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Monday  
December 22, 1997

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**Part V**

**Department of the Treasury**

Internal Revenue Service

26 CFR Part 54

**Department of Labor**

Pension Welfare Benefits Administration

29 CFR Part 2590

**Department of Health and  
Human Services**

Health Care Financing Administration

45 CFR Part 146

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**Mental Health Parity; Interim Rules  
HIPAA Mental Health Parity Act;  
Proposed Rule**

**DEPARTMENT OF THE TREASURY****Internal Revenue Service****26 CFR Part 54**

[T.D. 8741]

RIN 1545-AV53

**DEPARTMENT OF LABOR****Pension and Welfare Benefits Administration****29 CFR Part 2590**

RIN 1210-AA62

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Health Care Financing Administration****45 CFR Part 146**

RIN 0938-AI05

**Interim Rules for Mental Health Parity**

**AGENCIES:** Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

**ACTION:** Interim rules with request for comments.

**SUMMARY:** This document contains interim rules governing parity between medical/surgical benefits and mental health benefits in group health plans and health insurance coverage offered by issuers in connection with a group health plan. The rules contained in this document implement changes made to certain provisions of the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA or Act), and the Public Health Service Act (PHS Act) enacted as part of the Mental Health Parity Act of 1996 (MHPA) and the Taxpayer Relief Act of 1997. Interested persons are invited to submit comments on the interim rules for consideration by the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (Departments) in developing final rules. The rules contained in this document are being adopted on an interim basis to ensure that sponsors and administrators of group health plans, participants and beneficiaries, States, and issuers of group health insurance coverage have timely guidance concerning compliance with the requirements of MHPA.

**DATES:** *Effective date.* The interim rules are effective January 1, 1998.

*Applicability dates.* The requirements of MHPA and the interim rules apply to group health plans and health insurance issuers offering health insurance coverage in connection with a group health plan for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

*Information collection.* Affected parties are not required to comply with the information collection requirements in these interim rules until the Departments publish in the **Federal Register** the control numbers assigned to these information collection requirements by the Office of Management and Budget (OMB). Publication of the control numbers notifies the public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995. The Departments have submitted a copy of this rule to OMB for its review of the information collections. Interested persons are invited to send comments regarding these burdens or any other aspect of these collections of information on or before February 20, 1998.

*Comments.* Written comments on these interim rules are invited and must be received by the Departments on or before March 23, 1998.

**ADDRESSES:** Comments on the information collection requirements should be sent directly to: Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attention: HCFA Desk Officer. Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2-26-17, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: John Burke

Written comments on other aspects of the interim rules should be submitted with a signed original and three copies (except for electronic submissions sent to the Internal Revenue Service (IRS)) to any of the addresses specified below. For convenience, comments may be addressed to any of the Departments. Comments addressed to any Department will be shared with the other Departments.

Comments to the IRS can be addressed to: CC:DOM:CORP:R (REG-109704-97), Room 5228, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044.

In the alternative, comments may be hand-delivered between the hours of 8 a.m. and 5 p.m. to: CC:DOM:CORP:R (REG-109704-97), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224.

Alternatively, taxpayers may transmit comments electronically via the IRS Internet site at: [http://www.irs.ustreas.gov/prod/tax\\_regs/comments.html](http://www.irs.ustreas.gov/prod/tax_regs/comments.html).

Comments to the Department of Labor can be addressed to: U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW., Room N-5669, Washington, DC 20210; *Attention:* MHPA Comments.

Alternatively, comments may be hand-delivered between the hours of 9 a.m. and 5 p.m. to the same address.

Comments to the Department of Health and Human Services can be addressed to: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-2891-IFC, P.O. Box 26688, Baltimore, MD 21207.

In the alternative, comments may be hand-delivered between the hours of 8:30 a.m. and 5:00 p.m. to either:

Room 309-G, Hubert Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201

or

Room C5-09-26, 7500 Security Boulevard, Baltimore, MD 21244-1850

All submissions to the Internal Revenue Service will be open to public inspection and copying in Room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9:00 a.m. to 4:00 p.m.

