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Implementing Parity: Investing in Behavioral Health—Part 1

by Steve Melek

"Change is the law of life. And those who look only to the past or present are certain to miss the future."—John F. Kennedy

After much anticipation, interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) have been released by the Departments of Labor, Health and Human Services, and the Treasury. These regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010. Understanding compliance with MHPAEA is of great importance to all interested parties including health insurance companies, health plans, employers, providers, and consumers of behavioral health care. Part 1 of this article will address implementation details. Understanding how the rules could impact the business of behavioral health care and the decisions that follow is of even greater importance. This will be covered in Part 2, which will be included in the September 2010 issue of *Health Watch.*

Areas Clarified by the Regulations

The interim final regulations clear up many of the issues that were unclear in the legislation which was passed on Oct. 3, 2008 and generally effective for plan years beginning after Oct. 3, 2009:

Deductibles and Out-of-Pocket Limits The Departments' view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, a plan may not apply cumulative financial requirements or cumulative treatment limitations to mental health or substance use disorder benefits that accumulate separately from similar requirements for medical/surgical benefits. This is the death of the separate but equal deductible approach, and requires separate claim systems for behavioral health care benefits and medical/surgical benefits to be interfaced.

Nonquantitative Treatment Limitations The regulations require that any processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations (limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits for treatment, such as 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 a plan will cover more expensive therapies, conditional benefits on completion of a course of treatment, etc.) to mental health and 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. This enables separate processes for utilization management of behavioral health care and medical/surgical care as long as they are applied no more stringently to behavioral health care benefits. Disparate results do not mean that the treatment limitations do not comply with parity.

EAP as Gatekeepers The provisions of an EAP in addition to the benefits of a major medical program that otherwise complies with the parity rules would not violate MHPAEA. However, having a requirement that participants must exhaust the EAP mental health or substance abuse disorder counseling sessions before they are eligible for the major medical program's mental health or substance use disorder benefits would violate MHPAEA.

Separate Coverages or Benefit Packages The parity requirements apply separately to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant can simultaneously receive, and all such combinations constitute a single group health plan for purposes of the parity requirements. If an employer offered three medical/surgical plan options, Gold, Silver and Bronze and a mental health and substance use disorder benefit, Healthy Mind, that could be combined with each of Gold, Silver and Bronze,

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Steve Melek, FSA, MAAA, is a consulting actuary at Milliman Inc in Denver, Colo. He can be reached at *steve.melek@ milliman.com.*

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then the parity requirements must be satisfied with respect to each combination of benefits, that is Gold + Healthy Mind, Silver + Healthy Mind, and Bronze + Healthy Mind. And if the Gold plan option also had separate Gold Plus and Gold Standard options, each of these would also have to satisfy the parity requirements when combined with the Healthy Mind benefits.

Behavioral Health Care Providers, Specialists or Primary Care The regulations do not allow the separate classification of generalists and specialists in determining the predominant financial requirements that applies to substantially all medical/surgical benefits. Therefore, you cannot just set copays for behavioral health care specialists equal to the copays for medical/surgical specialists; rather, you must complete the determination of the "substantially all" and "predominant" requirements for the various financial requirements and quantitative treatment limitations for medical/surgical benefits (see below).

Interaction with State Insurance Laws MHPAEA requirements are not to be construed to supersede State laws except to the extent that such State standards or requirements prevent the application of a requirement of MHPAEA. A State law that, for example, mandates a minimum coverage amount of $50,000 for autism, does not prevent the application of MHPAEA. However, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.

MHPA 1996 Impact MHPAEA expands the parity requirements for aggregate lifetime and annual dollar limits to include protections for substance use disorder benefits. Plans with small lifetime limits of substance use disorder benefits will be making significant changes to those benefits.

Areas of Requested Input Within the Regulations

The Departments invite written comments on specific issues:

- Additional examples to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design.
- Scope of Service Issue—the Departments recognize that not all treatments or treatment settings for mental health conditions or substance abuse disorders have analogous treatments for medical/surgical conditions, but do not specifically address how to comply with MHPAEA for such conditions, and ask whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage.
- The regulations withdraw the MHPA 1996 regulatory guidance on the increased cost exemption and intend to issue, in the near future, guidance implementing the new requirements for the increased cost exemption under MHPAEA.

