

GRIST Report: Highlights of the new mental health and substance abuse parity regulations

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Summary

Newly released regulations explain key provisions of the Mental Health Parity and Addiction Equity Act, which is already in effect for many calendar-year group health plans. Under the regulations, a covered plan must have a single, shared deductible and out-of-pocket maximum for mental health/substance abuse (MHSA) and medical/surgical benefits. The new rules also establish six benefit classifications within which plans must provide parity in financial requirements and treatment limits. However, the regulations do not address how to apply financial requirements and treatment limits to MHSA benefits outside the six classifications. In addition, questions remain about other scope-of-service and continuum-of-care issues, the exemption for plans with increased costs, and disclosures of medical-necessity determinations and denials. The regulations generally will apply for plan years beginning on or after July 1, 2010, so calendar-year plans will have to comply by Jan. 1, 2011. Some collectively bargained plans will have more time to comply. This article summarizes key parity provisions in the new rules and includes an appendix replicating relevant examples from the regulations.

Regulations explain expanded parity law

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) aims broadly to eliminate group health plan discrimination on the basis of mental health or substance abuse (MHSA) ([GRIST #20080238](#), Jan. 6, 2009). The law expands the 1996 Mental Health Parity Act by imposing more stringent parity requirements and adding substance abuse treatment as a protected benefit. Newly released [regulations](#) give some clear answers on certain plan features that satisfy or violate the expanded law. However, the regulations set up data-intensive, prescriptive numerical tests that may complicate evaluating whether certain plan designs pass muster. Other tests are more subjective, making it difficult to clearly establish what design elements are permissible.

Background on MHPAEA. To achieve parity between MHSA and medical/surgical benefits, the law focuses on health plans' financial requirements – such as copays, coinsurance, deductibles and out-of-pocket limits – and treatment limits – such as day or session caps on visits,

preauthorizations, and case management provisions. Specifically, the law prohibits group health plans from having financial requirements or treatment limits for covered MHSA benefits that are more restrictive than the predominant requirements or limits that apply to substantially all covered medical and surgical benefits. It also expands to include substance abuse benefits under the existing rules on annual and lifetime aggregate dollar maximums that apply to mental health benefits. The regulations confirm that the act doesn't require group health plans to provide MHSA benefits, but if a plan does, its benefits must meet the law's provisions.

Penalties for parity violations. Employers (or plans in the case of a multiemployer plan) violating the parity rules face a potential excise tax of \$100 per affected employee for each day of violation. Violations must be reported and excise taxes paid using IRS Form 8928 ([GRIST #20090230](#), Oct. 2, 2009). Other potential consequences include ERISA penalties and individual lawsuits to recover benefits that should have been provided ([GRIST #20090331](#), Dec. 23, 2009).

Effective dates and good-faith compliance. The MHPAEA took effect for plan years beginning on or after Oct. 3, 2009, which meant many calendar-year plans had to comply by Jan. 1, 2010. The new regulations are effective for plan years beginning on or after July 1, 2010, so calendar-year plans must comply by Jan. 1, 2011. Until the regulations take effect, group health plans that have made a good-faith effort to comply with the law's provisions will not face enforcement actions by the departments of Labor, Health and Human Services, and Treasury.

Delayed effective date for certain collectively bargained plans. For plans operating under collective bargaining agreements (CBAs) ratified before Oct. 3, 2008, the *law* requires compliance for plan years starting on or after the later of (i) Jan. 1, 2010, or (ii) the termination date of the last CBA relating to the plan ([Select News](#), Dec. 15, 2008). These plans must comply with the *regulations* for plan years starting on or after the later of (i) July 1, 2010, or (ii) the termination date of the last CBA relating to the plan.

