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ALERT:
HEALTH CARE REFORM BILL

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PARITY REDEFINED

While parity is a simple concept, interim final regulations on achieving parity under the Mental Health Parity and Addiction Equity Act are anything but simple. Even so, the regulations provide much-needed guidance.

BACKGROUND

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) significantly expanded the parity requirements originally imposed by the Mental Health Parity Act of 1996 (MHPA). The MHPA required parity between the annual and lifetime dollar limits that a plan applied to its medical/surgical (M/S) benefits and its mental health (MH) benefits. The MHPAEA continues that parity requirement and extends it to substance use disorder (SD) benefits. More importantly, the MHPAEA generally prohibits the application of financial requirements (e.g., copayments and deductibles) or treatment limitations (e.g., annual limits on outpatient visits or hospital days) to MH/SD benefits unless those requirements and limitations are no more restrictive than the predominant ones that apply to substantially all M/S benefits. The MHPAEA changes apply to plan years starting on or after October 3, 2009 (January 1, 2010 for calendar-year plans), so most employers have already implemented plan changes to comply with the MHPAEA.

NOTE For group health plans maintained pursuant to one or more collective bargaining agreements (CBAs) ratified before October 3, 2008, the law's requirements will not apply to plan years beginning before the later of January 1, 2010 or the date on which the CBA relating to the plan terminates.

* Please note that the recently enacted health care reform legislation will generally prohibit group health plans starting with plan years beginning on or after September 23, 2010 from imposing certain lifetime and annual limits (on the dollar value of benefits) on essential health benefits. Mental health and substance use disorder services are considered an essential benefit. While the law grants HHS the authority to allow plans to impose reasonable annual limits with respect to essential health benefits during plan years beginning before 2014, it may not choose to do so in regard to MH/SD benefits (or any essential benefit). As such, this article does not discuss the parity rules as they apply to annual and lifetime limits. For additional information about health care reform, please see **Willis' Human Capital Practice *Alert*, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011**."

REGULATIONS REQUIRE RETHINKING PARITY

Interim final regulations (which require much more detailed analysis than many had expected) issued by the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health & Human Services (HHS) explain how to determine if a plan has achieved the parity required by the MHPAEA. Unfortunately, this means that many employers have a significant compliance assessment to complete before the regulations become effective and they may need to make a second round of changes in order to comply with the MHPAEA.

The interim final regulations apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2010 (January 1, 2011 for calendar-year plans). Given the complexity of the regulations as well as the many changes enacted under health care reform legislation, employers will want to waste no time in reviewing their current plans for continued compliance with the MHPAEA. Several employer groups, such as American Benefits Council and National Business Group on Health, have requested that the Employee Benefits Security Administration delay the effective date of the MHPAEA regulations. Given the significant effect the MHPAEA and health care reform will have on plan benefits and plan design, employers need adequate time to properly implement necessary changes.

NOTE Group health plans maintained pursuant to one or more CBAs approved before October 3, 2008 have a delayed effective date. The MHPAEA regulations will not apply to these plans for plan years beginning before the later of (a) the date on which the last of the collective bargaining agreements relating to the plan terminates or (b) July 1, 2010.

GOOD FAITH STANDARD

Given that the regulations are complicated and the fact that the statute is already effective for many plans, while the regulations do not become effective until on or after July 1, 2010, the agencies have indicated that, until the regulations' effective date, a good faith, reasonable interpretation of the MHPAEA statute will be deemed compliance. Please note, however, that this is a regulatory non-enforcement policy, and it will not protect employers from participants or beneficiaries who bring private actions under ERISA.

ACHIEVING PARITY

To the extent that an employer offers both M/S benefits and MH/SD benefits, the plans under which these benefits are provided, regardless of whether they are insured or self-insured, will be subject to the MHPAEA requirements. The regulations confirm that, while the parity requirements continue to apply to annual and lifetime dollar limits as they have for several years, the MHPAEA also prohibits imposing financial requirements or treatment limitations on MH/SD benefits that are more restrictive than the most common limitations and requirements that apply to M/S benefits. The analysis required by the regulations means that employers must now identify any financial requirements or treatment limitations imposed for MH/SD benefits and compare them against similar limitations and requirements that apply to M/S benefits.

