

MHPAEA Regulations Released

Last month, the Departments of Labor, Treasury and Health and Human Services jointly released interim final regulations implementing provisions of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).¹ These regulations are effective on April 5, 2010.

For many plans, the MHPAEA is currently in effect. Under the statute, non-collectively bargained plans had to comply by plan years beginning after October 3, 2009. Collectively bargained plans had a delayed effective date. The regulations will apply to group health plans and issuers for plan years beginning on or after July 1, 2010 (*i.e.*, January 1, 2011, for calendar-year plans). Collectively bargained plans have a delayed application date: plan years beginning on or after the later of either July 1, 2010, or the date of the termination of last collective bargaining agreement ratified before October 3, 2008. This “application date” will allow plans a good faith time period in which to comply with these standards.

KEY ISSUES ADDRESSED

This section summarizes the key issues addressed in the regulations.

Parity in Medical Management

The statute prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits. “Treatment limits” include limits on the scope and duration of treatment. The agencies include as treatment limits such items as medical management standards used to evaluate coverage based on medical necessity, exclusions from

coverage based on a failure to complete a course of treatment, and step therapy protocols. The regulations provide that plans cannot use these features for mental health and substance use disorder benefits unless they are *comparable to, and are not applied more stringently than,* treatment limits on medical/surgical benefits. Only to the extent that recognized clinically appropriate standards of care permit a difference between these limits on medical versus mental health and substance use benefits would a disparity be allowed. For example, a plan that requires a participant to exhaust counseling sessions with an employee assistance program (EAP) before he or she can receive mental health or substance use disorder benefits would violate the MHPAEA if there are no comparable requirements on coverage of medical/surgical benefits.

Framework for Parity Comparison

The regulations set out a framework for assessing compliance with respect to financial requirements (*e.g.*, deductibles and coinsurance) and quantitative treatment limits (*e.g.*, day and visit limits). Depending on the particular plan design, this analysis can be quite detailed.

If a plan provides a mental health or substance use disorder benefit in *any* of the following six classifications, mental health and substance use disorder benefits must be provided in *every* classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

Within each classification, plan sponsors must determine whether there is a “predominant” financial requirement or treatment limit that applies to “all or substantially all” medical/surgical benefits. Plans are prohibited from applying a more restrictive financial requirement or treatment limit than this predominant level on any mental health or substance use disorder benefit within each classification.²

¹ The regulations were published in the February 2, 2010 *Federal Register*: <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf> For information about the MHPAEA, see The Segal Company’s November 2008 *Bulletin*, “New Law Requires Parity in Coverage for Mental Health”: <http://www.segalco.com/publications/bulletins/nov08MHPAEA.pdf>

² There are specific numerical tests in the rules for determining what level is “predominant” and “all or substantially all.” Plans may have to project expected plan payments for medical benefits in a plan year to do these calculations. Special rules apply when determining parity for prescription drugs.

A different analysis is set out in the regulation to determine parity for aggregate dollar limits. These are dollar limits on the total amount of a specified benefit.

Note that smoking cessation programs could be considered mental health or substance use disorder benefits subject to a parity analysis where there are coverage limits.

Specific Plan Designs Prohibited

The regulations prohibit the following plan designs:

- Plans cannot have separate deductibles, out-of-pocket limits or other “cumulative” financial requirements or treatment limits for medical/surgical, mental health and substance use disorder benefits. This is the case even if the deductible and out-of-pocket limits are the same for all three separate categories, or the amounts are less for mental health and substance use disorder benefits.
- Plans cannot evade the parity standards by putting mental health/substance use disorder benefits in a plan separate from the plan providing medical benefits. The regulation will generally treat the separate plan, plus the medical benefits as a single plan for compliance with the law.

NEXT STEPS FOR PLAN SPONSORS

Plan sponsors that have already done an analysis and made changes to their design may have to revisit the analysis in light of the specific framework set out in the regulations. They will need to make sure all six classifications have been evaluated and, depending on the plan design, do a separate calculation to determine what medical benefits are the predominant benefit for all or substantially all medical benefits. In addition, changes will be required for plans with separate deductible or out-of-pocket limits for medical, mental health or substance use disorder benefits.

Second, plans will have to take a closer look at medical management techniques to make sure they are comparable across all benefits. Any distinctions will have to be justified based on recognized appropriate standards of care. EAPs, substance abuse protocols and prescription drug step therapy programs in particular, should be examined. In addition, any financial analysis of the impact of the MHPAEA will have to take into account any changes to medical management required by these regulations.

Third, plan sponsors should work with their attorneys to determine the timing for compliance. The Internal Revenue Service can impose a civil penalty of up to \$100 a day against a plan covered by the Employee Retirement

Income Security Act for failure to comply. The Center for Medicare & Medicaid Services could impose the same penalty against a self-insured state or local government plan.³ Plans will have a good-faith period to comply, but may still be vulnerable to legal challenge prior to the application dates.

Finally, plans may wish to consider providing written comments to the agencies on various issues by May 3, 2010. The agencies seek comments on their approach to medical management. In addition, they seek comments on two issues not addressed in the regulations: (1) how to implement the cost exemption in the statute, and (2) whether a plan is required to provide mental health or substance use disorder benefits for a particular treatment setting for a condition (e.g., residential treatment), if the plan covers comparable settings to treat medical conditions.



As with all issues involving the interpretation or application of laws and regulations, plan sponsors should rely on their attorneys for authoritative advice on MHPAEA and the new interim regulations. Segal can be retained to work with plan sponsors and their attorneys on compliance and plan redesign.

³ Note that self-insured state and local government plans can opt out of the MHPAEA rules.



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