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DEFINING MENTAL HEALTH PARITY AND ADDICTION EQUITY

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The Mental Health Parity and Addiction Equity Act [1] sketched out the idea that there should be parity between medical and surgical benefits on the one hand, and mental health and substance use disorder benefits on the other hand. On February 2, 2010, the federal agencies charged with implementing this Act filled in the details on how exactly parity can be measured.[2]

As you might expect, the rules begin by taking a stab at dividing benefits among "medical-surgical," "mental health," and "substance use disorder," which they do by deferring to the definition "under the terms of the plan and in accordance with applicable Federal and State law."[3] Thus, if neither federal nor state law has anything to say about whether a particular service is in a particular category, it is up to the plan to categorize the service; however, that must be done "consistent with generally recognized independent standards of current medical practice," with examples of such standards being "State guidelines" and the most current version of the International Classification of Diseases (ICD) and, for mental health and substance use disorders, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).[4] For example, if the current DSM categorizes a benefit as a mental health condition, then a plan must define it as such absent contrary state guidelines. Even then, the rules would not prevent a plan from excluding coverage for a particular benefit altogether;[5] if a mental health condition is covered, however, it must be covered on par with medical and surgical benefits.

Once benefits are categorized, the interim final rules issued in February take separate approaches to evaluating parity for:

- aggregate lifetime and annual dollar limits;
- financial requirements (such as deductibles, copays, coinsurance, and out-of-pocket maximums[6]) and quantitative treatment limitations (such as visit and day limits[7]);
- nonquantitative treatment limitations (such as medical management[8]); and
- multi-tiered prescription drug plans.

These separate approaches are described in order below.

Aggregate Lifetime and Annual Dollar Limits

This part of the rule has not changed much, except to expand it to substance use disorders (though it will be mitigated by restrictions on lifetime and annual limits in the federal health care reform legislation). Thus, a plan may not impose aggregate lifetime or annual dollar limits on mental health-substance use disorder benefits unless at least one-third of all medical-surgical benefits have such limits.[9] The one-third calculation is determined by the dollar amount of benefits paid for benefits subject to aggregate lifetime or annual dollar limits vs. the dollar amount of benefits paid for all other medical-surgical benefits.[10]

If a plan imposes aggregate lifetime or annual dollar limits on more than one-third but less than two-thirds of all medical-surgical benefits (with the two-thirds determined like the "dollar amount" calculation described above), then the plan must either impose no such limits on mental health-substance use disorder benefits or limits that are no less than the average limit for medical-surgical benefits.[11] Finally, if the plan imposes aggregate lifetime or annual dollar limits on at least two-thirds of all medical-surgical benefits, then the plan

must either also apply the limits to mental health-substance use disorder benefits (in a manner that does not distinguish them from the medical-surgical benefits), or apply the same or lesser limits separately to mental health-substance use disorder benefits.[12]

Financial Requirements and Quantitative Treatment Limitations

The rules provide a very complex, fact-intensive, slice-and-dice, plan-by-plan process for determining parity in financial requirements and quantitative treatment limitations. This process basically involves determining which such requirements and limitations are "predominant" and apply to "substantially all" medical-surgical benefits - those financial requirements and quantitative treatment limitations are then the most restrictive ones that can be applied to mental health-substance use disorder benefits.[13]

The first step in this process is to determine which of six classifications apply to a particular plan design, that is, (1) inpatient network, (2) inpatient out-of-network, (3) outpatient network, (4) outpatient out-of-network, (5) emergency, and (6) prescription drugs.[14] Note that if a plan "provides mental health or substance use disorder benefits in any classification of benefits ..., mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided."[15]

The second step is to allocate the benefits in the non-emergency or prescription drug classifications between medical-surgical benefits on the one hand and mental health-substance use disorder benefits on the other.

The third step is to determine which financial requirements and quantitative treatment limitations apply to each benefit in each category of benefits in each classification.

