

Update

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Mental health, substance abuse benefits must meet parity rules

Sweeping federal regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) give long-awaited guidance to ensure group health plans do not discriminate in benefits for mental health and substance abuse (MHSA). While the regulations clearly delineate permitted and prohibited benefit features, they also specify data-intensive, numerical parity tests that may complicate evaluating certain plan designs. Other tests are more subjective, leaving uncertainty about some design elements. The rules also present challenges for some commonplace behavioral health strategies used in managed care. This article answers basic questions about the new rules and offers some practical dos and don'ts for employers to consider.

Who must comply with the new federal rules, and by when?

Employers with more than 50 employees that sponsor self-funded or fully insured group health plans must comply with the MHPAEA rules. Insured plans may have additional requirements under state insurance laws.

Though the *law* has taken effect for many group health plans, the new *rules* generally won't apply until plan years starting on or after July 1, 2010 – or Jan. 1, 2011, for calendar-year plans. Some plans subject to collective bargaining agreements (CBAs) have more time to comply. Until the rules take effect, plans that make good-faith efforts to comply will not face government enforcement actions.

Must an employer offer MHSA benefits?

No. But employers that do so must provide MHSA benefits in each of these categories if medical/surgical benefits are covered:

- Inpatient/in-network
- Inpatient/out-of-network
- Outpatient/in-network

Multistep parity analysis

1. Identify whether the plan covers MHSA and medical/surgical benefits in the six benefit classifications: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care and prescription drugs.
2. Create a reasonable estimate of plan payments for medical/surgical benefits in each of the six categories.
3. Determine whether at least two-thirds (“substantially all”) of the plan payments in a category are subject to a particular financial requirement (such as copayments) or treatment limit.
4. If step 3 is met, determine whether the amount or level of the financial requirement or treatment limit (such as a \$20 copay) applies to more than half of the benefits within a category. (If so, it is the predominant level.)
5. If there is no predominant level, further analysis is needed.

- Outpatient/out-of-network
- Emergency care
- Prescription drugs

Although the rules allow plans to exclude coverage for certain conditions, employers considering this route must satisfy other laws, such as the Americans with Disabilities Act (ADA) or similar state statutes. Despite the new compliance obligations, most employers understand the value of covering MHSA treatments and are likely to continue to do so.

What do the rules require?

The new rules implement the law’s original intent that group health plans offering both MHSA and medical/surgical benefits treat them similarly (a concept known as “parity”). Parity applies to these plan elements:

- Financial or cost-sharing features, such as copays, coinsurance, deductibles and out-of-pocket maximums (shared deductibles/out-of-pocket maximums for MHSA and medical/surgical benefits are required)
- Treatment limits, such as annual caps on the number of visits or hospital inpatient days
- Annual and lifetime dollar maximums for MHSA benefits (MHSA caps lower than those applied to medical/surgical benefits are prohibited)

Does parity apply to nonquantitative approaches?

Yes. Parity is required in nonquantitative limits, such as preauthorization requirements, concurrent reviews, coverage denials due to failure to complete treatment and prescription drug formularies. In design and operation, plans must use comparable “processes, strategies, evidentiary standards or other factors” in applying these limits to MHSA and medical/surgical benefits. For example, precertification may be required for outpatient, in-network MHSA services only if this requirement also applies to outpatient, in-network medical/surgical services. If a plan does impose such restrictions, it can’t apply those limits more stringently to MHSA benefits than it would to medical/surgical coverage, unless recognized, clinically appropriate standards of care justify a difference.

What financial or treatment limits are overly restrictive?

The rules provide specific formulas to compare MHSA and medical/surgical benefits. Employers (and their vendors) will need to collect a fair amount of plan information to apply the formulas. However, the table on page 3 shows how some common plan features fare under the rules. If a plan feature doesn’t clearly meet or violate the parity rules,

employers must conduct a multistep analysis (see sidebar, page 2) to determine whether the MHSA financial requirements or treatment limitations are more restrictive than the predominant ones that apply to substantially all medical surgical benefits.

