

## Agencies Issue Final Rules for Mental Health Parity Act

Federal agencies have issued long-awaited regulations on providing parity for employees enrolled in group health plans who need treatment for mental health or substance use disorders. The interim final rules were issued by the Treasury Department, the U.S. Department of Labor and the U.S. Department of Health and Human Services (HHS), and published in the Feb. 2, 2010, issue of the *Federal Register*. **The rules apply to plan years starting after June 30, 2010.**

The new rules implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), **enacted in October 2008 and effective as of Jan. 1, 2010, for calendar-year plans.** MHPAEA prohibits group health insurance plans—typically offered by employers—from restricting access to care by limiting benefits and requiring higher patient costs than those that apply to general medical or surgical benefits.

**MHPAEA applies to employers with 50 or more workers whose group health plans choose to offer mental health or substance use disorder benefits.**

Plan sponsors should review plan documents to ensure that they comply with the new interim final rules. To the extent that plan managers decide to drop their mental health or substance use disorder coverage, Summaries of Material Reduction must be provided, and revisions will need to be made to the Summary Plan Descriptions, benefit booklets, and other benefit communications.

### The New Law Requires:

- Any group health plan that includes mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review.
- These practices must be based on the same level of scientific evidence used by the insurer for medical and surgical benefits.

For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits. They must be calculated as one limit.

### Financial Requirement

The rules repeat the statutory language in which the term “financial requirements” include deductibles, co-payments, co-insurance, and out-of-pocket maximums. The rules hold that MHPAEA’s general 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 deductibles).

The statute and the rules exclude aggregate lifetime and annual dollar limits that distinguish between mental health benefits and medical/surgical benefits from the meaning of “financial requirements”; these limits are subject to separate provisions originally enacted as part of the 1996 Mental Health Parity Act that remain in paragraph (b) of MHPAEA.

### Treatment Limitations

The rules provide that the parity requirements in the statute apply to quantitative and nonquantitative treatment limits. A quantitative treatment limit is expressed numerically, such as an annual limit of 50 outpatient visits. A nonquantitative treatment limit is not expressed numerically but otherwise limits the scope or duration of benefits for treatment. Nonquantitative treatment limits include:

- 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 (also known as fail-first policies or step therapy protocols).
- Conditioning benefits on completion of a course of treatment.



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## Benefit Classification

The rules specify six classifications of benefits:

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

If a plan does not have a network of providers for inpatient or outpatient benefits, all benefits in the classification are characterized as out of network.

The rules mandate that parity for financial requirements and treatment limits generally be applied on a classification-by-classification basis and that these are the only classifications used to satisfy MHPAEA's parity requirements. These classifications must be used for all financial requirements and treatment limits to the extent that a plan provides benefits in a classification and imposes a separate financial requirement or treatment limit for benefits in the classification.

## Measuring Plan Benefits

In order to apply the substantive rules, the regulations establish standards for measuring plan benefits. These are similar to those under the Mental Health Parity Act of 1996, and provide that the portion of plan payments subject to a financial requirement or quantitative treatment limit is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

Also similar to the 1996 act's regulations, any reasonable method may be used to determine the dollar amount expected to be paid under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limit.

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