Comments requested. Regulators have requested comments by May 3, 2010, on a variety of topics not addressed in the regulations: treatment settings and other scope-of-service and continuum-of-care issues for MHSA benefits (such as intensive outpatient therapy); the exemption for plans with increased costs due to parity compliance; and disclosures about medical-necessity determinations and benefit denials. In addition, regulators have asked whether more examples of nonquantitative treatment limits would help illustrate how medical management fits within the parity requirements.

What this article covers. This article gives an overview of the regulatory provisions and reproduces illustrative examples from the regulations in the Appendix. Later articles will provide a more in-depth look at various provisions and their impact on employers' group health plans.

Plans subject to parity

The law generally applies to insured and self-insured group health plans that offer both medical/surgical and MHSA benefits. Self-insured state or local government plans may annually opt out of the parity and certain other group health plan requirements ([GRIST #20080238](#), Oct. 15, 2008, and [GRIST #20020315](#), Oct. 25, 2002).

Parity required for separate plans. The regulations confirm that the parity requirements apply to stand-alone plans if employees can choose to be covered by both a plan providing only medical/surgical benefits and a plan offering only MHSA benefits. For parity purposes, all employer-sponsored benefits are treated as a single group health plan – even if the benefits are provided under plans that have separate Form 5500 filings.

Rules for insured plans. Insurers providing policies to plans that are subject to the federal parity rules must comply with both state-law and MHPAEA requirements. Insurers cannot sell policies that don't meet federal parity requirements unless the buyer is exempt from complying.

Shared deductible and out-of-pocket limits

Group health plans can't subject MHSA benefits to a separate deductible or out-of-pocket maximums – even if lower than the medical/surgical deductible or maximums. This means that both medical/surgical and MHSA expenses must count toward the same deductible, out-of-pocket maximums and any other [cumulative financial requirements](#) (except aggregate lifetime and annual dollar limits). While different benefits can have separate lifetime and annual dollar limits under a plan, the law prohibits setting these limits lower for MHSA benefits than for medical/surgical benefits.

Parity in financial requirements and quantitative treatment limits

The law's key requirement prohibits group health plans from imposing financial requirements or treatment limits on MHSA benefits that are more restrictive than the predominant ones that apply to substantially all medical/surgical benefits. These prohibitions apply within a benefit classification and within a coverage unit for each benefit package offered.

While the act itself left open many questions, the regulations establish very specific, numerical tests, using actual data from each benefit plan or arrangement, and a multistep analysis. This data-driven analysis makes it impossible to come up with universal answers to certain common questions, such as the following:

- Can a specialist copayment apply to all MHSA benefits under a plan?
- Can the highest level of coinsurance for inpatient medical/surgical benefits apply to inpatient MHSA benefits?

- Must limits on physical and speech therapy for autism be eliminated (assuming autism benefits are treated as MHSA benefits), even if similar limits apply to physical and speech therapy for medical/surgical benefits?

The discussion below briefly explains key terms defined in the regulations and discusses how these parity requirements operate, providing links where the Appendix replicates relevant examples from the regulations. A future article will look at these requirements and tests in more depth and explain how they might apply to particular plan designs.

Financial requirements. Financial requirements subject to this rule include common cost-sharing provisions: deductibles, copayments, coinsurance and out-of-pocket maximums. The rule does not apply to aggregate annual or lifetime dollar limits on benefits. Parity applies separately to each type of financial requirement; for example, MHSA copayments are compared to medical/surgical copayments, not coinsurance. If a type of financial requirement has different levels – such as copayments that vary by the nature of the service (\$0 for preventive care, \$20 for primary care and \$40 for specialty care) – the rule requires parity at the predominant level (discussed [below](#)).

Treatment limits. Quantitative treatment limits subject to the rule include episode, annual and lifetime limits on the number of treatment days and provider visits. Parity again applies separately to each type of treatment limit and, if applicable, at the predominant level for a particular type of limit, such as when a plan has varied visit limits for chiropractic and physical therapy. In addition, special rules apply to nonquantitative treatment limits (discussed in the next [section](#)).