MEDICAL, SURGICAL, MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Because the regulations require comparisons between M/S and MH/SD benefits, it is important to know which benefits are M/S benefits and which are MH/SD benefits. The regulations specify that – subject to certain standards – each plan defines for itself the conditions that are considered M/S conditions and those that are considered MH/SD conditions. A plan's definitions of M/S conditions and MH/SD conditions must be "consistent with generally recognized independent standards of current medical practice." In the case of MH/SD conditions, the plan could comply with this requirement by defining these conditions according to the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) or by referring to a state guideline.

The provision of MH/SD coverage for some conditions does not require benefits for any other conditions. (Of course, state laws may require certain coverage under a fully-insured plan.) In addition, the definition a plan adopts to distinguish between MH/SD and M/S does not require that the plan provide all of the MH/SD benefits that might fit within that definition. Consequently, plan sponsors are free to exclude coverage for certain types of MH/SD without running afoul of the parity rules (please note that whether such exclusions are an issue under other federal laws, such as the Americans with Disabilities Act, is not addressed in this article).

To the extent that the plan provides benefits for a condition that could be considered a physical condition or a mental health condition (e.g., autism), the plan's ability to classify benefits is very important, and care must be taken to ensure the classification is consistent with current medical practice. For example, if a state insurance law defined autism as being a physical condition rather than a mental condition, the plan should be in compliance the MHPAEA requirements if it used the same definition.

SINGLE PLAN RULE

Neither the MHPAEA nor the regulations require that MH/SD benefits be offered to employees. Plan sponsors retain the right to exclude these benefits from their group health plans, and if they do, the parity requirements are automatically met. This

analysis has led many to theorize that carving out the MH/SD benefits into a separate plan from any M/S benefits, results in complete avoidance of the parity requirements.

To prevent a plan from avoiding the parity requirements by offering MH/SD benefits under a separate plan, the rules provide that all group health plan options offered by the employer are treated as a single group health plan for purposes of the parity requirements. This rule applies regardless of how many plans the employer maintains for ERISA or other purposes. In addition, all plans of all employers that are considered part of a single controlled group are considered one plan for this purpose.

This appears to leave open the possibility of complying by simply offering no MH/SD benefits at all under any plan. However, if the employer provides coverage for any MH/SD benefit in addition to M/S benefits, then the parity requirements will apply. Given the requirement that the definition of MH/SD benefits be reasonable as well as health care reform requirements regarding minimum essential coverage, it is unlikely that a plan could completely exclude all MH/SD benefits.

SEPARATE APPLICATION RULE

Despite imposing the single plan rule, the regulations do not require that all benefits be considered together when determining parity. In fact, the parity rules apply separately with respect to each combination of M/S and MH/SD benefits under which an individual can simultaneously receive coverage from an employer (such a combination is referred to in this article as a benefits package). For parity purposes, it does not matter whether such benefits packages are actually provided by a single plan or two separate plans.

If an employer offers different health benefit options (e.g., an HMO and a PPO) and all enrollees in these options also receive coverage under a program that provides MH/SD benefits, the parity rules would be applied option-by-option, with each option deemed to include the program providing the MH/SD benefits.

EXAMPLE An employer offers a PPO High Option (Plan A1), a PPO Low Option (Plan A2), an HDHP (Plan B) and an HMO Option (Plan C). It also provides an employee assistance program (Plan D) to all of its employees, regardless of whether or which health plan option an employee elects. The regulations require that the parity requirements be satisfied in regard to Plan D by itself and in regard to each of Plan A1 + Plan D, Plan A2 + Plan D, Plan B + Plan D and Plan C + Plan D.

TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS

As noted earlier, the MHPAEA generally prohibits the application of financial requirements (e.g., copayments and deductibles) or treatment limitations (e.g., annual limits on outpatient visits or hospital days) to MH/SD benefits unless those requirements and limitations are no more restrictive than the predominant ones that apply to substantially all M/S benefits. The regulations explain the definitions of these terms.

TREATMENT LIMITATIONS

Treatment limitations refer to limits on the scope or duration of coverage including limits on benefits based on the frequency of treatment, number of visits or days of coverage. An exclusion of all benefits for a particular condition or disorder is not a treatment limitation, however. The regulations provide rules with respect to different types of treatment limitations.

