
EXECUTIVE SUMMARY OF PARITY INTERIM FINAL RULES ANALYSIS

On February 2, 2010, the U.S. Departments of Labor (“DOL”), Treasury, and Health and Human Services (“HHS”) published interim final rules (“regulations”) implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA” or “Act”) in the Federal Register.¹ The MHPAEA requires parity between mental health or substance use disorder (MH/SUD) benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

Patton Boggs, LLP was asked by the Parity Implementation Coalition to analyze a set of questions related to various issues that may arise regarding the interim final rules implementing the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. This document summarizes the key issues, questions and challenges that may arise as this historic law is implemented by providers, insurers and employers. The analysis was divided into questions regarding scope of service parity and classification of benefits, non-quantitative treatment limitations (NQTLs), and other general questions. Key issues addressed under the analysis fall under each of these major headings.

Scope of Service Parity and Classification of Benefits

Benefits Must Fit in One of Six Classifications

- The parity regulations create a six-classification scheme to implement the parity requirement. The regulations state clearly that these six classifications are the “only” possible classifications for implementing the parity rules.² Thus, the plain language of the statute prohibits a plan from creating a new classification of benefits. If a plan cannot create a new classification, it seems clear that all MH/SUD and medical surgical benefits covered by the plan must fit into one of these classes.

Moving Services Outside the Six Classifications to Avoid Parity Requirements Violates the Act

- To the extent that a plan creates a separate classification that applies treatment limitations or financial requirements only to the MH/SUD benefits within that classification, the plan would violate the clear meaning of the statute. Moving certain services outside the six classes to avoid the parity requirements would also be a clear violation of Congressional intent. Congress wanted MH/SUD benefits to be provided no more restrictively than medical/surgical benefits. Allowing plans to create a benefit classification that is not subject to the parity requirements opens the door to restrictions on MH/SUD that are more restrictive than those applied to medical/surgical.

¹ 75 Fed. Reg. 5410

² 75 Fed. Reg. 5413

While the Preamble States the Regulations Do Not Address Scope of Services, the Regulations' Rules Related to Classification, NQTLs and QTLs Confer a Scope of Services

- Although the preamble to the regulations explicitly states that the regulations do not address scope of services, other parts of the regulation define a scope of service parity requirement both across each of the required six classifications for applying the rule, and within each of the classifications. In addition, the underlying Act is clear that limits on the scope and duration of treatment must be applied no more restrictively in the MH/SUD benefit than in the medical/surgical benefit.

A Plan that Covers Few MH/SUD Treatment Services, While Providing Many Medical/Surgical Services, Violates the Act if it Has Applied a Treatment Limitation More Restrictively

- A plan that offers only one type of MH/SUD treatment service in any of the six required classifications, while at the same time offering many medical/surgical services within the relevant classification is not compliant with the parity regulations if the comparatively low level of MH/SUD services is a result of the application of a treatment limitation to MH/SUD benefits that is more restrictive than the predominant treatment limitation of that type that applies to substantially all medical/surgical benefits in the classification.

A Plan that Refuses to Cover a MH/SUD Service because there is no Medical/Surgical Analogue Will Violate the Act if it Does Not Refuse to Cover Medical/Surgical Benefits that have no MH/SUD Analogue

- A plan that refuses to cover a MH/SUD service because there is no medical/surgical analogue violates both the regulations and MHPAEA if the plan does not likewise refuse to cover medical/surgical benefits that have no MH/SUD analogue. In addition, practical and policy concerns weigh against allowing plans to refuse to cover MH/SUD benefits without medical/surgical analogues.

Non-Quantitative Treatment Limitations (NQTLs)

- The regulations state clearly that any “processes, strategies, evidentiary standards, or other factors” used in applying a NQTL to MH/SUD benefits in a classification must be “comparable to” and be applied “no more stringently” than the processes, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in a classification.³ The sole exception to this rule is in cases where “recognized clinically appropriate standards of care...permit a difference.”⁴ Under the regulations, one of the two critical factors for determining plan compliance with these requirements is the manner in which the processes, strategies, evidentiary standards, and other factors are used in *applying* the NQTL. Plans can have the same NQTL in both MH/SUD and medical/surgical and still violate the parity requirements by applying these NQTLs differently. The second critical prohibition prevents a plan from instituting a NQTL in MH/SUD that is not comparable to an NQTL in the medical/surgical benefit. In such a situation, the question is not whether the same NQTL is applied differently across

³ 75 Fed. Reg. 5416

⁴ *Id.*

MH/SUD and medical/surgical, but rather whether a NQTL is being applied in MH/SUD that does not exist in medical/surgical.

- There are two standards to which plans must adhere related to NQTLs. A plan may violate this section by utilizing processes, strategies, evidentiary standards, or other factors in the context of MH/SUD benefits that are either: (1) not comparable to *or* (2) applied more stringently, than those utilized in the context of medical/surgical benefits. Thus, a plan may violate this section by utilizing processes, strategies, evidentiary standards, or other factors in the context of MH/SUD benefits that are either not comparable to or applied more stringently than those utilized in the context of medical/surgical benefits.
- The MHPAEA unequivocally applies the “predominant and substantially all” standard to all treatment limitations. Although there is ambiguity in the regulations regarding whether the predominant/substantially all and the “comparable/no more stringently” tests are separate or additive, to remain consistent with the language and intent of the MHPAEA, the regulations should be interpreted to apply both standards to NQTLs. The Act sets forth three inquiries to determine plan compliance with the treatment limitation requirements: (1) Is the limitation applied to substantially all medical/surgical benefits; (2) Is it the predominant treatment limitation; and (3) Is it more restrictive in the MH/SUD benefit than in the medical/surgical benefit? The statute applies the three-part test to *all* treatment limitations. Because of the difference between QTLs and NQTLs, and the practical difficulties of applying the “no more restrictive” test in the context of NQTLs, the regulations establish a second standard to operationalize the “no more restrictive” statutory test. This second standard is the comparable and no more stringently standard, and it is additive to the predominant and substantially all standard.