[Benefit classifications and coverage units.](#) To determine whether a plan's financial requirements and treatment limits for MHSA and medical/surgical benefits satisfy the parity regulations, comparisons must be made within six benefit classifications:

- inpatient (in-network),
- inpatient (out-of-network),
- outpatient (in-network),
- outpatient (out-of-network),
- emergency care and
- prescription drugs.

Similarly, certain comparisons must be made within a coverage unit (or tier), such as single, employee plus one and employee plus family. For example, if singles and families have different

deductibles for medical/surgical benefits, evaluating MHSA benefits for parity involves separate comparisons of deductible requirements for single and family tiers.

Special rule for prescription drug plans. Most prescription drug plans that use a tiered cost-sharing approach will automatically satisfy the parity rules as long as the tiers reflect factors other than the drug's use to treat a medical/surgical or MHSA condition. For example, a prescription drug plan with tiered copayments for generic versus brand-name drugs or for mail-order versus retail pharmacy use satisfies the parity rules, as long as the tiered copayments apply to drugs prescribed for both MHSA and other purposes. Drug plans with limits applied only or differentially to MHSA drugs are unlikely to meet parity requirements.

Substantially all. Group health plans cannot apply any financial requirement or treatment limit to MHSA benefits unless it applies to substantially all medical/surgical benefits within a benefit classification. "Substantially all" means at least as two-thirds of medical/surgical benefits within a particular classification and is calculated using a reasonable projection of a plan's medical/surgical benefit payments within that classification. For example, if all medical/surgical benefits are subject to a \$20 copayment, then plans can impose a \$20 copay for MHSA benefits without violating the two-thirds standard. This calculation must be performed for each "type" of limit (coinsurance, copayments, visit limits, etc.).

Predominant. If a type of financial requirement or treatment limit applies to substantially all medical/surgical benefits but has multiple levels (such as copayments of \$10, \$20 and \$40), then the plan must determine the predominant level. The predominant level must apply to more than half of the benefits within a particular classification and is calculated using a reasonable projection of the plan's medical/surgical benefit payments (for each level within a classification). If no single level meets the "more than half" standard, the plan can combine any of the levels until the standard is met, but only the least restrictive level in the combination (for example, the lowest dollar copayment or the highest number of visits) can apply to MHSA benefits.

Putting it all together. Here are the basic steps for determining which financial requirements or quantitative treatment limits can apply to MHSA benefits:

- Identify which of the six benefit classifications the plan covers and the coverage units or tiers for each benefit package option (for example, PPO, HMO, etc).
- Create a reasonable estimate of plan payments for medical/surgical benefits subject to financial requirements or treatment limits in each of the six classifications (and by coverage unit if the financial requirement or treatment limit applies differently by coverage tier).
- Establish which type and level of financial requirement or treatment limit applies to each benefit classification and coverage unit for MHSA and medical/surgical benefits.

- Using the percentage (at least two-thirds) of the total projected plan payments in the benefit classification, determine whether a financial requirement or treatment limit applies to substantially all of the medical/surgical benefits.
- If multiple levels of financial requirements or treatment limits exist for medical/surgical benefits in a benefit classification, determine the predominant requirement or limit by establishing which level or a combination of levels applies to more than half of the medical/surgical benefits (excluding any benefits that aren't subject to a financial requirement or treatment limit).

If a financial requirement or treatment limit in a benefit classification satisfies these rules, then it may be applied to MHSA benefits. If it doesn't, consider and implement plan changes that will satisfy the parity rules.

