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February 2010

Employee Benefits

Alert

Mental Health Parity Guidance Issued

The Departments of Treasury, Labor, and Health and Human Services recently issued interim final regulations under the Mental Health Parity and Addiction Equity Act of 2008 (the Act). Under the Act, group health plans and health insurance issuers may not impose financial or treatment restrictions on mental health benefits or substance use disorder (MH/SUD) benefits that are more restrictive than the "predominant" restrictions applicable to "substantially all" medical and surgical benefits. The Act is effective for plan years beginning on or after Oct. 3, 2009. The interim final regulations apply to plan years beginning on or after July 1, 2010.

Some highlights of the final interim regulations include the following:

"Predominant" and "Substantially All." The regulations provide guidance for determining "predominant" limitations and whether they apply to "substantially all" benefits.

Benefit Classifications. Parity is determined based on the benefits offered under six classifications of benefits. If MH/SUD benefits are offered under one of the following classifications of benefits, they must be equivalent to medical and surgical benefits offered under the classification.

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

Specialists. Although many plans require higher co-pays for care provided by specialists, the interim final regulations do not allow plans to apply "specialist" co-payment requirements to MH/SUD care.

EAPs. A plan may not require participants to exhaust EAP benefits before being eligible for the plan's MH/SUD benefits.

Non-Quantitative Limitations. The application of the following "non-quantitative treatment limitations" to MH/SUD benefits may not be more restrictive than their application to medical and surgical benefits.

- Determining whether a treatment is medically necessary or experimental;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network;
- Plan methods for determining usual, customary, and reasonable charges;
- Fail first policies or step therapy protocols; and
- Exclusions based on failure to complete a course of treatment.

Although the regulations are not yet effective or final, plan sponsors should carefully review plan documents and administrative procedures to ensure good faith compliance with the Act. A DOL fact sheet providing additional information regarding the ACT is available here: http://www.dol.gov/ebsa/newsroom/fsAct.html#.

Please contact any of the Williams Mullen Employee Benefits Group lawyers if you have questions regarding this on any other Employee Benefits matter.

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