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APA Practice
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Information Alert

Date: February 18, 2010

To: SPTA and Division Federal Advocacy Coordinators
APAGS Coordinators

From: Marilyn Richmond, J.D., Assistant Executive Director for Government Relations
American Psychological Association Practice Organization

Cc: Katherine Nordal, Ph.D., Executive Director for Professional Practice
SPTA Executive Directors
SPTA Directors of Professional Affairs
CAPP

Re: **Details on the Interim Final Rule on Mental Health Parity**

We are pleased to report that the Departments of Health and Human Services, Labor and Treasury have released a highly favorable interim final rule implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the "MHPAEA"). This interim rule was released on February 2, 2010, and we anticipate that the regulators will finalize the rule sometime after a 90-day comment period. We are attaching a summary of the interim final rule, which provides extensive detail on how the MHPAEA will be implemented. Most health plans will have to meet the requirements of this new regulation for plan years beginning January 1, 2011, but in the meantime they must continue their "good faith" compliance with the law.

This new rule implements the requirements of MHPAEA, which means that it requires that for all group health plans of 50 or more employees that provide both medical/surgical and mental health/substance use disorder benefits, such plans must ensure that the financial requirements and treatment limitations applied to mental/substance use disorder benefits are no more restrictive than those imposed on medical/surgical benefits. This requirement applies to all aspects of the benefits coverage, including lifetime and annual dollar limits, deductibles, copayments, coinsurance, out-of-pocket maximums, and day or visit limits.

We are most pleased that the federal regulators chose to implement the MHPAEA in the manner that we had urged them to during the regulatory process. For instance, we had urged that the rule prohibit separate deductibles and out-of-pocket maximums for mental health and substance use

benefits, since such separate limits, even if equal, would violate the spirit of the law. This interim rule prohibits separate deductibles and out-of-pocket maximums for mental health and substance use disorder benefits.

In addition, we had urged the federal regulators to look beyond typical financial requirements and treatment limitations, to apply the law to prohibit any type of requirement or limitation that would violate the spirit of the law. For example, we flagged for the regulators episodic limits or plan differentials around reasonable or customary charges, and the regulators in implementing the MHPAEA also require parity for these aspects of plan coverage. In fact, the new rule will even require parity in medical management. For instance, a plan generally must apply a medical management standard to a mental health/substance use disorder service that is comparable to and applied no more stringently than that applied to a medical/surgical service.

Even regarding the parity standard itself, the regulators adopted our suggestion that parity be applied in a straightforward manner and most favorable to the plan enrollee. This means that requirements and limitations on mental health and substance use benefits cannot be applied in a more restrictive manner than those for medical and surgical benefits.

As regulators prepare for final rulemaking, we continue to work to ensure that any last minute changes to the interim final rule remain true to the spirit of the law. The interim final rule is a very positive start and a testament to the hard work and determination of psychologists across the country, who for several years lobbied their legislators at home and in Washington, DC, mobilized broad-based support, and made contributions to psychology's national PAC (AAP/PLAN). These efforts, coupled with those of our government relations team at the federal legislative and regulatory levels, have made possible this big step forward toward ending insurance discrimination against mental health and substance use. Thank you and we will keep you posted.

Summary begins on next page.

Summary of the Interim Final Rule Implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

On February 2, 2010, the Departments of Labor, Health and Human Services and Treasury (the "Regulators") published an interim final rule (75 Fed. Reg. 5,410 et seq.) to implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA"). For a summary of the requirements and provisions of the MHPAEA, see http://www.apapracticecentral.org/news/2008/parity-summary.aspx. The interim final rule may be seen at http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf.

This new regulation will replace the current regulation found at 45 C.F.R. § 146.136, which implemented the Mental Health Parity Act of 1996 ("MHPA"). MHPA required parity for lifetime and annual dollar limits. This new regulation—implementing the MHPAEA—will require parity between mental health and substance use disorder benefits and medical and surgical benefits for lifetime and annual dollar limits and for all other financial requirements and treatment limitations. After a 90 day comment period, the Regulators may publish a final rule, but the rule becomes effective for health plan years beginning on or after July 1, 2010.