Quantitative treatment limitations are expressed numerically. An annual limit of 30 outpatient visits would be an example of a quantitative treatment limitation. Quantitative treatment limits are generally treated the same way that financial requirements are for purposes of determining parity (see below).

Non-quantitative treatment limitations affect the scope or duration of benefits under the plan but are not expressed numerically. Examples of non-quantitative treatment limitations include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary and reasonable charges

- Refusal to pay for higher cost therapies until it can be shown that a lower-cost therapy is not effective
- Exclusions based on failure to complete a course of treatment

EXAMPLE ABC Company maintains both a medical plan and an employee assistance program (EAP). One of the benefits that the EAP provides is a limited number of MH/SD counseling sessions. Participants are eligible for MH/SD benefits under the medical plan only after exhausting the EAP's counseling sessions. However, no similar requirement to exhaust benefits applies with respect to M/S benefits provided under the medical plan. Limiting eligibility for MH/SD benefits only after EAP benefits are exhausted is a non-quantitative treatment limitation. Because no comparable requirement applies to M/S benefits, the requirement may not be applied to MH/SD benefits.

The use of the EAP as a gatekeeper for purposes of accessing MH/SD benefits under the medical plan, as used in the example above, is a common plan design. The rules are quite clear that unless a comparable requirement applies to M/S benefits this will violate the non-quantitative treatment limitation rules.

When comparable non-quantitative treatment limitations apply to both MH/SD and M/S benefits, the regulations require comparing how those limitations are applied. Any processes, strategies, evidentiary standards or other factors used in applying a non-quantitative treatment limitation to MH/SD benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the same limitation with respect to similar M/S benefits (see the discussion below regarding classifications of benefits). Any variation in application of non-quantitative treatment limitations is only allowed to the extent that recognized clinically appropriate standards of care may permit a difference.

Cumulative quantitative treatment limitations determine whether, or to what extent, benefits are provided based on an accumulated amount (e.g., no more than 30 hospital days per year). The rules prohibit quantitative treatment limitations from accumulating separately for M/S benefits and MH/SD benefits. For example, a plan that imposes an annual limit of 30 outpatient visits for M/S benefits and a separate limit of 30 outpatient visits per year for MH/SD benefits would be in violation of the parity rules. Plans are still permitted to apply combined cumulative treatment limitations for all benefits. This prohibition on applying limitations separately to MH/SE and M/H benefits is in addition to the compliance analysis that is required for all quantitative treatment limitations applied to MH/SD benefits, as explained below.

FINANCIAL REQUIREMENTS

Financial requirements are amounts paid by the participant in order for the participant to receive benefits under the plan (e.g., deductibles, co-pays, out-of-pocket expenses, etc.). Financial requirements, such as copayments and coinsurance, often apply separately to each covered expense, while other financial requirements, such as annual deductibles, accumulate across covered expenses. Just as with the cumulative quantitative treatment limits described above, the rules clarify that group health plans may not apply separate cumulative financial requirements for M/S benefits and MH/SD benefits, even if the same financial requirements are imposed on both types of benefits. For example, a plan that imposes a $300 deductible on M/S benefits and a separate $300 deductible on MH/SD benefits would be in violation of the parity rules. Plans are still permitted to apply a combined deductible for all benefits.

PARITY ANALYSIS – FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

The regulations provide detailed instructions for determining whether financial requirements and quantitative treatment limitations applied to MH/SD benefits are no more restrictive than the predominant requirements and limitations that apply to substantially all M/S benefits. In the case of very simple plans, this determination is not difficult.

EXAMPLE ABC Company offers only one plan that provides health benefits of any type. The plan imposes a $500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 10% 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. The parity requirements apply in regard to the $500 deductible and 10% coinsurance, because those financial requirements apply to MH/SD benefits. The parity requirements are met, however, because the deductible and coinsurance apply equally to all benefits under the plan.

