

Fact Sheet



U.S. Department of Labor
Employee Benefits Security Administration
January 29, 2010

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

MHPAEA, which amended the Public Health Service Act, the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, generally is effective for plan years beginning on or after October 3, 2009. For calendar year plans, the effective date is January 1, 2010. The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury will publish in the Federal Register an interim final rule implementing the provisions of MHPAEA on February 2, 2010. The regulation is effective on April 5, 2010, and applicable to plan years beginning on or after July 1, 2010.

Background

- The Mental Health Parity and Addiction Equity Act of 2008 (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 mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.
- MHPAEA 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 also applies to health insurance issuers who sell coverage to employers with more than 50 employees.
- The DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA. HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans. While State insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority.
- 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. DOL, HHS and Treasury issued regulations under MHPA 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. Also, MHPAEA does not apply to issuers who sell health insurance policies to employers with 50 or fewer employees or who sell health insurance policies to individuals.

MHPAEA Continues and Expands MHPA

- As noted above, MHPA required parity with respect to aggregate lifetime and annual dollar limits. However, MHPA 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, withdraws the MHPA regulations concerning the increased cost exemption, and reserves paragraph (g) for additional future guidance.

Additional Issues

- The MHPAEA interim final rule is intended to address the most pressing issues that affect the ability of plans and issuers to comply in the near term. The Departments noted several issues in the preamble, and specifically requested comments on:
 - Whether additional examples would be helpful to illustrate the application of the non-quantitative treatment limitation rule to other features of medical management or general plan design;
 - Whether and to what extent MHPAEA addresses the “scope of services” or “continuum of care” provided by a group health plan or health insurance coverage;
 - What additional clarifications might be helpful to facilitate compliance with the disclosure requirement for medical necessity criteria or denials of MH/SUD benefits; and
 - Implementing the new statutory requirements for the increased cost exemption under MHPAEA, as well as information on how many plans expect to use the exemption.