Reimbursement Methods are NQTLs Subject to Parity Requirements

- The plain language of the regulation, which specifically includes reimbursement rates as an example of a NQTL, demonstrates that provider rate calculation methods are an NQTL subject to the “comparable” and “no more stringently” standards. Inflation updates, which are tied closely to reimbursement rates and methods for determining charges, would similarly qualify as NQTLs subject to parity requirements. Although inflation updates are not mentioned specifically in the list of NQTL examples, the mention of reimbursement rates would reasonably be interpreted to include such updates.

Scientific Criteria that Limit or Exclude Benefits on Whether a Treatment is Experimental or Investigative are a Form of a NQTL

- Scientific criteria that limit or exclude benefits based on whether the treatment is experimental or investigative are a form of NQTL that is subject to the regulations’ predominant and substantially all and comparable and no more stringently standards. Although the regulations do not require identical scientific criteria or standards for determining whether a treatment or diagnostic test is experimental, such criteria must be comparable and be applied no more stringently in MH/SUD than in medical/surgical.

Regulations Should Define “Recognized” Independent Expertise Outside of Plans

- Although the regulations do not explicitly define “recognized clinically appropriate standards of care,” the regulations and other government coverage policies give guidance that regulators should heed in construing the term. Examples in the regulations demonstrate that “recognized clinically appropriate standards” are those that are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. In addition, at least one of the agencies that developed the regulations, the Centers for Medicare and Medicaid Services, regularly relies on independent expertise when making its coverage determinations.
- From a policy perspective, a clear definition of “recognized” is critical to ensure the integrity of the Act and to implement the intent of Congress. The only exception to the requirement that NQTLs be comparable and applied no more stringently is when “recognized clinically appropriate standards of care” permit a difference. Thus, any attempt to get around the parity requirements will involve finding a “recognized clinically appropriate” standard of care. If adequate requirements for when a standard is recognized are not established, the parity requirements may be circumvented. For example, a plan could trigger the exceptions simply because its own employees or hired consultants deem a standard “recognized”—with no outside verification. Permitting an exception to parity based on a plan’s internal review alone could weaken this intended strength.

Other Issues

When Defining a MH/SUD Benefit, Plans Terms Must Be Consistent with an Independent or Recognized Standard or State Guideline

- In defining benefits for MH/SUD conditions, plan terms must be “consistent with generally recognized independent standards of current medical practice.”⁵ The regulations do not clearly define what this means, but set forth a list of sources that would meet the “generally recognized” requirement, including 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. Although these are all “acceptable resources to determine” how benefits are classified, they are not the only sources.

Plans that State the Plan is Not Offering MH/SUD Benefits are Subject to MHPAEA if the Plan Reimburses for One or More MH/SUD Services

- Plans that provide MH/SUD treatment services are subject to the parity requirements of MHPAEA. Accordingly, if a plan states it is not providing MH/SUD benefits, but reimburses for specific treatment services for one or more MH/SUD, the plan would be subject to MHPAEA and the regulations. Since a plan in such a situation is offering a MH/SUD benefit, the regulations require the plan to offer services in every benefit classification in which medical/surgical benefits are offered.

⁵ 75 Fed. Reg. 5412

Medicaid Managed Care Organizations are Subject to the February 2, 2010 Regulations

- The Medicaid statute requires that Medicaid managed care plans comply with the parity provisions of the Act. Since the regulations implement the Act and do not contain an exemption for Medicaid managed care plans, Medicaid MCOs must comply with the parity requirements as spelled out in the regulations. This conclusion is supported by both the Act and the regulatory history of previous mental health parity laws.

Participants Can Bring a Private Right of Action Based on Violations of the Statute On or After 10/3/09 but a Claim Based on Improper Implementation of the Regulations May Not be Filed until 7/1/10

- An aggrieved beneficiary can bring a suit based on alleged violation of the statute that occurred on or after October 3, 2009—the date the Act became effective. However, if the beneficiary’s suit is based on a claim that the plan improperly implemented the *regulations*, the beneficiary would likely have to wait to bring such a suit until July 1, 2010—the date the regulations become effective.

If Plans Rely on Medical/Surgical Coverage Criteria to Deny MH/SUD Benefits, Plans Must Make these Criteria Available In Some Instances

- Although there is no general rule requiring plans to disclose the medical/surgical coverage criteria when denying reimbursement or payment for MH/SUD benefits, plans will likely be required to do so in certain instances. The regulations incorporate previous regulatory requirements which state that if an internal guideline, rule, protocol, or other similar factor was relied upon in making an adverse determination, the notification must either include the specific guideline, rule, guideline, protocol, or other similar factor, or the notification must include a statement that such a guideline, rule, protocol, or other similar factor was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant, upon request.⁶ If a plan relies upon medical/surgical coverage criteria in denying MH/SUD benefits, this requirement appears to require disclosure of these criteria, either initially or upon request. For example, if payment for a MH/SUD service is denied because no medical/surgical benefits are provided in the corresponding classification, the plan would likely have to include this information.

⁶ DOL Reg. § 2560.503-1 (g)(I)(v)(A).