I. Health Plans to which the MHPAEA Applies (146.36(e))

As with the MHPA, the MHPAEA applies to all group health plans of 50 or more employees that provide both medical/surgical and mental health and substance use disorder benefits. The rule requires that parity must be applied separately to separate benefits package options offered by an insurer (as was required in MHPA rulemaking) and clarifies that a plan may not circumvent the parity requirement by offering separate medical/surgical and mental health/substance use disorder benefits plans. Even with such separate plans, since they are provided "simultaneously" to participants (or beneficiaries), the parity law applies.

II. Parity Requirement (146.36(b) and (c))

A. Overview

MHPAEA amended the MHPA to add a parity requirement for financial requirements and treatment limitations beyond the already existing requirement for annual and lifetime dollar limits. Therefore, the new regulation will retain the current parity standard for lifetime and annual dollar limits and provide a new standard for all other financial requirements and treatment limitations. While two standards are necessary due to slight differences provided in the statutory language, they are in implementation essentially the same standard. In addition, this new regulation distinguishes and requires parity for

financial requirements and both “quantitative” treatment limitations and “nonquantitative” treatment limitations. As a result, the regulation provides for three similar but separate parity standards—

- Parity with respect to aggregate lifetime and annual dollar limits (146.136(b)),

- Parity with respect to financial requirements and “quantitative” treatment limitations (146.136(c)(2) and (3)), and

- Parity with respect to “nonquantitative” treatment limitations (146.36(c)(4)).

B. Parity with respect to aggregate lifetime and annual dollar limits (146.136(b))

This new regulation keeps in place the current regulatory standard for applying parity to lifetime and annual dollar limits for mental health and substance use disorder services. (Minor or technical changes have been made to reflect that these limits now apply to substance use disorder benefits and to clarify that these are *dollar* limits.)

> *Terminology: Under the rule an aggregate lifetime dollar limit and an annual dollar limit are dollar limitations on the total (lifetime) and 12-month (annual) amount of specified benefits that may be paid under a group health plan for any coverage unit.*
>
> *Terminology: A coverage unit refers to groupings of individuals for purposes of determining benefits, premiums or contributions. Typical plan coverage units include individual-employee-only, family, and employee-plus-spouse.*

Parity Standard—Parity applies depending on the aggregate lifetime or annual dollar limits that a group health plan imposes—

- If a plan does not impose an aggregate lifetime or annual dollar limit on medical/surgical benefits or imposes a limit on less than one-third of all medical/surgical benefits, then it may not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits.

  The determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents less than one-third of all medical surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid by the plan (using any reasonable method) for the plan year.

- If a plan does impose an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, then it may impose the same or a lesser limit on mental health or substance use disorder benefits.

The determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents at least two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments expected to be paid by the plan (using any reasonable method) for the plan year.

- If a plan meets neither of these descriptions—in other words it imposes a limit on more than one-third of all medical/surgical benefits but it does not impose an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits—for example, it imposes different limits on various categories of benefits so that no single limit is imposed on at least two-thirds of all medical/surgical benefits—then the plan must either not impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits, or it may impose a limit that is no less than an average limit calculated for medical/surgical benefits.

  This average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits that are applicable to the categories of medical/surgical benefits.

  Example—A plan imposes a $100,000 annual limit for cardio-pulmonary diseases. It does not impose an annual limit on any other medical/surgical benefits. The plan determines that 40% of plan payments for medical/surgical benefits are for cardio-pulmonary diseases. The plan determines that $1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan will incur with respect to the other 60% of medical/surgical payments. The plan may impose an annual dollar limit of no less than $640,000 on mental health and substance use disorder benefits, which is the weighted average of the plan annual dollar limits in all categories of benefits ($100,000 × 40% + $1,000,000 × 60% = $640,000).

