Mental Health Parity

The Mental Health Parity Act (MHPA) was originally passed in late 1996. It amended ERISA and the Public Health Service Act (PHSA) to prohibit a group health plan from offering benefits that contain annual and/or lifetime dollar maximums for mental health benefits that are more restrictive than limitations imposed on benefits for physical illness. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008, and extended the MHPA parity requirements in ERISA and the PHSA to substance use disorder benefits and required any such offered benefits to be similar to those for physical illness.

The Departments of Health and Human Services, Labor and the Treasury (Departments) issued regulations under the MHPA in 1997. Most recently, the Departments jointly issued interim final regulations implementing the MHPAEA, which replaced the 1997 MHPA regulations. These interim final regulations update, amend and modify certain provisions of the 1997 MHPA regulations, and demonstrate how the MHPAEA applies to group health plans and health insurance issuers.

When are mental health parity laws and regulations effective?
The MHPA was first effective for plan years beginning on or after January 1, 1998. The MHPAEA was applicable to plan years beginning after October 3, 2009, (for calendar year plans, that was **January 1, 2010**) and to group health plans under a collective bargaining agreement at the later of (1) plan years starting on or after Jan. 1, 2010, or (2) the termination date of the last collective bargaining agreement relating to the plan.

The MHPAEA interim final regulations are effective on April 5, 2010, and generally apply to group health plans and group health insurance issuers for plan years beginning **on or after July 1, 2010**. The Departments have stated that for purposes of enforcement, they will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of the regulations.

Who must comply?
The following group health plans must comply with the MHPA and the MHPAEA:

- Fully insured group health plans,
- Self-funded group health plans,
- Church plans, and
- Non-federal governmental plans.

Employers with fewer than 50 employees during the preceding calendar year are not required to comply with the MHPA and the MHPAEA. For purposes of determining group size, both part-time and full-time employees are included. Plans offering only HIPAA excepted benefits are not required to comply (e.g., dental, vision only).

Non-federal governmental plans that are self-funded may choose not to comply. In order to opt out, the plan must file an election with the Center for Medicare and Medicaid Services prior to the beginning of each plan year and notify the plan participants of its choice to opt out.

Does the law require that mental health or substance use disorder benefits be provided?
No. Neither the MHPA nor the MHPAEA requires that group health plans provide mental health or substance use disorder benefits. However, fully-insured group health plans located in a state where mental health and substance use disorder benefits are mandated must comply with both state law, the MHPA and the MHPAEA.

What coverage is required?
The MHPA and the MHPAEA require that any annual and/or lifetime dollar maximums imposed on mental health or substance use disorder benefits be no less than those applicable to coverage for physical illness and that offered benefits be comparable.

The final interim regulations further clarify that any group health plans that include mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review used by the insurer for medical and surgical benefits.

Does the MHPAEA govern benefits for treatment of alcohol and drug abuse?
Yes. The MHPAEA specifically includes substance use disorder benefits.

May a plan apply cost sharing to mental health or substance use disorder benefits under the MHPAEA?
The MHPAEA does not prohibit the application of cost sharing tools such as copayments/coinsurance and deductibles to mental health or substance use disorder benefits, so long as the cost sharing tools apply equally to physical health benefits. The interim final regulations clarify that under the MHPAEA, if a plan or issuer that offers medical/surgical and mental health or substance use disorder benefits imposes “financial requirements” (such as deductibles, copayments, coinsurance and out of pocket limitations), the financial requirements applicable to mental health or substance use disorder benefits can be no more restrictive than the “predominant” financial requirements applied to “substantially all” medical/surgical benefits.

Further, the interim final regulations clarify that combined deductibles are required for mental health or substance use disorder benefits and medical/surgical benefits, and that separate deductibles are prohibited. That is, a plan may not apply one deductible to mental health or substance use disorder benefits and another deductible to medical/surgical benefits.

For outpatient benefits, many plans 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). Can a plan use any sub-classifications when determining parity for outpatient benefits?
According to guidance issued July 1, 2010, the Departments have determined that they will not take action against plans that divide outpatient benefits into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under the MHPAEA: office visits and all other outpatient items and services. This means that a plan can apply the "substantially all" test separately for physician office visits that have copayments and for outpatient benefits that may be subject to other financial requirements. However, when determining parity under the regulations, plans and issuers may not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in either sub-classification (i.e., office 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.

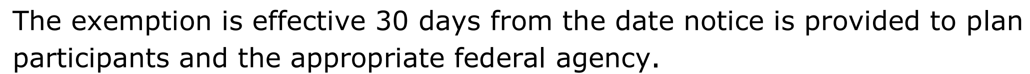
This enforcement safe harbor for outpatient benefits, and the special rule for multi-tier prescription drugs are the only sub-classifications that are permitted when applying the MHPAEA parity rules. It is still impermissible to have separate sub-classifications for generalists and specialists.

May a plan apply day or visit limits to mental health or substance use disorder benefits under the MHPAEA?
The MHPAEA does not prohibit application of day or visit limits to mental health or substance use disorder benefits, so long as the limits apply equally to physical health benefits. This is also true for other quantitative treatment limitations such as, for example, limits on the frequency of treatment, or days in a waiting period.

Does the law have an exemption when compliance is overly burdensome?
Yes. Until the MHPAEA becomes effective for a plan, the MHPA exemption provisions must be followed. The MHPA provisions provide that the MHPA does not apply to plans where compliance would result in a 1 percent increase in cost to the plan. In order for a group health plan to be exempt from the MHPA, it must:

- Comply with the MHPA for a period of at least six months,*
- Determine that the cost of compliance is at least 1percent by comparing retroactive claim data,
- Notify plan participants that the plan will be amended and that they may request at no charge a summary of information on which the exemption was based, and
- Notify the appropriate federal agency.

**In no event can the six-month period begin prior to the date the MHPAEA applied to the group health plan.*



The exemption is effective 30 days from the date notice is provided to plan participants and the appropriate federal agency.

Once the MHPAEA becomes effective for a plan, its provisions must be followed and are similar to the MHPA in the treatment of exemption criteria. However, the MHPAEA amends the applicable increased cost percentage to 2 percent in the case of the first plan year that the new requirement applies and 1 percent in the case of each subsequent plan year. Further, the interim final regulations clarify that the exemption may only be claimed for alternating years. Under the MHPAEA, plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year.

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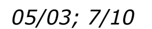

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