The fourth step is to look at each financial requirement and quantitative treatment limitation that is used in the plan to determine which ones apply to "substantially all" medical-surgical benefits in each classification, where "substantially all" means two-thirds[16] (with the two-thirds determined like the dollar amount calculation described above[17]). A financial requirement or quantitative treatment limitation that does not apply to two-thirds of the medical-surgical benefits in a classification cannot be applied to mental health-substance use disorder benefits in that classification.[18]

The fifth step, for each financial requirement and quantitative treatment limitation that meets the "substantially all" standard of the fourth step, is to determine which level is the "predominant" one in each classification, where "predominant" means more than half (with the one-half determined like the dollar amount calculation described above).[19] The level of financial requirement or quantitative treatment limitation that applies to more than half of the medical-surgical benefits, in a classification that is subject to the requirement or limitation, is the most restrictive one that can be applied to mental health-substance use disorder benefits in that classification.[20] If a plan also imposes different financial requirements and quantitative treatment limitations based on the "coverage unit" (*e.g.*, self-only, family, or employee-plus-spouse[21]), then the plan must determine which one is predominant after dividing the classification into coverage units.[22]

It is clear that evaluating parity for financial requirement and quantitative treatment limitations could take a substantial amount of time. Just gathering the dollar amount data could be a substantial job, as the insurer would potentially have to figure out how much it spends for each benefit (*e.g.*, physician visits, maternity, transplants, inpatient) in each applicable classification (*e.g.*, inpatient network, outpatient network, inpatient out-of-network and outpatient out-of-network).

Then evaluating just one plan design could take another substantial amount of time, since the plan must be broken down into all its parts and then comparisons and calculations must be made. Obviously, the more financial requirements and quantitative treatment limitations the plan uses, and the more levels of those

requirements and limitations it uses, the longer the evaluation would take. This might create an incentive to simplify plans. It also may be more cost-effective to "reverse engineer" a plan; that is, to design medical-surgical benefits in a way that will produce a certain result for mental health-substance use disorder benefits.

On the other hand, marketplace demands may make it difficult for plans to impose enough restrictions on medical-surgical benefits to allow imposition of restrictions on mental health-substance use disorder benefits. For example, a plan would have to impose a lot of day and visit limitations on medical-surgical benefits in order to satisfy the "substantially all" standard (two-thirds of such benefits) so that such limits could be imposed on mental health-substance use disorder benefits.

Nonquantitative Treatment Limitations

Nonquantitative treatment limitations are "limits on the scope or duration of treatment" under a plan that are not "expressed numerically."[23] The breadth of this definition will make it difficult to determine whether certain plan limits qualify,[24] unless those limits are described in or analogous to the examples provided by the rule:

- "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 (also known as fail-first policies or step therapy protocols); and
- "Exclusions based on failure to complete a course of treatment."[25]

While the rule literally subjects nonquantitative treatment limitations to the same "predominant" standard as quantitative treatment limitations,[26] the rule also states that application of the predominant standard to nonquantitative treatment limitations is addressed by a separate "comparable to and not more stringent than" standard.[27] Under that standard, a plan "may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan ... as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference."[28]

This standard is fairly easily applied to a limitation, like medical necessity, that applies across all benefits in a classification - that is, the limitation must be applied similarly to medical-surgical benefits on the one hand and mental health-substance use disorder benefits on the other - and that is the subject of most of the examples in the rule.[29] That leaves the question as to whether a plan can single out certain mental health-substance use disorder benefits for a nonquantitative treatment limitation, and the remaining example discussed below seems to answer that question in the negative:

In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically

appropriate standards of care.[30]

The rule goes on to state that, in this example, the plan violates the "comparable to and not more stringent than" standard: "Although the same nonquantitative treatment limitation -- medical appropriateness -- is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning."[31]

Multi-Tiered Prescription Drug Plans

The special rule for multi-tiered drug plans states that a plan may apply "different levels of financial requirements to different tiers of prescription drug benefits" if such application is (1) "based on reasonable factors determined in accordance with the rules ... relating to requirements for nonquantitative treatment limitations" (the "comparable to and not more stringent than" standard discussed above) and (2) "without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits."[32] In this context, "reasonable factors" include "cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up."[33]

Conclusion

It may have been inevitable that applying abstract concepts like parity and equity to complex and manifold health plans would result in an extraordinarily convoluted and difficult testing regimen. At least in the short term, until health plans can digest and explore this regimen, the counterintuitive result may be more simplicity in health plans. Since it is so difficult to apply requirements and limitations to mental health-substance use disorder benefits without applying them to medical-surgical benefits, and since the market will make it difficult to apply requirements and limitations to medical-surgical benefits, the main response may well be to eliminate many such requirements and limitations altogether.

Endnotes

1. 42 USC § 300gg-5 (while the Act appears in the tax code, ERISA, and the Public Health Service Act, with implementing rules coming from the three corresponding federal agencies, this summary will cite only the Public Health Service Act and Department of Health and Human Services rules). Generally, the Act applies only to employers with more than 50 employees.§ 300gg-5(c)(1).

2. 75 FR 5410. The rules "generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010." *Id.*

3. 45 CFR § 146.136(a).

4. 45 CFR § 146.136(a).