C. Parity with respect to financial requirements and "quantitative" treatment limitations (146.136(c)(2) and (3))

1. **Overview—**The rule requires parity with respect to all financial requirements and quantitative treatment limitations. The rule specifies that financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums; and 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 scope or duration of treatment. Financial requirements are quantitative, and the rule distinguishes those treatment limitations which are quantitative and those which are not for purposes of applying the parity law.

   Terminology: "Quantitative" requirements or limits are those that have a numerical limitation, such as an annual visit limit of 50 days or a copayment requirement of $20. A "nonquantitative" treatment limitation is a limitation that is not expressed numerically but which otherwise limits the scope or duration of the benefit.

The rule includes a nonexhaustive list of nonquantitative treatment limitations. For example, medical management standards that are more stringently applied to mental health and substance use disorder services is a nonquantitative treatment limitation that would be prohibited by this rule. The parity standard for these limitations is discussed in II. D. of this summary below.

2. **Parity Standard**—A group health plan may not apply any financial requirement or quantitative 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.

   The rule provides for six classifications of benefits. Parity is applied on a classification-by-classification basis. In other words, the rule provides that a plan must provide mental health and substance use disorder benefits in every classification for which it provides medical/surgical benefits, and parity is applied by comparing the benefits in each classification. The six classifications are: inpatient/in-network (benefits furnished on an inpatient basis by a network of providers); inpatient/out-of-network (benefits furnished on an inpatient basis and outside a network of providers or where a plan has no provider network); outpatient/in-network; outpatient/out-of-network; emergency care; and prescription drugs.

   > *Terminology: A "type" of financial requirement or treatment limitation includes a deductible, copayment, coinsurance, out-of-pocket maximum, day or visit limit, or episode of care. For purposes of parity, type is compared to type (i.e. copayments are compared to copayments).*

3. **Applying the Parity Standard—A two-step test—**

   - **Substantially All**—The first step is to determine whether a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification. A financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification. If this type is not applied to two-thirds of all medical/surgical benefits in a classification, then it cannot be applied to the mental health and substance use disorder benefits in that classification. No requirement or limitation applies to mental health and substance use disorder benefits (and there is no need to proceed to the second step).

   - **Predominant**—The second step—If a type of financial requirement or quantitative treatment limitation does apply to at least two-thirds of all medical/surgical benefits in a classification, then the predominant level is that which may be applied to mental health and substance use disorder benefits. The predominant level of a type of financial requirement or quantitative treatment limitation is that which applies to more than one-half of all medical/surgical benefits in a classification. If no single

level applies to more than one-half of the medical/surgical benefits, a plan may combine levels until the combination applies to more than one-half, and the least restrictive level within the combination is considered the predominant level. A plan may combine the most restrictive levels first in reaching the more-than-one-half threshold. Alternatively, a plan may simply treat the least restrictive level as the predominant level.

> *Terminology: A "level" of a type of financial requirement or treatment limitation refers magnitude of the requirement or limitation. For example, different levels of coinsurance are 20% and 30%. Different levels of copayments are $15 and $20.*

The determination of whether the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation represents two-thirds (substantially all) or more than one-half (predominant) of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid by the plan (using any reasonable method) for the plan year.

If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

Example #1—A plan imposes an annual 25 visit limit on physical therapy services. These services are outpatient services whether delivered in- or out-of-network. The plan does not impose any other visit limit on any of its other outpatient medical/surgical benefits. The plan determines that about 5% of plan payments is a reasonable estimate of how much it will spend on outpatient physical therapy services for the plan year. Conclusion—the plan may not impose a visit limit on outpatient mental health and substance use disorder services. The 25 visit limit on physical therapy is only applied on 5% of all outpatient medical/surgical benefits, which does not represent two-thirds, or substantially all, of the benefits provided on an outpatient basis.

