Compliance Alert

Mental Health Parity and Addiction Equity Act Regulations Issued

Alert Date: 2/19/10

On February 2, 2010 interim final regulations were published for the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) by the three regulatory agencies with jurisdiction over the Act; the Department of Labor (DOL), the Department of Health and Human Services (DHHS) and the IRS. The new regulations clarify a number of issues and are effective for plan years beginning on or after July 1, 2010.

MHPAEA applies fully insured and self-funded plans, offered by private and public sector employers, who averaged more than 50 employees on business days during the preceding calendar year.

Background

MHPAE expanded on rules originally included in the Mental Health Parity Act of 1996 (MHPA) which provided some parity between the lifetime limits and annual maximums imposed by health plans on mental health coverage as compared to other benefits offered by the plan. MHPA was widely seen as having little actual effect on creating parity between mental health coverage and other types of benefits offered by most health plans. MHPAEA brings mental health and substance abuse coverage much more in line with other plan coverage by including substance abuse coverage in the rules and requiring broader financial parity in areas such as deductibles and co-insurance.

It is important to remember that neither the MHPA nor MHPAEA require a plan to offer mental health or substance abuse benefits. Rather, if the benefits are offered they must meet the parity requirements. Fully-insured plans may be subject to other mandated mental health benefits under applicable state insurance laws.

"Predominant" and "Substantially All"

The MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles and co-insurance) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the *predominant* requirements or limitations applied to *substantially all* medical/surgical benefits.

The regulations attempt to clarify these terms by defining classifications of benefits to be used to determine if a plan satisfies these requirements. There must be parity in the benefits provided within each classification.

- A treatment limitation or financial requirement is considered "predominant" if it applies to more than half of the medical/surgical benefits in a classification.
- A treatment limitation or financial requirement applies to "substantially all" medical/surgical benefits if it applies to at least two thirds of the benefits in that classification.

MHPAEA benefit classifications include:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency
6. Prescription drugs

Other Regulatory Clarifications

- Plans may not impose separate deductibles for mental health or substance abuse coverage. The mental health and substance abuse coverage must be subject to the same combined deductible as other medical/surgical coverage.

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- Since the parity requirements apply to medical/surgical coverage some advisors have suggested that an employer could set up separate plans for medical/surgical benefits from other health plan benefits (such as hospital care) to reduce the impact of these rules. The final interim regulations prohibit separate plans to circumvent the parity rules, and state that all medical benefits offered by an employer will be considered part of a single plan for purposes of the parity requirements.

Exemption for Significant Increase in Cost
There is an optional exemption from the rules if a plan experiences a significant increase in cost due MHPAEA. If, due to the benefits required by the Act, plan costs increase more than 2% in the first year the plan is subject to MHPAEA, or more than 1% in subsequent years, a plan has an option of opting out for the following year. The cost increase must be actuarially certified and the Department of Labor must be notified for a group plan to take advantage of this exemption.

Since a plan must actuarially prove that the required benefits caused an increase to the prior year's plan costs an employer may only take advantage of the exemption on alternate years. After taking the exemption for one year, the plan would have to reinstate the required benefits for a year then once again actuality determine if the exemption couple apply to a subsequent year. The administrative requirements involved, and the on again/off again nature of the exemption, will likely limit the number of employers taking advantage of this provision.

Action Steps
Insurance carriers of fully-insured plans will be making benefit modifications to meet these requirements as plans renew. Employers sponsoring fully-insured plans should review new plan designs and communicate the changes to employees. Employer's who sponsor self-funded plans should work with their advisors to amends plan designs to assure compliance with these rules in time to implement the required changes for plan years beginning July 1, 2010.

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