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DOL FAQ Makes Mental Health Parity Compliance Easier for Plan Sponsors

Late last week the DOL posted a new frequently asked question (FAQ) on its website that provides welcome relief to many plan sponsors who were attempting to comply with the interim final regulations under the 2008 mental health parity law. This important new guidance will make it easier for some plans to comply with the parity requirements without expanding mental health benefits to 100% coverage or losing grandfather status under the new health reform law.

Background

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibits group health plans from imposing financial requirements (e.g., coinsurance or copayments) or treatment limitations (e.g., limits on number of visits) on mental health or substance use disorder benefits that are more restrictive than the most common or frequent requirements and limitations imposed on medical and surgical benefits. Interim final regulations implementing MHPAEA that were issued in February 2010 set out complex rules for establishing "parity." In order to satisfy the "substantially all" test under the regulations, any type of financial requirement or quantitative treatment limit applied to mental health or substance use disorder benefits must apply to two-thirds of the medical and surgical benefits within a particular classification. (See our March 2, 2010 *For Your Information*.) This test was particularly troublesome for sponsors of medical plans that have copayments for physician office visits but apply coinsurance for other outpatient services (e.g., outpatient surgery, diagnostic imaging and laboratory services) because in many cases neither copayments nor coinsurance applies to at least two-thirds of all medical benefits in that classification. Sponsors were concerned that their only options for complying with MHPAEA would be to eliminate copayments and apply coinsurance to all outpatient (medical, mental health and substance use disorder) benefits, or impose no cost-sharing on mental health or substance use disorder benefits.

New DOL FAQ

The DOL has now posted an FAQ on its website that provides significant relief to sponsors with the plan design described above. The guidance states that until final MHPAEA regulations are issued, the agencies will not take enforcement action against a plan that divides outpatient benefits into two sub-classifications – (1) office visits and (2) all other outpatient items and services – for purposes of applying the financial and treatment limitation rules

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under MHPAEA. This means that plans can apply the "substantially all" test separately for physician office visits that have copayments and for outpatient benefits that may be subject to other financial requirements.

The DOL stresses that this enforcement safe harbor only applies to outpatient benefits and not to benefits in other classifications (although it notes that the regulations already permit multi-tiered prescription drug benefits). It also reiterates that separate subclassifications for generalists and specialists are not permitted.

> ***BUCK COMMENT.*** *Until the issuance of this FAQ, plans that were considering changes to their medical and surgical benefits to come into compliance were caught in a "Catch-22" situation because by doing so they might lose their grandfather status under the new health reform law. This latest guidance provides them with much more flexibility.*

Conclusion

Buck's consultants would be pleased to discuss this relief with you and its effect on your plans.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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