

# Compliance Alert

## Mental Health Parity Regulations

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is effective for plan years beginning after October 3, 2009 (January 1, 2010 for calendar-year plans). MHPAEA applies to group health plans sponsored by employers with more than 50 employees. It also applies to health insurance issuers of group health plans purchased by an employer with more than 50 employees. Nothing in the MHPAEA requires a group health plan to offer Mental Health and Substance Use Disorder (MH/SUD) benefits; however, if such benefits are offered, then the parity requirements will apply.<sup>1</sup>

MHPAEA builds on earlier law (the Mental Health Parity Act of 1996) and requires a group health plan to ensure that:

- The financial requirements (e.g. deductibles, copays) and treatment limitations (e.g. office visit limits) are no more restrictive than the *predominant* requirements or limitations that apply to *substantially all* medical/surgical benefits;
- Aggregate lifetime and annual dollar limitations applicable to MH/SUD benefits are no more restrictive than the limitations imposed on other medical and surgical benefits;
- If a plan offers medical/surgical benefits on an out-of-network basis and also offers MH/SUD benefits, it must offer the MH/SUD benefits on an out-of-network basis.

The Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (IRS) (collectively, the Departments) published an interim final rule implementing the provisions of MHPAEA effective for plan years beginning on or after July 1, 2010. The following summarizes some of the key provisions in a question and answer format.

### What are Mental Health and Substance Use Disorder Benefits?

*Mental health benefits* means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice.<sup>2</sup>

*Substance use disorder benefits* means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice.

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<sup>1</sup> In a fully insured arrangement, state insurance law may require mental health and substance use disorder coverage. Such laws are not preempted by the Federal requirements to the extent such requirements do not prevent the application of the requirements under MHPAEA.

<sup>2</sup> *Independent standards of current medical practice* means, for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or State guidelines.

## My plan imposes financial and quantitative treatment limitations – how will this work under MHPAEA?

If a plan or issuer that offers MH/SUD benefits imposes financial requirements<sup>3</sup> or quantitative treatment limitations<sup>4</sup>, the requirements and limitations that apply to MH/SUD benefits cannot be more restrictive than the *predominant* financial requirements that apply to *substantially all* medical/surgical benefits.

A separate determination will be made for each type of financial requirement or treatment limitation that applies to *substantially all* medical/surgical benefits within a classification.

### What is a *classification*?

The regulations identify six classifications of benefits in which MH/SUD must be provided if medical/surgical benefits are provided:

- Inpatient, in network;
- Inpatient, out-of-network;
- Outpatient, in network;
- Outpatient, out-of-network;
- Emergency care; and
- Prescription drugs.

### What is meant by *Substantially All* and *Predominant*?

The type of financial requirement (e.g. copay, deductible, coinsurance) or quantitative limitation (e.g. office visit limit) is considered to apply to *substantially all* medical and surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. If the requirement does not apply to at least two-thirds of all medical and surgical benefits, then the requirement cannot be applied to MH/SUD benefits.

If the “*substantially all*” requirements are met, then the *level*<sup>5</sup> of the financial requirement must be considered. The level of the financial requirement that is considered the *predominant level* in a classification of benefits is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

### Example

For inpatient, out-of-network medical/surgical benefits (one of the designated classifications described above), a group health plan imposes five levels of coinsurance.

Using a reasonable method, the plan projects its payments for the upcoming year as follows:

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<sup>3</sup> *Financial requirements* include deductibles, copays, coinsurance or out-of-pocket maximums.

<sup>4</sup> *Quantitative treatment limitations* are limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment that are expressed numerically (such as 50 out-patient visits a year).

<sup>5</sup> *Level* refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20% and 30%, different levels of a copayment include \$15 and \$20, different levels of a deductible include \$250 and \$500, and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

Coinsurance	0%	10%	15%	20%	30%	Total
Projected Payments	\$200x	\$100x	\$450x	\$100x	\$150x	\$1,000x
% of Total Plan Costs	20%	10%	45%	10%	15%	
% Subject to Coinsurance	N/A	12.5% (100x/ 800x)	56.25% (450x/ 800x)	12.5% (100x/ 800x)	18.75% (150x/ 800x)	

The plan projects plan costs of \$800x to be subject to coinsurance (\$100x + \$450x + \$100x + \$150x = \$800x).

Thus, 80% (\$800x/\$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25% of the benefits subject to coinsurance are projected to be subject to the 15% coinsurance level.

In this example, the two-thirds threshold of the *substantially all* standard is met for coinsurance because 80% of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15% coinsurance is the *predominant level* because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15% level of coinsurance.

#### What about separate deductibles between medical/surgical and MH/SUD?

The regulations make it clear that separate deductibles for medical/surgical benefits and MH/SUD benefits would violate the requirements of the regulations.

#### Example

A plan imposes an annual \$250 deductible on all medical/surgical benefits and a separate annual \$250 deductible on all mental health and substance use disorder benefits.

The separate annual deductible on mental health and substance use disorder benefits violates the requirements.<sup>6</sup>

#### How do the rules apply to non-quantitative treatment limitations?

Limitations may also be *non-quantitative* (i.e. non-numerical), and operate to limit the scope or duration of benefits.

Examples of *non-quantitative limitations* include:

- Medical management standards limiting or excluding benefits based on medical necessity, or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary designs for prescriptions;
- Standards for provider admission to participate in a network;
- Plan methods for determining usual, customary and reasonable charges;
- First fail or step-protocol therapies; and
- Exclusions based on failure to complete a course of treatment.

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<sup>6</sup> The regulations clarify that even if the separate deductible for MH/SUD benefits was \$100 in the above example (less than the deductible applied to medical/surgical benefits), the plan design would still violate the requirements.