Example #2—For inpatient/out-of-network medical/surgical benefits, a plan imposes five levels of copayment. Using a reasonable method, the plan projects its payments for the upcoming year as follows—

Copayment amount	*$0*	*$10*	*$15*	*$20*	*$50*	
Projected payments	*$200×*	*$200×*	*$200×*	*$300×*	*$100×*	*$1,000×*
Percent of total plan costs	*20%*	*20%*	*20%*	*30%*	*10%*	

Percent subject to copayments	*N/A*	*25%* *(200×/800×)*	*25%* *(200×/800×)*	*37.5%* *(300×/800×)*	*12.5%* *(100×/800×)*	

The plan projects plan costs of $800× to be subject to copayments, therefore 80% of the benefits are projected to be subject to a copayment.

Conclusion—The two-thirds threshold of the substantially all step is met for copayments, since 80% of all inpatient/out-of-network medical/surgical benefits are subject to a copayment. The plan may impose a copayment requirement on mental health and substance use disorder benefits. Step 2—predominance—There is no single copayment level that applies to more than one-half of medical/surgical benefits. The plan may combine any levels of copayments, including the highest levels, to determine the predominant level that may be applied to mental health and substance use disorder benefits. If the plan applies the two highest levels (the $50 and $20 copayment amounts), these two levels are equal 50% of the projected plan payments ($100× + $300×). This combination is not the predominant amount since it does not constitute more than one-half of the benefits subject to a copayment amount. The plan could combine the three highest amounts ($50, $20 and $15), which does constitute more than one-half of the benefits subject to a copayment requirement ($100× + $300× + $200×; $600×/$800× = 75%) to meet the predominance standard. The plan then may apply the least restrictive of these copayment requirements on mental health and substance use disorder services, or $15.

4. Issues related to the parity standard—

- **Parity for out-of-network mental health and substance use disorder benefits—**As mentioned above, the rule provides that a health plan must provide mental health and substance use disorder benefits in every classification for which is provides medical/surgical benefits, and parity is applied by comparing the benefits in each classification. The rule specifically states that this means that if a plan provides out-of-network medical/surgical benefits, it must also provide out-of-network mental health and substance use disorder benefits at parity (146.36(c)(2)(ii)(B)).

- **Mental health providers may not be classified as "specialists" for purposes of copayments—**A common health plan design imposes lower copayments for treatment by primary care providers as compared with higher copayments for treatment by specialists. Some health plans classify mental health providers as specialists. This rule does not allow for a separate classification for specialist versus primary care services for purposes of applying the parity standard, therefore a health plan may not classify mental health providers as "specialists" for purposes of imposing a higher copayment requirement (75 Fed. Reg. 5,413).

- **No separate financial requirements or cumulative treatment limitations** (146.36(c)(3)(v))—A group health plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

  Cumulative financial requirements and quantitative treatment limitations are those that determine whether or to what extent benefits are provided. Typically, a cumulative financial requirement operates as a threshold amount that once satisfied will determine the extent of benefits provided. Cumulative financial requirements include deductibles (that must be satisfied before a plan will start paying for benefits) and out-of-pocket maximums. For purposes of the law, lifetime and annual dollar limits are not cumulative financial requirements. Cumulative quantitative treatment limitations include annual or lifetime day or visit limits.

  Example—A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all mental health/substance use disorder benefits. Conclusion—The separate annual deductible imposed on mental health and substance use disorder benefits violates MHPAEA.

- **Special rule for multi-tiered prescription drugs benefits—**The parity law could impose a significant burden on health plans with multi-tiered prescription drug benefits. Consequently, this rule provides that if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on "reasonable" factors (such as cost, efficacy, generic versus brand name) and without regard to whether a drug is generally prescribed with respect to medical/surgical or mental health or substance use disorder benefits, the plan satisfies the parity requirement with respect to the prescription drug classification in the rule. This special rule, in effect, allows a plan to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier.

