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Mental Health Parity Requirements Guidance On Health Plan Mental Health & Substance Abuse Copays, Utilization Management Limits Released

Group health plans and health insurers subject to the mental health parity requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) have additional guidance about the effect of these requirements on utilization management and copayment requirements.

The U.S. Departments of Health and Human Services (HHS), Labor and the Treasury (the Departments) on November 17, 2011 published additional FAQs that share insights on how the MHPAEA requirements impact certain common copayments and utilization review arrangements historically used by plans and insurers. The new FAQ guidance **here** provides additional clarification about the meaning of the interim final rules implementing MHPAEA the Departments jointly issued on February 2, 2010, and previous FAQ guidance published on June 30, 2010 and December 22, 2010 as applied to these practices.

MHPAEA Mental Health Parity Rules Generally

The MHPAEA supplemented the previously enacted mental health parity requirements enacted under the Mental Health Parity Act of 1996 (MHPA).

For plans and policies subject to its provisions, MHPAEA generally specifies that group health plans and health plan issuers whose plans or policies provide mental health or substance abuse coverage:

- Cannot impose financial requirements and treatment limitations on mental health and substance use disorder benefits that are more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits; and
- Cannot impose separate financial requirements or treatment limitations that are applicable only to mental health or substance use disorder benefits.

Under MHPAEA and the Departments' interim final rules, a group health plan or group health insurance issuer generally cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits in any of 6 classifications(3) that is more restrictive than the financial requirements or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits in the same classification. Thus, if a plan generally applies a $25 copayment to at least 2/3 of outpatient, in-network, medical/surgical benefits, a higher copayment could not be imposed on outpatient, in-network mental health or substance use disorder benefits.

In addition to financial requirements and quantitative treatment limitations, plans and issuers often impose nonquantitative treatment limitations, such as:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether a treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods used to determine usual, customary, and reasonable fee charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
- Exclusions based on failure to complete a course of treatment.

Utilization Provisions Under MHPAEA's Qualitative Treatment Limitations

The Departments' interim final rules provide that, under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation with respect to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.

The subjective nature of the nonquantitative treatment limitation as construed by the interim final regulation has raised several questions. The new FAQs share the Departments joint response to questions about their interpretation of the interim final rules on nonquantitative treatment limitations in various respects. Among other things, the new FAQs reflect:

The new FAQs respond to various questions about the effect of the MHPAEA on various medical necessity and other utilization management practices that health plans and health insurers historically have applied mental health and substance abuse coverage's.

The FAQs generally reaffirm that group health plans and health insurers generally cannot apply stricter medical necessity or other utilization review for mental health or substance abuse treatments than the prevailing requirements generally applicable to medical surgical benefits under the plan or policy.

The FAQ also provides insight into evidence that health insurers or health plan sponsors should consider and retain when designing fraud control or other medical management techniques to be defensible under the MHPAEA's parity requirements.

Furthermore, the new FAQs also provide guidance about the viability and use of differences in clinical standards of care, length of stay, and other clinical standards to justify differences in the periods of coverage provided for mental and substance abuse coverage versus other types of treatments.

Copayments Under MHPAEA Coverage Parity Rules

The FAQs also address when a group health plan or health insurer can require covered persons to pay a higher specialist copayment for mental health or substance abuse treatments than generally applies to care rendered to a non-specialist. According to the FAQ, the standard for determining the maximum copayment that a health insurer or group health plan can apply to mental health/substance use disorder benefits is determined by the "predominant copayment that applies to substantially all medical/surgical benefits within a classification." Accordingly, the FAQ states that if the copayment meets this standard is the one charged for a medical/surgical specialist, the group health plan or health insurer could require payment of the higher copayment for all mental health/substance use disorder benefits within that classification. On the other hand, if the copayment that meets this standard is the one charged for a medical/surgical generalist,

then that is the copayment is the amount that the group health plan or health insurer could require be charged to all mental health/substance use disorder benefits within that classification.

Affordable Care Act & Other Rules Impacting On Mental Health & Substance Abuse Coverage & Benefits

Mental health and substance abuse parity under the MHPAEA is one of a number of issues that health insurers and group health plans, their sponsors and administrators should consider when deciding the design and administration of mental health and substance abuse coverage under their program.

Insurers, plan sponsors, fiduciaries and administrators also should consider the potential implications of various other federal requirements on the design and administration of mental health and substance abuse coverage and benefits under their programs. For example, the express reference to mental health and substance abuse benefits as included within the definition of "essential benefits" for purposes of the Affordable Care Act requires additional consideration of the effect of the Affordable Care Act's annual and lifetime limit and other mandates relating to essential benefit coverage be evaluated and addressed. In addition, specific attention should be devoted to the potential effects of the Affordable Care Act's independent review and other rules concerning the processing and payment of health benefit claims by non-grandfathered health plans.

Along with considering the potential implications of these emerging requirements, health insurers, group health plans and those involved in their design and administration also should verify that their eligibility and other program terms or practices do not inappropriately violate the nondiscrimination rules of laws such as the Americans with Disabilities Act, the Health Insurance Portability & Accountability Act, the Genetic Information Nondiscrimination Act or other laws and that their plan and those involved in its administration are properly safeguarding the confidentiality of sensitive information about mental health , substance abuse or other health information about covered persons or their family.

For Help or More Information

If you need help reviewing and updating, administering or defending your group health or other employee benefit, human resources, insurance, health care matters or related documents or practices, please contact the author of this update, Cynthia Marcotte Stamer.

