ALERT
FEBRUARY 9, 2010
HEALTH LAW
News Concerning
Recent Health Law Issues
COZEN O'CONNOR
www.cozen.com

UNDER NEW RULES, PLANS OFFERING MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS MUST ENSURE PARITY IN MEMBER COSTS AND ACCESS TO CARE

Salvatore G. Rotella, Jr. • 215.665.3729 • *srotella@cozen.com*

On February 2, 2010, the Centers for Medicare & Medicaid Services, the Internal Revenue Service, and the Department of Labor's Employee Benefits Security Administration published long-awaited regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (the "MHPAEA").[1] The MHPAEA followed the Mental Health Parity Act of 1996, which had previously mandated parity in aggregate lifetime and annual dollar limits between mental health benefits and medical/surgical benefits. The MHPAEA expanded that mandate to encompass substance use disorder benefits and also imposed new restrictions on member costs (referred to as "financial requirements") and treatment limitations. As a result, under the 2008 law, group health plans must treat mental health or substance use disorder ("MH/SUD") benefits comparably to medical/surgical benefits with respect to both member costs and access to care.

The new regulations establish a wide-ranging and detailed set of implementing rules for the MHPAEA.[2] Because of the significant impact these rules will have on benefit plan designs, they also have important implications for mental health providers, pharmaceutical companies, and others in the health care industry.

Note, however, that the regulations only mandate that group health plans that choose to offer MH/SUD benefits, as well as medical/surgical benefits, follow this specific set of parity rules. They do not require plans to offer MH/SUD benefits in the first place, or that a plan that provides benefits for any one or more particular mental health condition or substance use disorder provide benefits for any other such condition or disorder. Nor do the rules affect the terms and conditions relating to the amount, duration, or scope of a plan's MH/SUD benefits, other than as specifically set forth in the regulations.

The rules establish three fundamental parity requirements.

First, they refine the existing parity mandates regarding aggregate lifetime and annual dollar limits based on how plans set such limits for medical/surgical benefits, as follows:

- Plans with no aggregate lifetime or annual dollar limit on medical/surgical benefits or that apply such limits to less than one-third of all medical/surgical benefits may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits;
- Plans with an aggregate lifetime or annual dollar limit on at least two-thirds of all medical surgical/benefits must either: (a) apply those limits to all member benefits in a manner that does not distinguish between medical/surgical and MH/SUD benefits; or (b) not include an aggregate lifetime or annual dollar limit for MH/SUD benefits that is less than the plan's corresponding limit on medical/surgical benefits; and
- Plans that do not fit either of the foregoing categories must either: (a) impose no aggregate lifetime or annual dollar limit on MH/SUD benefits; or (b) impose an aggregate lifetime or annual dollar limit that is no less than the average limit calculated for the plan's medical/surgical benefits under a methodology set forth in the regulation.

Second, a group health plan may not apply any "financial requirement" or "treatment limitation" to MH/SUD 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. The rules define the relevant terms of this multi-part requirement as follows:

1. *See* 75 Fed. Reg. 5410 (Feb. 2, 2010) (interim final rule).
2. *See* 45 C.F.R. 146.136; 26 C.F.R. 54.9812-1T; 29 C.F.R. 2590.172.

- "Financial requirements" include deductibles, co-payments, co-insurance, and out-of-pocket maximums;
- "Treatment limitations" include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment;
- The six "classifications" are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs; and
- "Substantially all" and "predominant" are both defined in terms of the dollar value of the payments for medical/surgical benefits expected to be paid under the plan for the plan year.

While the practical application of this requirement is often quite complex, the fundamental principle is straightforward. A plan, for example, could not impose a $500 deductible on all outpatient, in-network mental health benefits but only a $250 deductible on all outpatient, in-network medical/surgical benefits. Nor could it set a lower limit on the number of visits for outpatient, out-of-network mental health services than for outpatient, out-of-network medical/surgical services.

Third, a group health plan generally may not impose non-quantitative treatment limitations – *e.g.,* medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness – on MH/SUDs unless those limitations are comparably applied to medical/surgical benefits in the same classification. A plan would violate the regulation, for example, if it required concurrent review for inpatient, in-network mental health benefits, but required only retrospective review – and not concurrent review – for inpatient, in-network medical/surgical benefits.

The MHPAEA regulations, finally, apply to plan years beginning on or after July 1, 2010; however, the statutory effective date is for plan years beginning after October 3, 2009. Employers with fewer than 50 employees are exempted, and the government intends to issue guidance regarding separate, yearlong exemptions for any plan that can demonstrate that it has incurred increased costs above 2% as a result of application of the parity requirements.

For further information regarding the MHPAEA and these recent regulatory developments, please contact Sal Rotella of the Health Law Practice Group (215.665.3729, srotella@cozen.com) or Kathy Drapeau of the Employee Benefits and Executive Compensation Practice Group (at 212.908.1286 or kdrapeau@cozen.com).

© 2010 Cozen O'Connor. All Rights Reserved. Comments in the Cozen O'Connor Alert are not intended to provide legal advice. The analysis, conclusions, and/or views expressed herein do not necessarily represent the position of the law firm of Cozen O'Connor or any of its employees, or the opinion of any current or former client of Cozen O'Connor. Readers should not act or rely on information in the Alert without seeking specific legal advice from Cozen O'Connor on matters which concern them.