D. Parity with respect to "nonquantitative" treatment limitations (146.36(c)(4))

Parity Standard—Any processes, strategies, evidentiary standards, or other factors used by a group health plan in applying a nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification shall be comparable to and applied no more stringently than those used in applying the limitation to medical/surgical benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

The rule provides an illustrative list of nonquantitative treatment limitations to which it applies—

- Medical management standards that limit or exclude benefits based on medical necessity or appropriateness or whether treatment is experimental or investigative.

  Example—A plan that imposes concurrent review for inpatient/in-network mental health and substance use disorder benefits but retrospective review for inpatient/in-network medical/surgical benefits would violate the law, since such review is not comparable. Such difference might be permissible in certain individual cases based on recognized clinically appropriate standards of care but not as a general plan standard.

- Formulary design for prescription drugs.

- Standards for provider network participation, including reimbursement rates.

- Plan methods for determining usual, customary, and reasonable charges.

- Plan refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (first-fail policies or step therapy protocols).

- Exclusions based on failure to complete a course of treatment.

III. Additional Provisions

The primary purpose of this interim final rule is to establish the parity standard for group health compliance. The MHPAEA provides for other requirements related to the parity standard and this rule addresses some of these additional requirements—

A. Availability of plan information (146.36(d))

A group health plan must make available criteria for medical necessity determinations with respect to mental health and substance use disorder benefits to any current or potential participant, beneficiary, or contracting provider upon request.

A group health plan must make reasons for a denial of reimbursement or services payment with respect to mental health or substance use disorder benefits available to a plan participant or beneficiary upon request. The preamble of the rule (75 Fed. Reg. 5,417) notes that plans regulated by the Employee Retirement Income Security Act (“ERISA”) must satisfy this requirement in a form and manner consistent with current ERISA claims procedure regulations (29 CFR §2560.503-1). The rule clarifies that non-Federal governmental and church plans will meet this requirement by satisfying these same ERISA claims procedure regulations.

B. Employer exemptions (146.36(f) and (g))

The MHPAEA replaces the MHPA plan exemption from the law related to cost increases and makes technical changes to the definition of small employer for purposes of

applicability. This proposed rule does not address the cost exemption, which will be addressed according the Regulators (see 75 Fed. Reg. 5,419) in separate rulemaking in the near future. This rule does address the technical changes related to the small employer exemption. Under the proposed rule, a small employer is generally an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees (or one employee if permitted by state law) on the first day of the plan year.

C. Assistance and guidance

The MHPAEA requires that the Regulators publish and widely disseminate guidance and information about the parity law to group health plans, participants and beneficiaries, state and local regulatory bodies, and the National Association of Insurance Commissioners and to provide assistance concerning the law's requirements and the continued operation of applicable state law. This proposed rule does not provide this guidance or assistance.

D. Terms related to medical/surgical, mental health and substance use disorder benefits (146.36(a))

Medical/surgical benefits means benefits for medical or surgical services, as defined under the terms of the plan or health insurance coverage, but does not include mental health or substance use disorder benefits.

Mental health benefits means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

Substance use disorder benefits means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

Any condition defined by the plan as being or as not being a medical/surgical or mental health or substance use disorder condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases, the Diagnostic and Statistical Manual of Mental Disorders, or State guidelines). This additional requirement is intended to prevent plans from mischaracterizing a benefit in order to avoid compliance with the law.

E. Sale of nonparity health insurance coverage prohibited (146.36(h))

A health insurer may not sell a policy of insurance that does not meet the requirements of this rule, except if the plan meets the small employer or cost exemptions permitted in the law.

F. Applicability Date (146.36(i))

These regulations are applicable for plan years beginning on or after July 1, 2010. Since most group health plan years begin on January 1st of each year, for most group health plans, these regulations will apply beginning on January 1, 2011. There is a special rule for certain collectively bargained plans. The Regulators state in the preamble (see 75 Fed. Reg. 5,419) that since MHPAEA is already in effect (as of October 3, 2009), plans are expected to be in "good-faith" compliance with the statute's requirements, and that participants and beneficiaries are not prevented from bringing private action for perceived violations of the law.

APA Practice Organization
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