Determining Compliance

The regulations provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. This is not meant to imply that the standard must be a national standard, but that it must be generally accepted in the relevant medical community. Sample sources include the DSM, ICD, or a State guideline. This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements.

The regulations give specific meaning to certain terms for the purposes of MHPAEA:

"Classification of benefits" Six classifications of benefits are specified which each require parity compliance: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. If a plan has no network of providers, all benefits in the classification are characterized as out-of-network.

"Type" This is used to refer to financial requirements and treatment limitations of the same nature. Different types include copayments, coinsurance, annual visit limits and episode visit limits. A financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type within a classifi-

cation (copayments only compared to other copayments, annual visit limits only compared to other annual visit limits).

"Level" This refers to the magnitude of a type of financial requirement or treatment limitation (such as the dollar, percentage, day or visit amount).

"Coverage unit" This refers to how a plan groups individuals for purposes of determining benefits, premiums or contributions (such as single participant, participant plus spouse, participant plus children, or family).

The regulations require that the general parity requirement of MHPAEA for financial requirements and treatment limitations be applied separately for each classification of benefits and for each coverage unit. Additionally, the six classifications are the only ones used for purposes of satisfying the parity requirements of MHPAEA.

The regulations do not require an expansion of the range of mental health conditions or substance use disorder benefits covered under the plan; it merely requires parity for those covered conditions or disorders.

The regulations do not define inpatient, outpatient or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms.

Measuring Plan Benefits

The portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in a classification to be paid under the plan year. Any reasonable method may be used to determine the expected paid dollar amount under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

For purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied. For purposes of

out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly.

"Substantially all" The first step in applying the MHPAEA requirement is to determine whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. Regulations issued under MHPA 1996 interpreted the term "substantially all" to mean at least two-thirds. Under the regulations, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification. Benefits expressed as subject to a zero level of a type of financial requirement or an unlimited quantitative treatment limitation are treated the same as benefits that are not subject to that requirement or limitation (i.e., a $0 copayment for a benefit, such as well baby care, is treated as not subject to a copayment).

If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical/surgical benefits in a classification, that type of requirement or limitation **cannot be applied** to mental health or substance use disorder benefits in that classification. If a single level of a type of financial requirement or quantitative treat-

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ment limitation applies to at least two-thirds of the medical/surgical benefits in a classification, then it is also the predominant level, and that is the end of the comparative analysis.

However, if the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels, and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then additional analysis is required—determining which level of the financial requirement or quantitative treatment limitation is considered predominant.

"Predominant" MHPAEA provides that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement, and applies to more than one-half of medical/surgical benefits subject to the financial requirement or treatment limitation in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to **more than one-half** of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs), the plan may not apply that particular financial requirement of quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant.

If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation in a classification, plan payments for multiple levels can be combined until the portion of plan payments subject to the financial requirement or quantitative treatment limitation **exceeds** one-half. Then, the plan may not apply that particular financial requirement of quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the **least** restrictive level within that combination. The plan may combine plan payments for the most restrictive levels first, with each less restrictive level added until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.

When a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, but no single level applies to more than one-half of the medical/surgical benefits, a plan is permitted to treat the least restrictive level of the financial requirement or quantitative treatment limitation applied to medical/surgical benefits in that classification as the predominant level. Determining the predominant level of a particular financial requirement or quantitative treatment limitation must be done separately for each coverage unit.

Prescription Drug Benefits If a plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic vs. brand name, and mail order vs. pharmacy pick-up) determined in accordance with the requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health or substance use disorder benefits, the plan satisfies the parity requirements with respect to the prescription drug classification of benefits. The special rule for prescription drugs, in effect, allows a plan or issuer to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier of prescription drug benefits.

For any tier, the financial requirements and treatment limitations imposed with respect to the drugs prescribed for medical/surgical conditions are the same as the financial requirements and treatment limitations imposed with respect to the drugs prescribed for mental health conditions and substance use disorder benefits in the tier. Moreover, because the financial requirements and treatment limitations apply to 100 percent of the medical/surgical drug benefits in the tier, they are the predominant financial requirements and treatment limitations that apply to substantially all of the medical/surgical drug benefits in the tier.

Part 2 of this article in the September 2010 issue of *Health Watch* will address how these regulations could impact the business of behavioral health care and the decisions that follow for payors, employers, providers and insureds. ■