5. 45 CFR § 146.136(a) (only annual or lifetime dollar limits, financial requirements, and treatment limitations are regulated by the rules, and a total exclusion does not fall within the definitions of the first two and is specifically excluded from the last one).

6. *See* 45 CFR § 146.136(a).

7. *See* 45 CFR § 146.136(a).

8. *See* 45 CFR § 146.136(c)(4)(ii).

9. 45 CFR § 146.136(b)(2).

10. 45 CFR § 146.136(b)(5) (the determination "is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year .... Any reasonable method may be used" to make the determination).

11. 45 CFR § 146.136(b)(6). Per § 146.136(b)(6)(i)(B), "The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits." Per § 146.136(b)(6)(ii), the weighting for any category is determined in the same manner as the "dollar amount" calculations.

12. 45 CFR § 146.136(b)(3).

13. In addition, 45 CFR § 146.136(c)(3)(v)(A) prohibits use of a cumulative financial requirement or cumulative quantitative treatment limitation for mental health-substance use disorder benefits that accumulates separately from such a requirement or limitation for medical-surgical benefits in any classification, where § 146.136(a) defines "cumulative" financial requirements and quantitative treatment limitations as those "that determine whether or to what extent benefits are provided based on accumulated amounts." While this prohibition is easy to apply for a financial requirement like a deductible - which is a dollar amount that applies across all types of benefits (so that the prohibition would prevent using a deductible that applies separately to mental health-substance use disorder benefits on the one hand and medical-surgical benefits on the other) - it is more difficult to apply to quantitative treatment limitations like day and visit limits. (Indeed, all the examples for this prohibition deal with deductibles, § 146.136(c)(3)(v)(B).) Presumably, the prohibition means that similar benefits with visit limitations would have to accumulate visits together to be applied to the limitation. For example, a plan would probably have to limit outpatient visits for medical-surgical treatment in order to limit outpatient visits for mental health-substance use disorder treatment (for the reasons described above), so all outpatient visits - regardless of whether they are mental health, substance use disorder, or medical-surgical - would have to count toward satisfaction of the visit limit for all benefits.

14. 45 CFR § 146.136(c)(2)(ii)(A).

15. 45 CFR § 146.136(c)(2)(ii)(A).

16. 45 CFR § 146.136(c)(3)(i)(A).

17. 45 CFR § 146.136(c)(3)(i)(C) and (E). *See* § 146.136(c)(3)(i)(D) for calculations involving threshold requirements such as deductibles and § 146.136(c)(3)(iv) for examples of this calculation.

18. 45 CFR § 146.136(c)(3)(i)(A).

19. 45 CFR § 146.136(c)(3)(i)(B). If no level of financial requirement or quantitative treatment limitation is predominant, then levels are combined until the combination is predominant, and then the least restrictive level in that combination is deemed to be the predominant one. § 146.136(c)(3)(i)(B)(2). *See* § 146.136(c)(3)(iv) for examples of this calculation.

20. 45 CFR § 146.136(c)(2)(i).

21. 45 CFR § 146.136(c)(1)(iv)

22. 45 CFR § 146.136(c)(3)(ii).

23. 45 CFR § 146.136(a).

24. For example, may coverage for mental health services be limited to providers or programs certified by a certain government or other body? May a plan automatically request certain information from a mental health care provider to determine medical necessity? Would such differences be permitted by "recognized clinically appropriate standards of care" under 45 CFR § 146.136(c)(4)?

25. 45 CFR § 146.136(c)(4)(ii).

26. 45 CFR § 146.136(c)(2)(i).

27. *See* 45 CFR § 146.136(c)(4). It might have made more sense simply to acknowledge that nonquantitative treatment limitations are subject to a different standard - instead of stating that one standard is applied using a different standard - but the rule's roundabout approach still leaves it fairly clear that parity for nonquantitative treatment limitations is governed by the "comparable to and not more stringent than" standard.

28. 45 CFR § 146.136(c)(4)(i).

29. 45 CFR § 146.136(c)(4)(iii), Examples 1, 2, 3, and 5.

30. 45 CFR § 146.136(c)(4)(iii), Example 4.

31. 45 CFR § 146.136(c)(4)(iii), Example 4.

32. 45 CFR § 146.136(c)(3)(iii). The one example for multi-tiered drug plans in § 146.136(c)(3)(iv), Example 4, basically just repeats this rule in the context of a 4 tier plan (90% coverage for generic, 80% coverage for preferred brand name, 60% coverage for nonpreferred brand name, and 50%coverage for specialty).

33. 45 CFR § 146.136(c)(3)(iii).