

How Do You Solve A Problem Like MHPAEA?

The Mental Health Parity Interim Final Regulations

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Statutory Overview – Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- General – Financial requirements and treatment limitations for mental health and substance abuse disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations placed on substantially all medical and surgical benefits.

Overview (cont'd)

- Key Provisions:
 - No coverage mandate
 - Applies to insured and self-insured group health plans, and to insurance coverage
 - No sunset provision
 - Out-of-Network Parity Requirement
 - Benefits defined under plan in accordance with applicable Federal and state law
 - Small Employer and Cost Exceptions

Overview (cont'd)

- Key Provisions (cont'd):
 - Financial Requirements – include deductibles, payments, coinsurance and out-of-pocket expenses
 - Treatment Limitations – include limits on the frequency of treatment, number of visits, days of coverage or “other similar limits on the scope or duration of coverage.”

Overview (cont'd)

- Key Dates:
 - October 3, 2008 – Enactment
 - April 28, 2009 – Request for Information
 - October 3, 2009 – MHPAEA Effective Date
 - October 9, 2009 – Agencies Miss Deadline
 - February 2, 2010 – Interim Final Rules Issued
 - April 5, 2010 – Original IFR “Effective” Date
 - May 3, 2010 – Close of Comment Period
 - July 1, 2010 – IFR applicability date

Interim Final Regulations - Summary

- General Structure:
 - Aggregation of Employer Plans
 - Parity applied within each “Coverage Unit”
 - Parity applied using six specified classifications of benefits
 - Distinction between Quantitative and Nonquantitative treatment limitations
 - “Substantially All” Rule – No requirement or limitation can be applied to MH/SA benefits unless the same is applied to at least 2/3 of the medical/surgical benefits in the same coverage unit and benefit classification

Interim Final Regulations – Summary (cont'd)

- “Predominant” Rule –
 - Predominant means over 50%
 - A single requirement or limitation meeting the “substantially all” test is also predominant.
 - Aggregation permitted when a limitation has tiers or components, but then only least restrictive standard can be applied
- Special Rule for Nonquantitative Limitations
- Special Rule for Prescription Drugs

Interim Final Regulations – Issues and Ambiguities

- The Interim Final Nature of the Rules
 - No notice and comment
 - No general termination date (IRS sunset rule)
- No Guidance on Scope of Services
 - Agencies recognize that MH/SA disorders and medical/surgical conditions involve different treatments and treatment settings
 - Agencies nevertheless refuse to issue guidance
 - Collateral Effect throughout regulations – “apples to oranges” comparisons

Interim Final Regulations – Issues and Ambiguities (cont'd)

- Nonquantitative Treatment Limitations
 - Questionable Statutory Basis
 - Absence of clear definition
 - “Illustrative List” includes most current managed care practices for MH/SA benefits
 - Contrast with preamble’s approval of use of managed care to reduce costs
 - Requirement to assure parity of standards “as written” and “in practice”
 - Exception only for “recognized clinically appropriate standards of care”

Interim Final Regulations – Issues and Ambiguities (cont'd)

- Unified Deductible
 - “Separate but Equal” deductibles banned despite Agencies’ recognition that such a structure was permissible under MHPAEA
 - Administrative and technological costs and difficulties
 - Problem for “carve-out” managed behavioral care organizations

Interim Final Regulations -- Issues and Ambiguities (cont'd)

- Application of “Substantially All” Standard
 - Possibility of “super-parity”
 - Absence of safe harbor for mirror-image arrangements
 - Abandonment of current regulatory standard that limits should not be applied “in a manner that does not distinguish between” MH/SA and medical/surgical benefits

Interim Final Regulations – Issues and Ambiguities (cont'd)

- Prescription Drug Benefits
 - Creation of Formulary treated as nonquantitative treatment limitation
 - Uncertainty regarding drugs used only for MH/SA disorders
- Provider Credentialing
 - Standards for admission to network is a nonquantitative treatment limitation
 - Many more classes of providers for MH/SA care than for medical/surgical care

Interim Final Regulations – Issues and Ambiguities

- Classifications of Benefits
 - Limitation to six classes ignores varieties of treatments
 - Lack of “specialist” classification
 - Imperfect match between MH/SA and medical/surgical care (example – residential facilities)

Looking Ahead

- Comment Period ends on May 3, 2010
- Potential Substantive Challenges after finalization
- PPACA changes and potential interpretive difficulties