Example. Bananafish Inc. wants to determine whether a coinsurance percentage can be applied to the outpatient, in-network MHSA services in its PPO option. First, Bananafish obtains a reasonable estimate of its medical/surgical outpatient, in-network PPO costs. Then, Bananafish determines what percentage of those costs is subject to coinsurance. This analysis reveals that coinsurance applies to over two-thirds of the medical/surgical costs, which means Bananafish can apply a coinsurance requirement to covered MHSA benefits. To determine which coinsurance level can be applied, Bananafish establishes the percentage of the total outpatient, in-network medical/surgical costs at each of its two coinsurance levels:

Coinsurance level	% of total outpatient, in-network costs
15% coinsurance for primary care provider	30%
20% coinsurance for specialist provider	70%

Because the 20 percent specialist coinsurance level applies to more than half of the PPO's outpatient, in-network medical/surgical costs, this amount is the predominant financial requirement and Bananafish may require 20 percent coinsurance for outpatient, in-network MHSA services under the PPO.

Parity in nonquantitative treatment limits

The somewhat mechanical calculation described above doesn't apply to treatment limits that are nonquantitative. [Nonquantitative treatment limits](#) include these types of plan provisions (among others):

- prior authorization, case management and other medical management processes used to determine whether a treatment is medically necessary or appropriate and thus covered by the plan;

- denial of coverage because an individual failed to complete a course of treatment;
- methods of determining reasonable and customary charges; and
- procedures for admitting providers to a plan's network and setting their reimbursement rates.

How parity applies. Under the regulations, both the design and operation of any “processes, strategies, evidentiary standards, or other factors” used in applying nonquantitative treatment limits to MHSA benefits must be comparable to those applied to medical/surgical benefits. For example, precertification requirements may only be applied to outpatient, in-network MHSA services if they also apply to outpatient, in-network medical/surgical services. Even if the standards are the same, they can't be applied more stringently to MHSA benefits. For example, a plan administrator cannot require precertification for all inpatient, in-network MHSA services but enforce this requirement for just a few medical/surgical services. The only exception is if recognized clinical standards of care justify applying a nonquantitative treatment limit differently for MHSA services.

Special rule for some EAPs. Employee assistance plans (EAPs) typically provide a set level of MHSA counseling visits, either as a prerequisite to getting additional MHSA benefits from the group health plan or as a supplemental benefit. The regulations say that plans violate parity if they require employees to exhaust EAP visits before using any MHSA benefits under the group health plan (essentially a mandatory gatekeeper approach), unless a similar limit applies to medical/surgical benefits.

Open issues

While the regulations provide needed guidance on applying parity rules, some issues have not yet been addressed, while others are left to plan sponsors and their vendors to decide.

Providing required disclosures. Under the law, plans must make available information about medical-necessity determinations and other reasons for denying MHSA benefits/ The regulations provide little additional guidance but do confirm that plans following ERISA requirements for claim procedures satisfy the denial disclosure rules. (For information on ERISA claim procedure rules, see [GRIST #2001002](#), Jan. 3, 2001.)

Defining MHSA benefits. The regulations leave to group health plans the task of determining what qualifies as a MHSA benefit, requiring only that the definition must be consistent with “generally recognized independent standards of current medical practice.” Examples of those standards include the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR), the World Health Organization's International Classification of Diseases, and even state law guidelines. For example, plans may cover autism as a neurological, neurobehavioral or mental health disorder. However, if a plan uses the DSM-IV-TR as the standard for determining MHSA benefits, autism would be covered as a MHSA disorder.

Handling unique services. The regulations do not define inpatient, outpatient or emergency care, but they do require a plan to apply these terms uniformly to medical/surgical and MHSA services. Even though regulators acknowledge that not all MHSA and medical/surgical treatments are identical, the regulations do not address how to gauge parity when a plan's levels of MHSA care, such as intensive outpatient programs for substance abuse treatment, do not have a clear medical/surgical counterpart.

Identifying collectively bargained plans. The law and regulations allow a delayed effective date for certain collectively bargained plans but don't specify what constitutes a collectively bargained plan (for example, what percentage of employees must be subject to the CBA for a plan to be a collectively bargained). Thus, employers with a group health plan covering both union and nonunion employees will have to work with counsel to reach a good-faith compliance approach for the appropriate effective date.