Plan features likely to comply with MHPAEA	Plan features likely to violate MHPAEA
<ul style="list-style-type: none"> ■ Single, shared deductible and out-of-pocket limit for medical/surgical and MHSA benefits ■ Plan terms that define particular conditions – e.g., autism – as medical or mental health conditions, as long as the definitions are consistent with generally recognized, independent standards of current medical practice or state guidelines ■ Prescription drug plans with a tiered cost-sharing approach that varies for generic vs. preferred brands, mail-order vs. retail purchases or factors other than the drug’s use to treat medical/surgical vs. MHSA conditions ■ Permanent exclusion of all benefits for a particular condition or treatment or for all MHSA conditions (but such exclusions could raise compliance issues under ADA or state laws) ■ Precertification requirement for inpatient medical/surgical and MHSA services ■ Aggregate annual and lifetime dollar limits for MHSA benefits that are the same or higher than those for medical/surgical benefits ■ All outpatient medical/surgical benefits subject to copay, and plan applies lowest outpatient copay to MHSA benefits 	<ul style="list-style-type: none"> ■ Separate MHSA deductible or out-of-pocket maximum, even if more generous than the medical/surgical deductible or maximum ■ Requirement to exhaust employee assistance program (EAP) benefits (as a mandatory gatekeeper) before using group health plan’s MHSA benefits, unless medical/surgical benefits also require a mandatory gatekeeper ■ Specialist (higher) copay schedule for all MHSA services without doing the required analysis ■ Out-of-network coverage of medical/surgical treatments, but not out-of-network MHSA expenses ■ Copayment for inpatient medical/surgical hospital stays, but coinsurance for inpatient MHSA stays ■ Precertification requirement for MHSA benefits in a particular benefit classification (such as in-network/outpatient), but not for medical/surgical benefits in the same classification ■ Copay of \$50 for MHSA emergency care, but \$25 for medical/surgical emergency care ■ Higher cost share for psychotropic medications not prescribed by psychiatrist, but same cost share for other drugs, regardless of prescriber
<p>Plan features likely to require data-intensive, multistep analysis to assess compliance</p>	
<ul style="list-style-type: none"> ■ Multiple types and levels of financial requirements for different benefit classifications ■ Coinsurance for MHSA inpatient benefits set at highest level under the medical plan ■ Same copayments for MHSA providers and medical/surgical specialists ■ Limits on physical/speech therapy for MHSA conditions, even if similar limits apply to those therapies for medical/surgical benefits 	

What happens if a plan doesn’t comply with the rules?

Parity violations can trigger an excise tax of up to \$100 per affected employee for each day of noncompliance. Employers (or plans, in the case of a multiemployer plan) must report and pay excise taxes using the Internal Revenue Service’s Form 8928. Other potential consequences include ERISA penalties and individual lawsuits to recover benefits that should have been provided.



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What compliance steps should employers take now?

- Eliminate separate deductibles and other financial accumulators (such as out-of-pocket maximums).
 - Work with medical and MHSA vendors to ensure that technologies can support shared deductibles and out-of-pocket limits for standalone plans or carved-out behavioral health programs.
- Review and gather data on medical plan costs, quantitative cost-sharing and treatment limits, and nonquantitative limits for these plan features:
 - **Annual and lifetime dollar limits** for MHSA and medical/surgical benefits
 - **Availability of medical/surgical and MHSA coverage in the six benefit classifications** (inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care and prescription drugs)
 - **Financial limits** (such as copayments, coinsurance, deductibles and out-of-pocket minimums) in each benefit classification and any differences in coverage tiers (for example, individual vs. family) for medical/surgical and MHSA benefits
 - **Treatment limits** (such as day, episode, frequency, or annual visit or stay limits) in each classification for both medical/surgical and MHSA benefits
 - **Nonquantitative limits** (such as EAP exhaustion, precertification, concurrent review, case management, step therapy, formulary design, condition and service exclusions, and provider rate-setting and reasonable/customary reimbursements) for medical/surgical and MHSA benefits
- Apply multistep mathematical tests to determine the predominant levels of financial requirements and quantitative treatment limits for substantially all medical/surgical benefits that also can apply to MHSA benefits.
- Consider excise tax implications of noncompliance.
- Document the good-faith compliance basis for 2010 benefit designs.
- Work with MHSA vendors to identify strategies for managing quality that are consistent with the parity rules, such as reviewing care that falls outside of national clinical practice guidelines and implementing MHSA performance guarantees.