Employee Benefits & Executive Compensation ADVISORY

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Interim Final Regulations Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

The Federal Register published on Tuesday, February 2, 2010, the interim final regulations (the "Interim Regs") implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act"). The Interim Regs, issued jointly by the Department of Treasury, Department of Labor and Department of Health and Human Services (the "Agencies"), replace the existing regulations in place for the Mental Health Parity Act of 1996.

Applicability. The Interim Regs generally apply to group health plans for plan years beginning on or after July 1, 2010 (i.e., beginning January 2011 for calendar year plans). A special rule applies for plans maintained pursuant to one or more collective bargaining agreements (CBA) ratified before October 3, 2008—the Interim Regs do not apply to such plans for plan years beginning before (i) the CBA(s) terminates (ignoring any extensions agreed to after October 3, 2008) or (ii) July 1, 2010, whichever is later.

> **Practice Pointer:** Although several commenters requested clarification on how to determine whether a plan is maintained "pursuant to" a CBA if the plan covers both union and non-union employees, the Agencies declared such a determination to be outside the scope of these Interim Regs.

The statutory provisions were effective for plan years beginning on or after October 3, 2009; however, the Agencies will take into account good faith efforts to comply with a reasonable interpretation of the statutory provisions until the date the Interim Regs are effective.

The Core Requirement. Generally, the Interim Regs prohibit a plan or health insurer from applying any financial requirement or treatment limitation on mental health or substance abuse disorders that are more restrictive than the predominant financial requirement or treatment limitation imposed on substantially all medical/surgical benefits in the same "classification." The Interim Regs identify six benefit classifications: (i) inpatient/in-network, (ii) inpatient/out-of-network, (iii) outpatient/in-network, (iv) outpatient/out-of-network, (v) emergency care and (vi) prescription drugs. The Interim Regs do not define inpatient, outpatient or emergency care; such terms are subject to plan design and their meanings may differ from plan to plan (although state health insurance laws may define these terms). Nevertheless, a plan must apply these terms uniformly for both medical/surgical benefits and mental health/substance use disorder benefits. Moreover, the requirements of the Interim Regs are applied separately for each coverage unit (e.g., single, participant plus spouse, family, etc.).

"Mental Health" and "Substance Use Disorder." The Interim Regs do not provide specific definitions for "mental health conditions" and "substance abuse disorders." Rather, plans may define mental health conditions or substance use disorders, but such definitions must be "consistent with generally recognized independent standards of current medical practice." This standard does not necessarily have to be a national standard, but must be generally accepted in the relevant medical community. A plan may, for example, follow the most current version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), the most current version of the *International Classification of Diseases* (ICD) or a state guideline.

> **Practice Pointer:** The Interim Regs do not require a plan to provide any specific mental health or substance use disorder benefits. Moreover, providing benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder. However, if a plan provides benefits for a mental health condition or substance abuse disorder, benefits must be provided for that condition in each classification for which medical/surgical benefits are provided.

> **Practice Pointer:** These guidelines raise questions with regard to where the line is drawn for certain conditions. For example, a smoking cessation benefit could possibly fall into the category of a "substance use disorder" (e.g., "nicotine dependency") benefit under the Interim Regs. Another example is autism, which has been the subject of controversy as to whether it is a physical or mental health condition (autism is included in the DSM IV). Plan sponsors will need to take a close look at whether certain conditions treated under a plan are considered "mental health" or a "substance use disorder" according to current medical practice.

Comparing Financial Requirements & Treatment Limitations. For each of the six benefit classifications, each type of financial requirement and treatment limitation (e.g., copay, annual visit limits, etc.) must be compared. For example, copay and annual visit limits applicable to in-patient/in-network medical/surgical benefits must be compared to copay and annual visit limits applicable to in-patient/in-network mental health or substance use benefits.