Qualifying for a one-year cost exemption. A plan may receive a one-year exemption from the parity rules if the cost of compliance exceeds a certain thresholds. Regulators confirmed that the exemption may be claimed only for alternating plan years but did not provide any additional guidance on how plans could obtain the exemption.

Next steps

Although calendar-year plans have until Jan. 1, 2011, to comply with these regulations, any group health plan sponsor with a plan year starting in July or later has to make any necessary changes before the next plan year begins in 2010. While some plan design features will be easily identified as compliant or noncompliant, others will require more extensive data analysis. Here are some ideas for approaching parity compliance:

- Revisit MHSA program objectives and design.
- Work with vendors to eliminate separate deductibles and out-of-pocket maximums and to discuss compliant plan designs for other financial requirements and treatment limits.
- Confirm that all annual and lifetime dollar limits on both mental health and substance abuse benefits are not lower than the limits on medical/surgical benefits.
- Determine whether any financial requirements or treatment limits comply with the parity rules without data analysis.
- Gather medical/surgical plan data on payments, cost-sharing and treatment limits for each benefit package option, using the six benefit classifications and coverage tiers.

- Apply reasonable methods to determine which financial requirements and quantitative treatment limits apply to substantially all medical/surgical benefits within each benefit classification.
- If any financial requirement or quantitative treatment limit has several levels, determine the predominant level and confirm that MHSA requirements and limits are no more restrictive.
- Work with medical/surgical and MHSA plan vendors to determine whether comparable nonquantitative treatment limits (such as preauthorization requirements, concurrent review) apply to both types of benefits and are enforced no more stringently for MHSA benefits than for medical/surgical benefits.
- Remove mandatory EAP “gatekeeper” requirements and offer MHSA benefits regardless of EAP use.
- Consider excise tax implications and other potential consequences of noncompliance.

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Appendix: Examples from the regulations

The regulations offer a variety of examples illustrating how the parity requirements affect different plan provisions. For convenience, this section reproduces some of those examples, grouped by the relevant parity requirement.

Cumulative financial requirements. These three examples illustrate plans that meet or violate the requirement for a single deductible and out-of-pocket maximum covering both medical/surgical and MHSA expenses (Treas. Reg. Section 54.9812(c)(3)(v)(B)):

Example 1. (i) Facts. A group health plan imposes a combined annual \$500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) Conclusion. In this Example 1, the combined annual deductible complies with the cumulative financial requirements.

Example 2. (i) Facts. A plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

(ii) Conclusion. In this Example 2, the separate annual deductible on mental health and substance use disorder benefits violates the cumulative financial requirements.

Example 3. (i) Facts. A plan imposes an annual \$300 deductible on all medical/surgical benefits and a separate annual \$100 deductible on all mental health or substance use disorder benefits.

(ii) Conclusion. In this Example 3, the separate annual deductible on mental health and substance use disorder benefits violates the cumulative financial requirements.

Benefit classifications and coverage units. The following examples illustrate how to compare MHSA and medical/surgical benefits for parity within benefit classifications and coverage units or tiers (Treas. Reg. Section 54.9812(c)(2)(ii)(C)):

Example 1. (i) Facts. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a \$500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 1, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical

benefits, the parity rules apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

Example 2. (i) Facts. A plan imposes a \$500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 2, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the parity rules apply with respect to the deductible and the coinsurance across all benefits.

Example 3. (i) Facts. Same facts as Example 2, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 3, because the plan imposes separate financial requirements based on classifications, the parity rules apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency classification; and

(B) All other benefits.

Example 4. (i) Facts. Same facts as Example 2, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) Conclusion. In this Example 4, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the parity rules apply with respect to the deductible and coinsurance separately for—

(A) Inpatient, out-of-network benefits; and

(B) All other benefits.

