



## Equality for Behavioral Health Coverage

CLIENT ADVISORY

### I. What is the MHPAEA

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), amends the Public Health Service Act, the Employee Retirement Income Security Act and the Internal Revenue Code, requiring group health plans with 50 or more employees that provide medical/surgical and behavioral health (mental health and substance use) benefits to ensure that financial requirements and treatment limits for both are equal. The MHPAEA expands on an earlier law, the Mental Health Parity Act of 1996 (MHPA), which required parity only with respect to aggregate lifetime and annual dollar limits for mental health benefits and did not extend to substance use benefits. Under the new MHPAEA, any group health plan that includes behavioral health benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. The Department of Health and Human Services, the Department of Labor and the Department of the Treasury have issued an Interim Final Rule implementing the provisions of the MHPAEA. Most employers have until July 1, 2010 to ensure that their health plans are in compliance with these regulations.

### II. What plans are subject to the MHPAEA?

MHPAEA applies to both self-funded and fully insured large group health plans with more than 50 employees that currently offer behavioral health benefits. It does not apply to small group health plans (50 employees or less) or health insurance coverage in

the individual market (non-employment based) nor does it require large group health plans and their health insurance issuers to include behavioral health benefits in their benefits package. If behavioral health benefits are not offered, then the MHPAEA is not implicated.

### III. Summary of MHPAEA Protections

Key provisions of the MHPAEA include the following:

- If a group health plan includes medical/surgical benefits and behavioral health benefits, the financial requirements (e.g. deductibles and co-payments) and treatment limitations (e.g. number of visits or days of coverage) that apply to behavioral health benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (substantially all means the requirement/limitations apply to at least two-thirds of the benefits in that classification);
- Behavioral health benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical/surgical benefits and behavioral health benefits and the plan provides out-of-network coverage for medical/surgical services, it must provide out-of-network coverage for behavioral health services;
- Standards for medical necessity determinations and reasons for any denial of benefits relating to



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behavioral health use must be disclosed upon request;

- The MHPA parity requirements under the earlier law (regarding annual and lifetime dollar limits) continue and are extended to substance use benefits.

#### IV. Interim Final Rule Clarifications

While the MHPAEA provides general rules regarding behavioral health parity, the Interim Final Rules issued February 2, 2010 provide detailed guidance in applying these rules to individual insurance plans and benefits. Some of the more pertinent provisions found in the regulation are described below:

##### A. Benefit Classifications

The parity requirements must be applied separately to six classifications of benefits:

- inpatient in-network
- outpatient in-network
- inpatient out-of-network
- outpatient out-of-network
- emergency
- prescription drug

In other words, if a plan provides behavioral health benefits, behavioral health benefits must be provided in every classification in which medical/surgical benefits are provided. To be clear, the regulation does not require plans to offer behavioral health benefits, but if they do, they must provide behavioral health benefits in all classifications in which medical/surgical benefits are provided. An insurance plan may, however, choose to cover some behavioral health conditions but exclude others.

##### B. Substantially All / Predominant Tests

Financial requirements and quantitative treatment limitations must be in parity with the requirements and limitations applied to “substantially all” medical/surgical benefits in the applicable benefit classification (i.e. inpatient in-network, outpatient in-network, etc.). “Substantially all” means that the requirement or limitations apply to at least two-thirds of the benefits in that classification. 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 behavioral health benefits in that classification.

However, if a 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 the predominant level or a less restrictive level of the financial requirement or quantitative treatment limitation must be applied to behavioral health benefits. A financial requirement or treatment limitation is predominant if it applies to more than one-half of medical/surgical benefits.

##### C. Cumulative Financial Requirements (Single Deductible Limit)

All cumulative financial requirements, including deductibles and out-of-pocket limits, must integrate both medical/surgical and behavioral health benefits. In other words, medical/surgical as well as behavioral health deductibles must be combined to satisfy a single limit.

##### D. Quantitative versus Nonquantitative Treatment Limitations

The Interim Final Rules distinguish between quantitative treatment limitations and non-quantitative treatment limitations. Quantitative treatment limitations are numerical such as day limits, visit limits, and frequency of treatment limits. Nonquantitative treatment limitations include 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; and conditioning benefits on completion of a course of treatment. A group health plan cannot impose a nonquantitative treatment limitation with respect to behavioral health benefits in any classification, unless under the terms



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of the plan as written or in operation, any processes, strategies, evidentiary standards, or other factors used in applying nonquantitative treatment limitations to behavioral health benefits in a classification are comparable to and applied no more stringently than what is applied to medical/surgical benefits, except to the extent that recognized clinically appropriate standards of care may permit a difference.

#### E. Employee Assistance Programs

In general, the provision of behavioral health benefits by an Employee Assistance Program (EAP) in addition to the benefits offered by a major medical program that otherwise complies with the parity rules would not violate MHPAEA. However, EAP programs cannot serve as gatekeepers, restricting or directing behavioral health care, unless a similar form of medical management is applied to medical/surgical benefits. In other words, employers cannot require employees to exhaust employee assistance benefits before they can access behavioral health care if a similar requirement does not exist for accessing medical care.

#### V. Conclusion

Already, behavioral health providers are seeing volume growth as a result

of this new law. Insurance companies are eliminating pre-authorization requirements for behavioral healthcare and reducing copayments to match those of their medical/surgical benefits providing easier and quicker access to behavioral health treatment at a reduced cost. At the same time, however, many insurers question whether the Interim Final Rule exceeded its statutory authority going beyond Congress' intent. The actual date of the Final Rule is unknown, but additional comments have been filed and the Final Rule will likely address some of the issues and concerns raised by insurers as well as provide further guidance regarding the Rule's applicability.

If your organization has questions related to the Mental Health Parity and Addiction Equity Act of 2008 or if you need assistance in ensuring that your plan complies with the MHPAEA, please feel free to contact Molly August Huffman or Michelle Elaine Calloway by telephone at (804) 967-9604 or by email at [mhuffman@hdjn.com](mailto:mhuffman@hdjn.com) or [mcalloway@hdjn.com](mailto:mcalloway@hdjn.com). Additional information about Hancock, Daniel, Johnson & Nagle, P.C. is available on the firm's website at [www.hdjn.com](http://www.hdjn.com).

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