In an apparent effort to compare apples to apples, the regulations call for analysis of financial requirements and treatment limitations separately for several different types of coverage and benefits. As noted above, the parity requirements apply separately to each benefits package. Within a benefits package, the analysis applies separately for each type of financial requirement or treatment limitation imposed by the plan. For example, copayments are compared to copayments and deductibles are compared to deductibles. When a financial requirement or treatment limitation varies depending on the number of individuals covered (e.g., a family deductible), the parity analysis also applies separately for each "coverage unit." These are the groups of individuals that are used for purposes of determining benefits, eligibility or contributions. Common coverage units include single coverage, employee plus one coverage and family coverage. If a financial requirement or treatment limit applies differently based on whether an employee has enrolled dependents, the comparison would be done separately for each coverage unit variation.

EXAMPLE GEF Company offers only one plan that provides health benefits of any type. The plan imposes a $250 deductible on all benefits for self-only coverage and a $500 deductible on all benefits for family coverage. The plan has no network of providers. For all benefits, the plan imposes a 20% coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

Because self-only and family coverage are subject to different deductibles under GEF's plan, the parity analysis (see below) is applied separately for self-only M/S benefits and family M/S benefits. Because the 20% coinsurance is applied without regard to coverage units, the parity analysis is applied without regard to coverage units.

Even after applying these rules, a single benefits package may have several different deductible or copayment requirements or other financial requirements and quantitative treatment limitations. Variations may be based on the type of provider, the treatment setting or other factors.

PERMITTED BENEFIT CLASSIFICATIONS

It is not uncommon for plans to have different cost-sharing arrangements (e.g., co-payments or co-insurance) based on certain classifications, such as whether care is provided on an inpatient or outpatient basis or whether care is provided in-network or out-of-network. To address these issues, the regulations allow the benefits included in a benefits package to be divided into six different classifications and for each classification to be considered separately for parity purposes. Essentially, under the parity regulations, a plan may not apply a financial requirement or treatment limitation to MH/SD benefits in a classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in the same classification. (The meanings of "predominant" and "substantially all" are discussed below.)

The only classifications of benefits permitted in applying the parity rules are:

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

EXAMPLE DEF Company offers only one plan that provides health benefits of any type. The plan imposes a $400 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 30% coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient or prescription drug benefits. However, the plan exempts emergency care benefits from the 30% coinsurance requirement. As it imposes different financial requirements for some benefits, the parity rules call for analysis of the deductible and the coinsurance separately for:

(A) Benefits in the emergency classification
(B) All other benefits

The plan is charged with making the determination as to the classification in which a particular benefit belongs. In making this decision, the plan must apply the same standards to M/S benefits and to MH/SD benefits. If a plan provides MH/SD benefits in any of the six classifications, then MH/SD benefits must be provided in all classifications in which M/S benefits are provided. For example, if the plan provides M/S benefits on an in-network and out-of-network basis, the plan cannot limit MH/SD benefits to only in-network coverage.

If a plan varies financial requirements or treatment limitations on any basis other than the six classifications specified (e.g., higher copayments for specialist visits than for primary care provider visits), the parity rules are not applied separately because of those variations. The result is that the financial requirement or treatment limitation may not be applied to MH/SD benefits within a classification unless the same requirement or limitation applies to substantially all M/S benefits within that classification, and the more restrictive level of the requirement or limitation may not be applied to MH/SD benefits in the classification unless that level is predominant for M/S benefits in that classification.

DETERMINING "SUBSTANTIALLY ALL" AND "PREDOMINANT"

As noted earlier, the regulations prohibit a plan from applying any financial requirement or treatment limitation on MH/SD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation that is imposed on substantially all M/S benefits in the same classification.

The regulations generally define "substantially all" to mean at least two-thirds of the benefits in a classification. A plan is only permitted to apply a particular type of financial requirement (e.g., a copayment or deductible) or quantitative treatment limitation (e.g., an annual limitation on outpatient visits) to MH/SD benefits in a particular classification if at least two-thirds (i.e., substantially all) of the payments the plan projects it will make that plan year for all M/S benefits in the same classification are subject to the same type of financial requirement or quantitative treatment limitation. For example, if more than two-thirds of benefits for outpatient, in-network M/S claims are subject to a copayment, but are not subject to coinsurance, then coinsurance cannot be applied to claims for outpatient, in-network MH/SD claims, but a copayment can be applied.