Nonquantitative Treatment Limits. The Interim Regs impose the parity rules not only to "quantitative" treatment limits (e.g., numerically stated limits such as an annual physician visit limit) but also "nonquantitative" treatment limits. The Interim Regs provide an illustrative list of nonquantitative treatment limitations, which includes the following: medical management standards; prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary and reasonable amounts; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment. The factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the factors used in applying the limitation to medical/surgical benefits. However, even though nonquantitative treatment limitations can be "applied no more stringently" to mental health/substance use disorder benefits as to medical/surgical benefits, the Interim Regs allow for some variations to the extent that recognized "clinically appropriate standards of care may permit a difference."

Practice Pointer: Plans that require preauthorization for outpatient, inpatient or emergency treatment for mental health/substance use disorder but not for medical/surgical benefits violate the Interim Regs. A violation also exists if failure to obtain preauthorization for a mental health condition results in no coverage, while failure to obtain preauthorization for medical/surgical benefits results in a mere reduction of coverage. While nothing in the Interim Regs suggests that penalties may not be imposed for failure to obtain preauthorization, the Interim Regs indicate that all penalties and reductions in coverage related to failure to comply with preauthorization requirements (including emergency care scenarios) or other nonquantitative treatment limitations should be reviewed for compliance.

Special Rule for Prescription Drugs. Many drugs are placed into a given tier based on factors such as cost and efficacy that are unrelated to whether they are prescribed for mental health/substance abuse or medical/surgical benefits. To the extent the plan doesn't distinguish between drugs as medical/surgical benefits or mental health/substance abuse disorder benefits, the Agencies indicated that requiring a plan to make that distinction solely to determine the predominant financial requirements or treatment limitations would create significant burdens for plans without ensuring any greater parity. Thus, to the extent a plan imposes different levels of financial requirements on different tiers of prescription drugs, the plan satisfies the parity requirement with respect to the prescription drug classification of benefits if the financial requirements are based on reasonable factors (such as cost, efficacy, generic vs. brand name and mail order vs. retail pharmacy) determined in accordance with the requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits.

No "Specialist" Designation. Mental health/substance use disorder providers are treated the same as primary care providers in terms of comparing financial/treatment limits within the six categories.

Employee Assistance Plans (EAPs). EAP offered in addition to a major medical plan with compliant mental health/substance use disorder benefits is not a violation of the Interim Regs; however, if an EAP is used as a gatekeeper (i.e., you cannot receive the major medical plan's mental health benefits until you exhaust your EAP benefit), then the EAP violates the Interim Regs if there is no similar exhaustion requirement for medical/surgical.

Cumulative Financial and Quantitative Treatment Limitations. The Interim Regs prohibit plans from imposing separate cumulative financial requirement or cumulative quantitative treatment limitations on mental health/substance abuse benefits, even if such limitations are equal to those imposed on medical/surgical benefits. The Interim Regs define cumulative financial requirements and cumulative quantitative treatment limitations as limitations that determine whether and to what extent benefits are provided based on an accumulated amount. Examples of a cumulative financial requirement are deductibles and out-of-pocket maximum. An example of a cumulative quantitative treatment limitations is a maximum annual visit limitation. Cumulative limitations may not be applied separately to medical/surgical benefits and mental health/substance abuse disorder benefits. Thus, a plan that currently imposes a $500 deductible on medical/surgical benefits and a $500 deductible on mental health/substance abuse benefits must establish a combined deductible for both mental health/substance abuse benefits and medical/surgical benefits.

Disclosure Requirements. As specifically provided in the Act, the Interim Regs also provide that the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the insurer) to any current or potential participant, beneficiary or contracting provider. Generally, compliance with the form and manner of the ERISA claims procedure requirements for group health plans (even for plans not subject to ERISA, such as non-federal governmental plans and church plans) satisfies the disclosure requirements under the Interim Regs.

Definition of "Group Health Plan." The Interim Regs indicate that the parity rules apply separately with respect to each combination of medical/surgical and mental health/substance benefits that a participant can simultaneously receive from an employer, without regard to whether such combinations are provided by a single plan or two separate plans (in fact, all such combinations are considered to be a single plan for purposes of these rules). This "anti-abuse" rule will prevent employers from evading the rules by establishing separate carve-out plans for mental health/substance abuse benefits.