A Fellow in the American College of Employee Benefit Council, immediate past Chair of the American Bar Association (ABA) RPTE Employee Benefits & Other Compensation Group and current Co-Chair of its Welfare Benefit Committee, Vice-Chair of the ABA TIPS Employee Benefits Committee, a council member of the ABA Joint Committee on Employee Benefits, and past Chair of the ABA Health Law Section Managed Care & Insurance Interest Group, Ms. Stamer is recognized, internationally, nationally and locally for her more than 24 years of work, advocacy, education and publications on cutting edge health and managed care, employee benefit, human resources and related workforce, insurance and financial services, and health care matters.

A board certified labor and employment attorney widely known for her extensive and creative knowledge and experienced with these and other employment, employee benefit and compensation matters, Ms. Stamer continuously advises and assists employers, employee benefit plans, their sponsoring employers, fiduciaries, insurers, administrators, service providers, insurers and others to monitor and respond to evolving legal and operational requirements and to design, administer, document and defend medical and other welfare benefit, qualified and non-qualified deferred compensation and retirement, severance and other employee benefit,

compensation, and human resources, management and other programs and practices tailored to the client's human resources, employee benefits or other management goals. A primary drafter of the Bolivian Social Security pension privatization law, Ms. Stamer also works extensively with management, service provider and other clients to monitor legislative and regulatory developments and to deal with Congressional and state legislators, regulators, and enforcement officials concerning regulatory, investigatory or enforcement concerns.

Recognized in Who's Who In American Professionals and both an American Bar Association (ABA) and a State Bar of Texas Fellow, Ms. Stamer serves on the Editorial Advisory Board of Employee Benefits News, the editor and publisher of **Solutions Law Press HR & Benefits Update** and other Solutions Law Press Publications, and active in a multitude of other employee benefits, human resources and other professional and civic organizations. She also is a widely published author and highly regarded speaker on these matters. Her insights on these and other matters appear in the Bureau of National Affairs, Spencer Publications, the Wall Street Journal, the Dallas Business Journal, the Houston Business Journal, Modern and many other national and local publications. You can learn more about Ms. Stamer and her experience, review some of her other training, speaking, publications and other resources, and register to receive future updates about developments on these and other concerns from Ms. Stamer **here**.

Other Resources

If you found this update of interest, you also may be interested in reviewing some of the other updates and publications authored by Ms. Stamer available including:

- **Group Health Plans & Insurer To Get More Time To Meet Affordable Care Act Summary of Benefits and Coverage Requirements**
- **CMS Final Medicare Rule Imposes Many Conditions On Access To Medicare Claims Data To Evaluate Providers & Suppliers**
- **OSHA Updates Safety Resources To Prevent Construction, Other "Top 10″ Exposures**
- **OSHA Silo Safety Citations Heads Up To Grain Operators To Manage Safety**
- **OSHA Updates Safety Resources To Prevent Construction, Other "Top 10″ Exposures**
- **EBSA Releases Collection of New M-1 and Other Guidance Impacting Multiple Employer Welfare Plans**
- **New Obama Administration Affirmative Action Guidance Highlights Organization's Need To Tighten Nondiscrimination Practices**
- **Incentives To Get Employee Into Wellness Education Requires Legal Risk Management**
- **HR Key Player In Managing Rising Risk of Disability, Other Discrimination Suits Under Obama Administration Justice Department**
- **HHS Chides Insurer For "Excessive" Premium Increases After Affordable Care Act Rate Audit**
- **IRS U-Tube Video Discusses 2012 Flexible Benefit Plan Rule Change**
- **Employers Considering Using New IRS Voluntary Worker Classification Settlement Program To Resolve Payroll Tax Risks Must Also Manage Other Legal Exposures**
- **Participant Notification Added To Required Procedures For Church Plan Determination Letter Requests**
- **HHS Credits Affordable Care Act Adult Dependent Child Coverage Rule With Getting 1 Million Young Adults Health Coverage**

- **2010 Webcast Series on Federal Employer Employment of Persons With Disabilities Planned**
- **EBSA Plans To Include Health Care Reform Compliance In Health Plan Audits Beginning In FY 2012; Disputes OIG Criticism Of ACA Enforcement Efforts**
- **New Labor Department Video Tries To Educate Young Workers About Benefits & Benefit Rights**
- **Employer Assistance and Resource Network Offers Free Webinars For Employers During October In Honor of Disability Employment Awareness Month on Thursdays in October from 2:00 – 2:30 p.m. Eastern Time. Topics will include Employer Preparedness to Include Veterans with Disabilities**
- **HHS Projects Medicare Advantage Enrollment Will Rise As Premiums Decline In 2012; Plans Face Increased Regulation & Enforcement**
- **HHS Credits Health Reform For Getting Health Coverage For Added 1 Million Young Adults**
- **4th Circuit Rejects Two Challenges To Affordable Care Act Constitutionality**
- **Stamer Named Fellow In American College of Employee Benefits Counsel**
- **ABA TIPS Section Appoints Cynthia Marcotte Stamer Vice Chair of Employee Benefits General Committee**
- **Affordable Care Act To Require Health Plans Cover Contraception & Other Women's Health Procedures In 2012**
- **Company Executives, Plan Sponsors & Others May Face Personal Liability When Others Defraud Plans or Mismanage Employee Benefit Plan Responsibilities**
- **EEOC Finalizes Updates To Disability Regulations In Response to ADA Amendments Act: Employers Should Manage Risks**
- **Employer Charged With Misclassifying & Underpaying Workers To Pay $754,578 FLSA Back pay Settlement**
- **HHS Imposes 1st HIPAA Privacy Civil Penalty of $4.3 Million**
- **NLRB Settlement Shows Care Necessary When Employers Use Social Networking & Other Policies Restricting Employee Communications**
- **Wage & Hour Law Settlements Highlight Rising Wage & Hour Risks of U.S. Employers**
- **OCR Requires Rhode Island DHS To Provide Translation, Other Services For Limited English, Other Language Impaired Accommodations**