Once it is determined that a particular type of financial requirement or quantitative treatment limitation can be applied to MH/SD benefits in a classification, the next question is: What level of that financial requirement or quantitative treatment limitation is "predominant" with respect to M/S benefits in that classification? A level of financial requirement or treatment limitation generally is predominant if it applies to more than one-half of the M/S benefits of that type in that classification. If a particular type of financial requirement or quantitative treatment limitation applies at the same level to at least two-thirds of all M/S benefits in a classification, then it is automatically considered to be the predominant level. For example, if a $10 copayment applies to two-thirds of M/S benefits in the outpatient, in-network classification, then the $10 copayment is the predominant level for that classification. This means that the plan cannot charge more than a $10 copayment for MH/SD benefits within the outpatient, in-network classification.

For plans that apply uniform financial requirements and treatment limitations within the six permitted classifications, the most difficult issue in applying the parity analysis may be determining the projected amount of M/S benefits within a classification. The rules allow use of any reasonable method to determine the expected dollar amount of M/S benefits within a classification and the proportion of those benefits subject to a particular level of financial requirement or quantitative treatment limitation. It is expected that insurers and third-party administrators (TPAs) will provide assistance with such projections.

The regulations provide special rules for determining the amount of M/S benefits that are subject to cumulative financial requirements and treatment limitations. When determining the amount that the plan expects to pay, for purposes of a deductible, for example, the dollar amount of M/S benefit payments that are considered subject to the deductible includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied – not just those that actually are subject to the deductible. A similar rule applies in regard to an out-of-pocket maximum limit. The dollar amount of M/S benefits payments includes all

payments associated with out-of-pocket payments for M/S conditions that are taken into account toward the out-of pocket maximum as well as all payments associated with out-of-pocket payments that would have been made toward the out-of-pocket maximum if it had not been satisfied.

The rules further provide that M/S benefits are treated as not being subject to a financial requirement or quantitative treatment limitation to the extent that such benefits are subject to a zero level of such a financial requirement or treatment limitation (e.g., no copayments are charged for annual physicals). For example, a plan imposes a 20% coinsurance requirement on all outpatient, in-network claims, except those for preventive care. Preventive benefits are paid at 100%. So long as at least two-thirds of outpatient, in-network claims are not preventive, the 20% coinsurance requirement can be imposed on outpatient, in-network MH/SD benefits. This is because coinsurance applies to substantially all of the M/S benefits in the outpatient, in-network classification and, since 20% is the only level of coinsurance applied, it is automatically predominant.

If a type of financial requirement or treatment limitation varies in amount within a classification (deductibles only apply to certain benefits or various co-payments and co-insurance levels are applied to different types of benefits within a classification), then the parity analysis is more complicated. For each financial requirement and treatment limitation applied to MH/SD benefits within a classification, it will be necessary to determine whether that type of financial requirement or quantitative treatment limitation applies to two-thirds (substantially all) M/S benefits in the classification and, if so, what level of the financial requirement or quantitative treatment limitation is "predominant."

As noted previously, the regulations define "predominant" to mean the most common or frequent level of a type of financial requirement or quantitative treatment limitation. Level refers to the magnitude of the type of financial requirement or treatment limitation. Examples of different levels of coinsurance would include 10%, 20% and 30%; different levels of copayments would include $10, $15 and $25. The level of a financial requirement or quantitative treatment limitation is predominant if the level applies to more than one-half of the M/S benefits in that classification.

It is not uncommon for plans to provide multiple levels of benefits within the same classification.

EXAMPLE 1 In the following example, copayments apply to at least two-thirds of the M/S benefits under the outpatient, in-network classification.

Under the outpatient, in-network classification, CAB Company's plan charges a $10 copayment for office visits to primary care providers and a $20 copayment for office visits to specialists. The plan determines that 80% of the payments the plan projects to make that plan year will be for services that are subject to the $10 copayment and only 20% of the projected payments will be subject to the $20 copayment. As the $10 copayment is the predominant financial requirement, no copayments in excess of $10 can be charged for MH/SD benefits in regard to the outpatient, in-network classification.

