

Compliance Alert

Mental Health Parity and Addiction Equity Act: New FAQ Creates a Safe Harbor for Benefits Provided on an Outpatient Basis

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is effective for plan years beginning after October 3, 2009. Among other things, MHPAEA requires that the financial requirements (e.g., deductibles, copays) and treatment limitations (e.g., office visit limits) imposed on mental health and substance use disorder (MH/SUD) benefits are no more restrictive than the *predominant* requirements or limitations that apply to *substantially all* medical/surgical benefits.

Recently the Departments of Labor (DOL), the Treasury and Health and Human Services issued interim final rules providing further guidance on MHPAEA. Effective for plan years beginning on or after July 1, 2010, the regulations laid out a rather complicated series of tests to determine compliance with the parity requirement.¹ It appears the tests may have had some unintended consequences as it related to outpatient benefits.

Many plans and insurance carriers commonly require a copayment for office visits (e.g., physician or psychologist visits), but apply coinsurance to other outpatient services (e.g., outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items). Under the regulations, a plan is required to test outpatient office visits together with other outpatient services under the classification of "outpatient services." Thus, plans that contained both copayments and coinsurance for outpatient benefits had difficulty satisfying the parity requirements.

The DOL announced it will establish an enforcement safe harbor for plans and insurers and allow benefits for outpatient services (whether in-network or out-of-network) to be divided into specific sub-classifications:

- (1) office visits; and
- (2) all other outpatient items and services.

Once these sub-classifications are established, the plan or insurer may not impose any financial requirement on MH/SUD benefits that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the same sub-classification.

By allowing this new sub-classification, plans may be able to retain certain plan designs that previously did not satisfy the requirements under the regulations.

The FAQ reiterates that, other than the sub-classification described above and the permitted sub-classifications for multi-tier prescription drug formularies, sub-classifications are generally not permitted when applying the financial requirement and treatment limitations rules under MHPAEA. This general prohibition includes separate sub-classifications for generalists and specialists.

For more information, visit <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

¹ If a plan or issuer that offers MH/SUD benefits imposes financial requirements or quantitative treatment limitations, 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. The permitted classifications are:

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

The type of financial requirement (e.g., copay, deductible, coinsurance) or quantitative treatment limitation (e.g., office visit limit) is considered to apply to *substantially all* medical/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/surgical benefits, then the requirement cannot be applied to MH/SUD benefits.

If the “*substantially all*” requirements are met, then the *level* 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.



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