

## Federal Agencies Issue Mental Health Parity Final Interim Regulations

The Treasury, Labor and Health and Human Services Departments have jointly issued interim final regulations under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The regulations implement limits under the MHPAEA to financial and treatment restrictions on mental health or substance use disorder benefits under group health plans or coverage written by health insurance issuers.

The new requirements under the MHPAEA apply generally for plan years beginning after October 3, 2009. The regulations, however, apply for plan years beginning on or after July 1, 2010. The agencies note in the preamble to the regulations that, for purposes of enforcement relating to violations occurring before the first plan year beginning on or after July 1, 2010, good faith efforts to comply with a reasonable interpretation of MHPAEA requirements will be taken into account. They further note that this good faith standard may not apply in a private action brought by participants or beneficiaries.

Generally, the MHPAEA and these interim final regulations prohibit limitations on mental health/substance use disorder benefits that exceed corresponding limitations on medical/surgical benefits under the same group health plan. Here are some of the operational highlights under the regulations.

- The parity requirements are applied separately to each (i) classification of benefits (i.e., inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs); (ii) type of financial requirement or treatment limitation (e.g., copayments, co-insurance, annual visit limits, and episode visit limits), and (iii) coverage unit (e.g., single participant, participant plus spouse, family, etc.).
- In determining the permissible level of financial requirements for mental health/substance use disorder benefits, separate classifications for generalists and specialists cannot be used to calculate the corresponding limitation that the plan applies to medical/surgical benefits.
- If a plan provides benefits for a particular mental health condition or substance use disorder, benefits must be provided for that condition or disorder in each classification (i.e., inpatient, in-network; inpatient, out-of-network; etc.) for which any medical/surgical benefits are provided.
- The general rule is that financial requirements or treatment limitations for mental health/substance use disorder benefits in any classification cannot be more restrictive than the predominant financial requirements or treatment limitations for substantially all medical/surgical benefits in the same classification. For purposes of this analysis, a restriction applies to substantially all medical/surgical benefits in a classification if it applies to at least 2/3 of the benefits in that classification, based on total dollar amounts spent on medical/surgical benefits in the classification. A restriction is predominant if it applies to more than 1/2 of the medical/surgical benefits subject to the restriction in the classification. Multiple levels of restrictions on medical/surgical benefits in a classification may need to be combined in order to identify restrictions that apply to dollar amounts of medical/surgical benefits in a classification that are sufficient to meet these thresholds. In that case, the greatest permissible restriction on mental health/substance use disorder benefits cannot exceed the least restrictive level of financial requirements or treatment limitations within the combination of restrictions on medical/surgical benefits. For purposes of this combination, however, the group health plan may combine payments for the most restrictive levels  rather than the least restrictive levels  of financial requirements or treatment limitations on medical/surgical benefits.
- There is a special rule permitting multiple levels of financial requirements for different tiers of prescription drugs, so long as the levels are based on reasonable factors (e.g., generic versus brand name, mail order versus pharmacy pick-up), determined in accordance with requirements for nonquantitative treatment

limitations, and without regard to whether a drug is generally prescribed for medical/surgical conditions or mental health/substance use disorder conditions.

- The regulations prohibit cumulative financial requirements (e.g., deductibles) or cumulative quantitative treatment limitations (e.g., number of visits) on mental health/substance use disorder benefits in a classification that accumulate separately from such restrictions for medical/surgical benefits in the same classification.
- An EAP cannot be used as a gatekeeper for mental health/substance use disorder benefits unless similar gatekeeping processes with similar exhaustion requirements are applied to medical/surgical benefits.
- The parity requirements apply separately to each combination of medical/surgical coverage and mental health/substance use disorder coverage that any participant or beneficiary can receive simultaneously from any employer's plan or plans to provide medical care benefits. In other words, the parity requirements are applied on a participant-by-participant basis, treating all coverage options or combinations offered by the employer as provided under a single plan.

If you have questions or would like additional information about the MHPAEA parity requirements or the new interim final regulations, please feel free to contact Brian Dougherty at 215-587-5919 or [bdougherty@postschell.com](mailto:bdougherty@postschell.com).

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