Q:Since the interim final regulations were issued, some plans and issuers have stated that it is common with respect to outpatient benefits for plans and issuers to require a copayment for office visits (e.g., physician or psychologist visits) but coinsurance for other outpatient services (e.g., outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

For purposes of determining parity for outpatient benefits (whether in-network or out-of network), can a plan or issuer establish any sub-classifications, similar to the special rule for multi-tier prescription drugs?

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.