Mental Health Parity and Addiction Equity Act

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On January 29, 2010, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services jointly issued interim final regulations for the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The MHPAEA became effective for most health plans on January 1, 2010. The new interim regulations are effective April 5, 2010, and become applicable for group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010.

As a reminder, neither the MHPAEA nor the regulations require that a group health plan provide mental health or substance use disorder benefits. ***If*** a group health plan provides mental health or substance use disorder benefits, then the plan cannot impose lifetime or annual benefit limits on the mental health or substance use disorder benefits unless those same limits also apply to medical and surgical benefits. In addition, the group health plan cannot impose financial requirements or treatment limitations on the mental health or substance use disorder benefits, unless those provisions also apply to the medical and surgical benefits.

The MHPAEA defines the term "financial requirement" to include deductibles, co-payments, coinsurance and out-of-pocket expenses. The term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. According to the MHPAEA and its new regulations, the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits cannot be restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

The new regulations recognize that plans often vary the financial requirements and treatment limitations imposed on benefits based on whether the treatment is provided on an in-network or out-of-network basis, or whether the treatment is rendered on an inpatient or outpatient basis. Therefore, determining the predominant financial

requirements and treatment limitations for the entire plan without taking these distinctions into account could lead to an absurd result. The regulations fortunately provide for the following six classifications of benefits: (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. The parity requirements for financial requirements and treatment limitations should therefore be applied on a classification-by-classification basis.