EXAMPLE 2 For inpatient, out-of-network M/S benefits, GHI Company's group health plan imposes five levels of coinsurance. Using a reasonable method, the plan makes the following projections with respect to its payments for M/S benefits in the inpatient, out-of-network classification for the upcoming year:

COINSURANCE LEVEL	0%	10%	15%	20%	30%	Total
Projected payments at coinsurance level	$200,000	$100,000	$450,000	$100,000	$150,000	$1 million
Percent of projected payments at coinsurance level	20%	10%	$45%	10%	15%	
Percent of projected payments subject to coinsurance at 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 $1,000,000 for M/S claims in the inpatient, out-of-network classification, with 80% of those costs projected to be for claims subject to coinsurance. (Claims subject to 0% coinsurance are not considered subject to coinsurance.) That means that the two-thirds threshold of the substantially all standard is met for coinsurance, so coinsurance may be required for inpatient, out-of-network MH/SD claims. In addition, of those benefits in this classification for M/S claims that are subject to coinsurance, 56.25% is projected to be subject to the 15% coinsurance level. Therefore, the 15% coinsurance applies to more than one-half of inpatient, out-of-network M/S benefits subject to the coinsurance requirement and is the predominant level. The plan may not impose any level of coinsurance greater than 15% with respect to inpatient, out-of-network MH/SD benefits.

It sometimes happens that the substantially all test (i.e., the two-thirds test) is met in regard to a particular type of financial requirement or quantitative treatment limitation, but there is more than one level of that financial requirement or treatment limitation and no single level applies to at least one half of all M/S benefits within the classification (i.e., no one level is predominant). In that case, two or more levels of that type of financial requirement or quantitative treatment limitation are aggregated and the lowest of the aggregated levels is the level that is predominant (i.e., is deemed to apply to more than one-half of M/S benefits subject to the requirement or limitation) within the particular classification, based on projected plan costs for M/S benefits within that classification.

EXAMPLE For inpatient, out-of-network M/S benefits, GHI Company's group health plan imposes five levels of copayments. Using a reasonable method, the plan makes the following projections with respect to its payments for M/S benefits in the inpatient, out-of-network classification for the upcoming year:

COPAYMENT AMOUNT	$0	$10	$15	$20	$50	Total
Projected Payments at Copayment Amount	$200,000	$200,000	$200,000	$100,000	$150,000	$1 million
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 $1,000,000 for M/S claims in the inpatient, out-of-network classification, with 80% of those costs projected to be for claims subject to copayments. (Claims subject to $0 copayment are not considered subject to copayments.) That means that the two-thirds threshold of the substantially all standard is met for copayments, so copayments may be required for inpatient, out-of-network MH/SD claims. However, there is no single level of copayment that applies to more than one-half of M/S benefits in the classification subject to a copayment.

The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to MH/SD 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 M/S benefits subject to a copayment because they are exactly one-half ($300,000 + $100,000 = $400,000; $400,000/$800,000 = 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 M/S benefits subject to the copayments ($100,000 + $300,000 + $200,000 = $600,000; $600,000/$800,000 = 75%). However, under the rules, the plan may not impose any copayment on outpatient, in-network MH/SD benefits that is more restrictive than the *least restrictive* copayment in the combination which, in this example, is the $15 copayment.

MULTI-TIERED PRESCRIPTION DRUG BENEFITS

Special rules apply for the parity analysis of the prescription drug classification if different levels of financial requirements apply to different tiers of prescription drugs benefits. If the tiers are based on reasonable factors (e.g., cost, generic versus brand name, mail order versus in-store pickup), without regard to whether the drug is prescribed with respect to M/S conditions or MH/SD conditions, the parity requirements will be satisfied with respect to the financial requirements applied to MH/SD benefits in the prescription drug classification. The process for determining the reasonable factors upon which the tiers are based must be comparable to, and applied no more stringently than, the process used in applying the same limitation with respect to M/S benefits (as discussed above in the section on non-quantitative treatment limitations).

EXAMPLE NOP Company's group health plan applies the following financial requirements for prescription drug benefits.

