public comment including:
  - Whether additional examples of non-quantitative treatment limitations and how the parity analysis would be applied to these medical management tools would be helpful
  - Whether and how the MHPAEA addresses the issue of scope of services/continuum of care
  - Which clarifications would help to ensure compliance with disclosure requirements for medical necessity criteria and denials of SUD or MH benefits
- The 90-day public comment period closes on May 3, 2010