Substantially all and predominant. The examples below show how to assess whether a plan's financial requirements or treatment limits for MHSA benefits are no more restrictive than the predominant ones that apply to substantially all medical/surgical benefits (Treas. Reg. Section 54.9812(c)(3)(iv)):

Example 1. (i) Facts. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

Coinurance rate	0%	10%	15%	20%	30%	Total
Projected payments	\$200x	\$100x	\$450x	\$100x	\$150x	\$1,000x
Percent of total plan costs	20%	10%	45%	10%	15%	
Percent subject to coinsurance level	N/A	12.5% (100x/800x)	56.25% (450x/800x)	12.5% (100x/800x)	18.75% (150x/800x)	

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) Conclusion. In this Example 1, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

Example 2. (i) Facts. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

Copayment amount	\$0	\$10	\$15	\$20	\$50	Total
Projected payments	\$200x	\$200x	\$200x	\$300x	\$100x	\$1,000x
Percent of total plan costs	20%	20%	20%	30%	10%	
Percent subject to copayments	N/A	25% (200x/800x)	25% (200x/800x)	37.5% (300x/800x)	12.5% (100x/800x)	

The plan projects plan costs of \$800x to be subject to copayments (\$200x + \$200x + \$300x + \$100x = \$800x). Thus, 80 percent (\$800x/\$1,000x) of the benefits are projected to be subject to a copayment.

(ii) Conclusion. In this Example 2, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the

\$10 copayment, 25 percent; for the \$15 copayment, 25 percent; for the \$20 copayment, 37.5 percent; and for the \$50 copayment, 12.5 percent). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the \$50 copayment and the \$20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($\$300x + \$100x = \$400x$; $\$400x/\$800x = 50\%$). The combined projected payments for the three highest copayment levels—the \$50 copayment, the \$20 copayment, and the \$15 copayment—are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($\$100x + \$300x + \$200x = \$600x$; $\$600x/\$800x = 75\%$). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the \$15 copayment.

Example 3. (i) Facts. A plan imposes a \$250 deductible on all medical/surgical benefits for self-only coverage and a \$500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) Conclusion. In this Example 3, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits.

Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

Example 4. (i) Facts. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as “generic”, “preferred brand name”, “nonpreferred brand name”, or “specialty” complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

	Tier 1	Tier 2	Tier 3	Tier 4
Tier description	Generic drugs	Preferred brand name drugs	Nonpreferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent paid by plan	90%	80%	60%	50%

(ii) Conclusion. In this Example 4, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with parity requirements; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements.

Nonquantitative treatment limits. Four examples in the regulations indicate how differences in nonquantitative treatment limits may violate or satisfy an exception in the parity regulations (Treas. Reg. Section 54.9812(c)(4)(iii)):

Example 1. (i) Facts. A group health plan limits benefits to treatment that is medically necessary. The plan requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits.

(ii) Conclusion. In this Example 1, the plan violates the parity rules. Although the same nonquantitative treatment limitation—medical necessity—applies to both mental health and substance use disorder benefits and to medical/surgical benefits for inpatient, in-network services, the concurrent review process does not apply to medical/surgical benefits. The concurrent review process is not comparable to the retrospective review process. While such a difference might be permissible in certain individual cases based on recognized clinically appropriate standards of care, it is not permissible for distinguishing between all medical/surgical benefits and all mental health or substance use disorder benefits.

Example 2. (i) Facts. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) Conclusion. In this Example 2, the plan violates the parity rules. Although the same nonquantitative treatment limitation—medical necessity—is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network

services, the penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

Example 3. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.

(ii) Conclusion. In this Example 3, the plan complies with the parity rules because the nonquantitative treatment limitation—medical appropriateness—is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

Example 4. (i) Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) Conclusion. In this Example 4, the plan violates the parity rules. Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

Example 5. (i) Facts. An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after

exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program.

(ii) Conclusion. In this Example 5, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements. Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.