	Tier 1	Tier 2	Tier 3	Tier 4
Tier Description	Generic drugs	Preferred brand name drugs	Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives)	Specialty drugs
Percent of total plan costs	90%	80%	60%	50%

Under NOP's plan, these financial requirements are applied without regard to whether a drug is generally prescribed with respect to M/S conditions or with respect to MH/SD conditions. Moreover, the process for certifying a particular drug as "generic," "preferred brand name," "non-preferred brand name" or "specialty" complies with the rules regarding non-quantitative treatment limitations.

In this example, 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.

FEDERAL LAW PREEMPTION AND STATE INSURANCE LAW

There are state laws that mirror the intent of the federal parity law as well as state mandates that require a certain type or level of mental health coverage. Which laws are preempted by the MHPAEA? Congress intended to apply a very narrow preemption so that a state law is not preempted unless it prevents the application of the federal law. The net result is that, if a plan can comply with both federal and state law (e.g., to the extent that state law is more generous), the state law is not preempted by the MHPAEA. It may, however, be preempted by ERISA's broader preemption provision.

EXEMPTIONS FROM THE LAW

The MHPAEA does not apply to small employers. Under the parity regulations, a small employer is one who has employed "an average of at least two but not more than 50 employees on business days during the preceding calendar year." Recently enacted health care reform legislation made several amendments to the Public Health Services Act (PHSA) (and conforming changes to ERISA and the Internal Revenue Code). One such amendment appears to have changed the definition of small employer to employers with one to 100 employees. The effective date of this change, however, is uncertain and additional guidance is needed.

Health care reform legislation also appears to have eliminated the provision that exempted a group health plan from most of the HIPAA portability and nondiscrimination requirements, as well as certain other requirements including mental health parity if it covered fewer than two current employees at the beginning of the plan year. Some have argued that this provision exempted retiree-only plans from complying with these requirements. With the elimination of this provision, retiree-only plans no longer have this argument available. Additional guidance is needed to determine the effect of health care reform on the small employer exemption and retiree-only plans.

The prior parity rules also provided plans an exemption if compliance with the requirements would result in an increase in the cost under the plan of at least 1%. The MHPAEA still allows for an exemption due to increased costs but it has changed. Plans may apply for a one-year cost exemption, but the threshold for qualification has been raised from 1% to 2% for the first year that the plan is subject to the MHPAEA. Plans that comply with the parity requirements for one entire year and then satisfy the cost exemption requirements are exempt from the requirements for the following plan year. This results in allowing the cost exemption only to be claimed every other year. The prior regulations on the increased cost exemption have been withdrawn, and agencies intend to issue additional guidance regarding the cost exemption at a later date.

The PHSA allowed a non-federal government employer to elect to exempt its self-funded group health plan from most of the HIPAA portability and nondiscrimination requirements, as well as certain other requirements including mental health parity. However, the PHSA was significantly amended by the recently enacted health care reform law, and it now looks like this opt-out is no longer available with respect to the MHPAEA and certain other requirements. The provision making this change appears to be effective as of the date the legislation was signed (March 23, 2010), but questions remain as to what this means for employers currently taking advantage of the opt-out provision. Additional guidance is necessary to fully understand the impact of this change.

REQUIRED DISCLOSURES

The regulations also introduce new disclosure requirements. The plan administrator or insurer must make available, upon request, to current or potential participants, beneficiaries or contracting providers the criteria for medical necessity determinations made under the plan (or health insurance coverage) in regard to MH/SD benefits. The plan administrator or insurer must also provide, upon request, the reason for any denial of a participant's or beneficiary's claim for reimbursement or payment of services in regard to MH/SD benefits. Compliance with the form and manner of the ERISA claim procedures requirements applicable to group health plans (even for those plans not subject to ERISA, such as church plans) will satisfy the disclosure requirements for purposes of the claim denial notice requirement.

CONCLUSION

The interim regulations are extensive and will make compliance with the MHPAEA more complex and burdensome to plan sponsors than originally expected. Unfortunately, employers are now also dealing with the many changes brought by federal health care reform. Given the quickly approaching effective date of the regulations, employers will need to immediately begin the process of analyzing their group health plans for parity purposes. Employers will also need to review how health care reform, as it applies to the mental health parity requirements, will impact their current benefits plans. This is particularly true for those employers who are relying on an exemption from the MHPAEA that may no longer exist.

KEY CONTACTS

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