Small Employer/Plan Exemption. Employers who employed an average of at least two, but not more than 50, employees on business days during the preceding calendar year are exempt from these requirements. Moreover, the parity rules do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

> **Practice Pointer:** The parity rules literally do not apply to stand-alone retiree health plans because such plans do not have at least two current active employees who are participants on the first day of the plan year.

Increased Cost Exemption. The Interim Regs clarify that the cost exemption may only be claimed for alternating years. Thus, plans that comply with the parity requirements for one full year and are subject to the increased cost exemption are exempt during the following year and the exemption lasts for one year only.

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Members of Alston & Bird's Employee Benefits & Executive Compensation Group

Robert A. Bauman
202.756.3366
bob.bauman@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Philip C. Cook
404.881.7491
philip.cook@alston.com

Patrick C. DiCarlo
404.881.4512
pat.dicarlo@alston.com

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

David R. Godofsky
202.756.3392
david.godofsky@alston.com

Anna Grant
404.881.7124
anna.grant@alston.com

Anne Tyler Hamby
404.881.4839
annetyler.hamby@alston.com

John R. Hickman
404.881.7885
john.hickman@alston.com

H. Douglas Hinson
404.881.7590
doug.hinson@alston.com

James S. Hutchinson
212.210.9552
jamie.hutchinson@alston.com

Lindsay Jackson
202.756.3002
lindsay.jackson@alston.com

David C. Kaleda
202.756.3329
david.kaleda@alston.com

Laurie Kirkwood
404.881.7832
laurie.kirkwood@alston.com

Johann Lee
202.756.5574
johann.lee@alston.com

Blake Calvin MacKay
404.881.4982
blake.mackay@alston.com

Emily W. Mao
202.756.3374
emily.mao@alston.com

Sean K. McMahan
404.881.4250
sean.mcmahan@alston.com

Michael G. Monnolly
404.881.7816
mike.monnolly@alston.com

Craig R. Pett
404.881.7469
craig.pett@alston.com

Nancy B. Pridgen
404.881.7884
nancy.pridgen@alston.com

Thomas G. Schendt
202.756.3330
thomas.schendt@alston.com

John B. Shannon
404.881.7466
john.shannon@alston.com

Maya D. Simmons
404.881.4601
maya.simmons@alston.com

Carolyn E. Smith
202.756.3566
carolyn.smith@alston.com

Michael L. Stevens
404.881.7970
mike.stevens@alston.com

Laura G. Thatcher
404.881.7546
laura.thatcher@alston.com

Kerry T. Wenzel
404.881.4983
kerry.wenzel@alston.com

ATLANTA
One Atlantic Center
1201 West Peachtree Street
Atlanta, GA 30309-3424
404.881.7000

CHARLOTTE
Bank of America Plaza
Suite 4000
101 South Tryon Street
Charlotte, NC 28280-4000
704.444.1000

DALLAS
Chase Tower
Suite 3601
2200 Ross Avenue
Dallas, TX 75201
214.922.3400

LOS ANGELES
333 South Hope Street
16th Floor
Los Angeles, CA 90071-3004
213.576.1000

NEW YORK
90 Park Avenue
New York, NY 10016-1387
212.210.9400

RESEARCH TRIANGLE
Suite 600
3201 Beechleaf Court
Raleigh, NC 27604-1062
919.862.2200

SILICON VALLEY
Two Palo Alto Square
Suite 400
3000 El Camino Real
Palo Alto, CA 94306-2112
650.838.2000

VENTURA COUNTY
Suite 215
2801 Townsgate Road
Westlake Village, CA 91361
805.497.9474

WASHINGTON, D.C.
The Atlantic Building
950 F Street, NW
Washington, DC 20004-1404
202.756.3300

www.alston.com