



## **Feds: Parity Regs To Raise Premiums 0.4%**

Federal agencies have issued interim final rules for implementing a new mental health benefits parity law, but they acknowledge that they are still working out some of the details.

The Internal Revenue Service, the Employee Benefits Security Administration and the Centers for Medicare and Medicaid Services joined to issue the interim final rules, which implement the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

The IRS is in the process of making the same rules permanent IRS regulations.

The interim final rules and proposed IRS regulations, which are set to appear in the Federal Register Tuesday, would apply to group plans and group health issuers for plan years starting on or after July 1. The IRS, EBSA and the CMS are asking for comments on the interim final rules, and comments will be due 60 days after the Federal Register publication date.

An older parity act, the Mental Health Parity Act of 1996, has required plans that offer mental health benefits to use the same aggregate lifetime and annual limits for mental health benefits and general medical benefits.

The MHPAEA goes further. It prohibits health plans that offer mental health benefits from "applying any financial requirement or treatment limitation to mental health or substance abuse disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification."

"The general parity requirement of MHPAEA applies separately for each type of financial requirement or treatment limitation (that is, for example, copayments are compared to copayments, and deductibles to deductibles)," officials write in a preamble to the interim final rules.

The MHPAEA also bans differences in "nonquantitative treatment limitations."

Officials note in the preamble that they are still thinking about how to explain some parts of the MHPAEA. They ask, for example, whether commenter's want more examples of how the ban on differences in nonquantitative treatment limitations will work.

In April 2009, the IRS, EBSA and the CMS published a notice seeking comments from members of the public on the MHPAEA requirements.

The commenter's who replied to the April request for comments asked whether "MHPAEA requirements apply when eligibility for mental health and substance use disorder benefits under a major medical program is conditioned on exhausting some limited number of mental health and substance use disorder counseling sessions offered through an employee assistance program," officials write.

"Generally, the provision of mental health or substance use disorder benefits by an EAP in addition to the benefits offered by a major medical program that otherwise complies with the parity rules would not violate MHPAEA," officials write. "However, requiring participants to exhaust the EAP benefits – making the EAP a gatekeeper – before an individual is eligible for the major medical program's mental health or substance use disorder benefits is a nonquantitative treatment limitation subject to the parity requirements."

Commenter's also sent in questions about how the MHPAEA will interact with state laws.

The MHPAEA requirements supersede state laws only if the state law standard prevents the application of an MHPAEA requirement, officials write.

This is a narrow preemption of state laws, officials write.

"A state law, for example, that mandates that an issuer offer a minimum dollar amount of mental health or substance use disorder benefits does not prevent the application of MHPAEA," officials write. "Nevertheless, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the state law minimum in order to comply with MHPAEA."

In an impact analysis section, officials include Congressional Budget Office projections that the MHPAEA will increase private health insurance premiums about 0.4%. That translates into about \$26 billion in additional spending on health coverage from 2010 to 2019, officials write.

The 10-year value would be \$19 billion with a 7% discount rate and more than \$22 billion with a 3% discount rate, officials estimate.

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