



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

LEGISLATION AFFECTING SELF-FUNDED PLANS

Mental Health Parity Addiction Equity Act of 2008 (MHPAEA) Background

The MHPAEA statute was enacted October 3, 2008, and became effective for plan years starting on or after October 3, 2009. MHPAEA affects groups with 51 or more employees. Regulations were published on February 2, 2010, which were intended to provide clarity to this new law. In general, these new rules are effective for plan years beginning on or after July 1, 2010.*

MHPAEA greatly expands on an earlier law, the Mental Health Parity Act of 1996 which required parity only in aggregate lifetime and annual dollar limits between the categories of benefits, and did not extend to substance use disorder benefits.

While MHPAEA does not mandate that benefits be offered, the new law generally requires that any group health plan that offers mental health and substance use disorder benefits must treat them in parity with standard medical and surgical coverage in terms of all financial requirements including out-of-pocket costs, visit and benefit limits — and also treatment limitations such as prior authorization and utilization review. These practices must be based on the same level of scientific evidence used by the insurer for medical and surgical benefits.

Six separate classifications have been established to determine whether there is parity. The specific classifications are:

- Inpatient In-network
- Inpatient Out-of-network
- Outpatient In-network
- Outpatient Out-of-network
- Emergency care
- Prescription drugs

No other classifications are allowed. If benefits are provided under a plan in one classification, then benefits must be provided in all other classifications in which medical-surgical benefits are provided. Where plans offer different levels of medical coverage and a separate mental health plan, or a carve-out, then the parity rules must be applied option by option, and must include the mental health and substance use disorder benefit with each option.

Intensive calculations must be performed across each of the six classifications, and separately across all coverage units, for each group health plan, for each financial requirement. Under the Regulations, a type of financial requirement (e.g., copayment, coinsurance) applies to “substantially all” medical-surgical benefits in each classification, if it applies to at least two-thirds of the benefits in that classification. If this standard is met, then the “predominant level” of that type of financial requirement must be determined. For a level of financial requirement to be “predominant,” it must apply to more than 50% of the benefit provided in that classification. If less than two-thirds of medical-surgical benefits have a financial requirement, then that particular type of cost-sharing is not allowed on mental health and substance use disorder benefits. Similar calculations are made for quantitative treatment limitations.

What are the six classifications to determine parity?

The specific classifications are:

- Inpatient In-network
- Inpatient Out-of-network
- Outpatient In-network
- Outpatient Out-of-network
- Emergency care
- Prescription drugs

What This Legislation Means to You

- Wellmark is conducting analysis to assist plans in determining if they meet MHPAEA compliance tests. For those plans that do not comply, we can consult with you to provide benefit change recommendations that intend to stay as close to your current benefit design as possible, to minimize disruption and avoid creating a reduction in your current benefits.
- For self-funded accounts, Wellmark will conduct compliance testing and provide you with information and recommendations you can use when you seek advice from your own legal counsel regarding MHPAEA. Compliance with MHPAEA as well as other laws, such as the Patient Protection and Affordable Care Act (PPACA), is the responsibility of plan sponsors of self-funded plans. Wellmark is not providing any legal advice with regard to compliance with these requirements. In addition, Wellmark makes no representation as to the impact of plan changes (that may be required by MHPAEA) on the grandfathered provisions of PPACA. Plan sponsors should communicate with their own legal counsel for guidance on the application of these requirements. Any questions about Wellmark's approach to MHPAEA may be referred to your Wellmark account representative.
- While there is no requirement that the "substantially all" and "predominant" tests be certified by an actuary, for purposes of showing compliance with MHPAEA and the Regulations, consideration should be given to having some formal method of documenting an actuarial review.
- Group health plans are now required to self-report violations of MHPAEA and the Regulations and pay an excise tax for violations with various group plan mandates, including MHPAEA, occurring on or after January 1, 2010. In the preamble to the Regulations, it is stated that the Government will take into account good faith efforts to comply with reasonable interpretations of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of the Regulations, but notes that this does not prevent participants or beneficiaries from bringing private actions.
- Failure to comply with the MHPAEA and the Regulations could subject both the insurer and the group health plan with substantial penalties, including excise taxes of up to \$100 per person per day per violation. In addition, there is potential liability to participants, beneficiaries, and the Department of Labor.

July 1 Legislative Update

On July 1, 2010, the effective date of the Interim Final Rules, the U.S. Department of Labor Employee Benefit Security Administration released an FAQ stating that until final rules are issued, an "enforcement safe harbor" will allow a plan or issuer to divide its benefits provided on an Outpatient/In-Network and Outpatient/Out-of-Network basis, into two sub-classifications, for purposes of applying the financial requirement and treatment limitation rules under the Mental Health Parity and Addiction Equity Act (MHPAEA):

- Office visits
- All other outpatient items and services

This clarification may allow groups to comply with MHPAEA based on their original mental health benefits (without increasing the benefits). However, now that grandfathering interim final rules under the health care reform Affordable Care Act (ACA) are in effect, a reduction in benefits (including MHCD) can cause a group to lose grandfather status.



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