Implementing Parity: The Safe Harbor for Outpatient Benefits

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Subsequent to the May 2010 publication of the Milliman Healthcare Reform Briefing Paper "Implementing Parity: Investing in Behavioral Health" (available at: *http://publications.milliman.com/publications/healthreform/pdfs/implementing-parity-investing-behavioral.pdf*), the U.S. Department of Labor released important new guidance that will ease compliance with the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) for many group health plan sponsors and issuers of group health plan insurance. This issue brief describes the relief available.

The U.S. Department of Labor (DOL) posted the following compliance assistance on its website on July 1, 2010:

Until the issuance of final regulations, the Agencies have determined that they will establish an enforcement safe harbor under which the Agencies will not take enforcement action against a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA:

(1) office visits, and

(2) all other outpatient items and services.

After the sub-classifications are established, the plan or issuer may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the interim final rules.

Other than as permitted under this enforcement policy, and except as permitted under the interim final rules for multi-tier prescription drug formularies, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, and as stated in the preamble to the interim final rules, separate sub-classifications for generalists and specialists are not permitted.

SOURCE: Department of Labor, Employee Benefits Security Administration (*http://www.dol.gov/ebsa/faqs/faq-mhpaea.html#*), "FAQ About Mental Health Parity and Addiction Equity Act"

COMPLIANCE TESTING

The first step in complying with this MHPAEA provision is to determine whether a financial requirement (e.g., coinsurance or copayments) or quantitative treatment limitation (e.g., office visit limits) applies to "*substantially all*" medical/surgical benefits in an outpatient subclassification. For many plans that use a mix of copays and coinsurance depending on the type of outpatient service, this new enforcement safe harbor is positive news and a welcomed surprise. This change will likely result in an increase in the number of plans that can satisfy the "*substantially all*" standard for financial requirements in the outpatient classifications. Before the DOL issued the safe harbor allowing for the establishment of the outpatient subclassifications, many of these plans were failing the "*substantially all*" test and faced having to offer mental health and substance use disorder benefits in the outpatient setting without cost to covered members.

APPLICATION OF THE SAFE HARBOR

Take, for example, a plan design that has 50% of outpatient service costs for which a $20 copay is applied and the services are for office visits, and 50% of outpatient service costs for which 20% coinsurance is applied for other outpatient medical/surgical benefits, and the plan is charging a $20 copay for outpatient mental health and substance abuse services. In this case, without the safe harbor, neither the $20 copay nor the 20% coinsurance exist for "*substantially all*" services in the outpatient classification, which is defined as at least two-thirds of service costs. Therefore, because no single cost sharing type exists that is for "*substantially all*" medical/surgical outpatient services, the result was that plans could not charge any member cost sharing for the mental health and substance use disorder services in the outpatient class.

However, with the issuance of the DOL's safe harbor, the copay and coinsurance services may be tested separately when they are in different outpatient subclasses. When tested separately, 100% of the medical/surgical office visit services in this example have a $20 copay applied, and therefore "*substantially all*" services have a $20 copay. Therefore, the plan could continue to charge its $20 copay for the outpatient class (office visit subclass) for mental health and substance use disorder services, as opposed to $0 under the DOL's interim final rule (IFR) that was published in February 2010.

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UNCERTAINTIES REMAIN

While this change sheds light on the intent of the IFR in this one area, it does bring back the episodic copay issue in an even more important way. Can ancillary medical/surgical services that are provided during an office visit be included as subject to copays for the purposes of testing (to achieve two-thirds or "*substantially all*")? And how far can one stretch with this interpretation? The more services that are linked to copays, the easier it will be to pass the "*substantially all*" tests in both outpatient subclasses for many plans.

As a final note, this safe harbor does not require the use of these outpatient subclassifications. It just offers another option in the testing of financial requirements and quantitative treatment limitations for insured benefit plans that must comply with MHPAEA. This temporary enforcement safe harbor will eventually be replaced with final MHPAEA rules. Until then, it is a welcomed addition to the IFR.

Any opinions expressed in this issue brief are those of the author and should not be interpreted as representing a position of Milliman. This paper is not intended to support or detract from any particular legislation.

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