MHPAEA

Mental Health Parity and Addiction Equity Act (MHPAEA)
Group health plans (of employers with over 50 employees) offering mental health benefits.

Notice Requirement	Summary
Notice of cost exemption - Group health plans claiming the increased cost exemption must promptly notify the appropriate federal and state agencies, plan participants and beneficiaries. Notice must also be provided upon request.	The cost exemption will apply to a group health plan if its cost increase exceeds 2% in the first plan year and 1% in each subsequent year. Cost-increase determinations must be made and certified in a written actuarial report. The plan must comply with the parity requirements for the first 6 months of the plan year involved. The written report and underlying documentation must be maintained for 6 years following the notification to elect the cost exemption. A group health plan or health insurance issuer shall promptly notify the Secretaries of the DOL, HHS and the Treasury, the appropriate State agencies, and participants and beneficiaries in the plan of such election. A notification to the Secretaries shall include: • A description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption by such plan (or coverage); • For both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and • For both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan. Upon request – The plan administrator or health insurance issuer must provide the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits, upon request by a current or potential participant, beneficiary or contracting provider. The plan administrator or health insurance issuer must also make available upon request, or as otherwise required, the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary.

5/10, KP 12/11