CONNER STRONG

Legislative Update

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New Mental Health Parity Rules Released

Long awaited mental health parity regulations have been released outlining how employers can provide benefits at parity for mental health and substance use disorders (MH/SUD) if they offer them. Interim final rules regarding implementing the provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally apply to group health plans for plan years beginning on or after July 1, 2010 (January 1, 2011 for calendar-year plans), with a special effective date for certain collectively bargained plans. The agencies will take into account good faith efforts to comply with a reasonable interpretation of the MHPAEA in the case of violations occurring before the regulations apply.

Summary of the MHPAEA

- Requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.
- Applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements.
- MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. Regulations under MHPA were issues in 1997. The MHPAEA interim final rule amends and modifies certain provisions in the MHPA regulations.
- Although MHPAEA provides significant new protections to participants in group health plans, it is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions.

MHPAEA Continues and Expands MHPA

- MHPA required parity with respect to aggregate lifetime and annual dollar limits, but did not apply to substance use disorder benefits. MHPAEA continued the MHPA parity rules as to limits for mental health benefits, and amended them to extend to substance use disorder benefits.
- Therefore, plans and issuers that offer substance use disorder benefits subject to aggregate lifetime and annual dollar limits must comply with the MHPAEA's parity provisions.
- The regulations demonstrate how the expanded rules apply, and update certain defined terms and examples as necessary.

Additional MHPAEA Protections Relating to Financial Requirements

- Under MHPAEA, if a plan or issuer that offers medical/surgical and MH/SUD benefits imposes "financial requirements" (such as deductibles, copayments, coinsurance and out of pocket limitations), the financial requirements applicable to MH/SUD benefits can be no more restrictive than the "predominant" financial requirements applied to "substantially all" medical/surgical benefits.
- The regulations provide that the "predominant/substantially all" test applies to six classifications of benefits on a classification-by-classification basis. The regulation also includes other rules and definitions that are necessary in order for plans, issuers and their advisers to apply this general parity test.

Additional MHPAEA Protections Relating to Treatment Limitations

- MHPAEA also provides similar protections for treatment limitations. "Treatment limitations" mean limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.
- The regulation clarifies that there may be both quantitative and non-quantitative treatment limitations, and provides rules for each. Since they are similar to financial requirements, quantitative treatment limitations are subject to the same general test as the financial requirements discussed above.
- Because non-quantitative treatment limitations (such as medical management standards, formulary design, and determination of usual/customary/reasonable amounts) apply differently, the regulation includes a separate parity requirement for them.

Parity with Respect to Out of Network Benefits

- If a plan or issuer that offers medical/surgical benefits on an out-of-network basis also offers MH/SUD benefits, it must offer the MH/SUD benefits on an out-of-network basis as well.

MHPAEA Availability of Plan Information Requirements

- MHPAEA requires that plans make certain information available with respect to MH/SUD benefits. First, the criteria for medical necessity determinations with respect to MH/SUD benefits must be made available to any current or potential participant, beneficiary, or contracting provider upon request.
- MHPAEA also provides that the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits must be made available, upon request or as otherwise required, to the participant or beneficiary.
- The regulation clarifies that, for non-Federal governmental plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, compliance with the form and manner of the ERISA claims procedure regulations for group health plans satisfies this disclosure requirement.

Exemptions from MHPAEA

- MHPAEA retains the exemption for small employers contained in MHPA. MHPAEA modified the exemption contained in MHPA based on increased cost in several respects, which are explained in the statute.
- The MHPAEA regulation updates the small employer exemption and withdraws the MHPA regulations concerning the increased cost exemption.

Certain information in this email was excerpted from the U.S. Department of Labor Fact Sheet, available at the following website: http://www.dol.gov/ebsa/newsroom/fsmhpaea.html.

Please contact your Conner Strong representative with any questions, toll-free at 1-877-861-3220.