A group health plan may not impose such non-quantitative limitations with respect to MH/SUD benefits in any classification (as described above) unless, under the terms and operation of the plan, any processes, strategies, evidentiary standards or other factors used to apply the non-quantitative treatment limits are comparable to and no more stringent than what applies with respect to medical/surgical benefits in the same classification.

For example, this requirement would prohibit a plan from requiring an individual to exhaust an EAP counseling benefit before accessing mental health benefits offered under the medical plan, if no other comparable requirement were imposed on medical or surgical benefits.

### How does the parity requirement apply to aggregate lifetime and annual dollar limitations?

A group health plan that provides both medical and surgical benefits and MH/SUD benefits must provide parity with respect to aggregate lifetime and annual dollar limits. The regulations clarify this parity requirement.

In general, if the plan does not impose any aggregate lifetime or annual dollar limitations on medical or surgical benefits, or imposes aggregate lifetime or annual dollar limitations on less than one-third of all medical/surgical benefits, the plan may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits.

If the plan includes aggregate lifetime or annual limitations on at least two-thirds of all medical and surgical benefits, then the plan must either:

- Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to MH/SUD benefits in a manner that does not distinguish between the medical/surgical benefits and MH/SUD benefits; or
- Not include an aggregate lifetime or annual dollar limit on MH/SUD benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

Special rules apply to plans not described in the above scenarios.<sup>7</sup>

### Example

A plan has a \$100,000 annual limit on medical/surgical inpatient benefits and a \$50,000 annual limit on medical/surgical outpatient benefits. To comply with the parity requirements, the plan sponsor is considering each of the following options:

- Imposing a \$150,000 annual limit on mental health and substance use disorder benefits; and
- Imposing a \$100,000 annual limit on mental health and substance use disorder inpatient benefits and a \$50,000 annual limit on mental health and substance use disorder outpatient benefits.

Either option under consideration by the plan sponsor would comply with the requirements.

Recent health care reform legislation<sup>8</sup> will likely prohibit a group health plan from imposing lifetime limitations on *essential benefits*, effective for the first plan year that begins on or after September 23, 2010. Further, unless permitted by HHS, annual dollar limitations on *essential benefits* will also be restricted. This may apply to MH/SUD benefits as the statute included these benefits as a general category of *essential benefits*. However, more guidance is needed.

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<sup>7</sup> See 29 CFR 2590.712(b)(6); 26 CFR 54.9812-1T(b)(6).

<sup>8</sup> Health care reform legislation encompasses two bills – *The Patient Protection and Affordable Care Act (Public Law No. 111-149)* and the *Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152)*, enacted March 23, 2010 and March 30, 2010 respectively.

**Can we create two separate plans, allocating medical/surgical benefits under one plan and MH/SUD under the other. As no medical/surgical benefits would be offered under the plan providing MH/SUD benefits do we avoid the MHPAEA parity requirements?**

No. The regulations clearly prohibit this type of design. In this scenario, the parity requirements would apply to the combined benefit plan (both medical/surgical and MH/SUD).

**Are there any notification requirements?**

Plans will need to make the following available:

- 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; and
- The reason for any denial under a group health plan for a MH/SUD benefit must be made available by the plan administrator or beneficiary in a form and manner consistent with ERISA claims procedure rules (see *29 CFR 2560.503-1*). A group health plan that is not subject to ERISA will comply with this requirement if it follows the ERISA claims procedures.

**Are there any exemptions from this requirement?**

Yes.

- Group health plans of small employers (generally, 50 or fewer employees).<sup>9</sup>
- Plans may qualify for a cost exemption if the plan can demonstrate that the costs to implement this requirement increase total plan costs by more than 2% in the first year, and more than 1% in each subsequent year. This analysis requires implementing the MH/SUD provisions for one-year and hiring an actuary make this determination based on at least 6-months of data. If the plan can demonstrate the required cost impact and provide appropriate notification then, in the following year, the plan may be exempt from the requirement. The exemption only lasts for one year, thus creating an administrative issue for plans, as the exemption can only be claimed in alternating years if the requirements are satisfied. The Departments intend to issue future guidance on implementing the cost exemption.

**Are there penalties for non-compliance?**

Penalties of up to \$100 per individual per day may be assessed.

**What should I do to comply with this requirement?**

Your plan may already comply with the statutory requirements of MHPAEA (as this was effective for the first plan year that began after October 3, 2009). As the regulations are not effective until the first plan year that begins on or after July 1, 2010, the following are some items to consider:

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<sup>9</sup> The term *small employer* is generally defined, in connection with a group health plan with respect to a calendar year and a plan year, as an employer who employed an average of not more than 50 employees on business days during the preceding calendar year. For these purposes:

- If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year;
- Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer ; and
- Controlled group rules apply in counting employees for purposes of this requirement (See *Code 414 (b), (c), (m), and (o)*).

- The Departments 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 effective date.
- As you approach renewal, ensure your carrier (or TPA in a self-insured arrangement) can determine whether your benefit offerings meet the *substantially all/predominant* test and the aggregate lifetime and annual dollar limitation requirements (as applicable). Adjustments to plan design may be needed to ensure compliance.
- Comply with any requests to provide criteria for a medical necessity determination.
- Monitor developments with respect to this requirement. The Departments issued a request for comment and additional guidance is expected, including information on the cost-exemption as well as possible changes to the *substantially all/predominant* test.

A copy of the MHPAEA is available at

<https://www.cms.gov/HealthInsReformforConsume/Downloads/MHPAEA.pdf>

A copy of the regulations is available at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>

For more information, see <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>



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