All submissions to the Department of Labor will be open to public inspection and copying in the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW, Washington, DC from 8:30 a.m. to 5:30 p.m.

All submissions to the Department of Health and Human Services will be open to public inspection and copying in Room 309-G of the Department of Health and Human Services offices at 200 Independence Avenue, SW, Washington, DC from 8:30 a.m. to 5:00 p.m.

**FOR FURTHER INFORMATION CONTACT:** Terese Klitenic, Health Care Financing Administration, Department of Health and Human Services, at (410) 786-1565; Mark Connor, Pension and Welfare Benefits Administration, Department of Labor, at (202) 219-4377; or Russ

Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622-4695.

*Customer service information.*

Individuals interested in obtaining a copy of the Department of Labor's booklet entitled "Questions and Answers: Recent Changes in Health Care Law," which includes information on MHPA, may call the following toll-free number: 1-800-998-7542.

**SUPPLEMENTARY INFORMATION:**

**A. Background**

The Mental Health Parity Act of 1996 (MHPA) was enacted on September 26, 1996 (Pub. L. 104-204, 110 Stat. 2944). MHPA amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) to provide for parity in the application of certain dollar limits on mental health benefits with dollar limits on medical/surgical benefits. Provisions implementing MHPA were later added to the Internal Revenue Code of 1986 (Code) under the Taxpayer Relief Act of 1997 (Pub. L. 105-34).

*1. Regulatory Responsibility*

The provisions of MHPA are set forth in Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act.<sup>1</sup> The Secretaries of the Treasury, Labor, and Health and Human Services share jurisdiction over the MHPA provisions. These provisions are substantially similar, except as follows:

- The MHPA provisions in the Code generally apply to all group health plans other than governmental plans, but they do not apply to health insurance issuers. A taxpayer that fails to comply with these provisions may be subject to an excise tax under section 4980D of the Code.

- The MHPA provisions in ERISA generally apply to all group health plans other than governmental plans, church plans, and certain other plans. These provisions also apply to health insurance issuers that offer health insurance coverage in connection with such group health plans. Generally, the Secretary of Labor enforces the MHPA provisions in ERISA, except that no enforcement action may be taken by the Secretary against issuers. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State law.

<sup>1</sup> Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Title XXVII of the PHS Act were added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191.

- The MHPA provisions in the PHS Act generally apply to health insurance issuers that offer health insurance coverage in connection with group health plans and to certain State and local governmental plans. States, in the first instance, enforce the PHS Act with respect to issuers. Only if a State does not substantially enforce any provisions under its insurance laws will the Department of Health and Human Services enforce the provisions, through the imposition of civil money penalties. Moreover, no enforcement action may be taken by the Secretary of Health and Human Services against any group health plan except certain State and local governmental plans.

The interim rules being issued today by the Secretaries of the Treasury, Labor, and Health and Human Services have been developed on a coordinated basis by the Departments. In addition, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604). Except to the extent needed to reflect the statutory differences described above, the interim rules of each Department are substantively identical. However, there are certain non-substantive differences. The interim rules reflect certain stylistic differences in language and structure to conform to conventions used by a particular Department. These differences have been minimized and any differences in wording are not intended to create any substantive difference.

*2. Preemption of State Laws*

The McCarran-Ferguson Act of 1945 (Pub. L. 79-15) exempts the business of insurance from federal antitrust regulation to the extent that it is regulated by the States and indicates that no federal law should be interpreted as overriding State insurance regulation unless it does so explicitly. Section 514(a) of ERISA preempts State laws relating to employee benefit plans (including group health plans). Section 731 of ERISA and section 2723 of the PHS Act provide that Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act (including the MHPA provisions) do not in any way affect or modify section 514 of ERISA with respect to group health plans.

Section 514(b)(2) of ERISA saves from preemption any State law that regulates insurance. However, section 731(a) of ERISA and section 2723(a) of the PHS Act preempt State insurance laws relating to health insurance issuers in connection with group health insurance

coverage to the extent such laws "prevent the application of" Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act, including the MHPA provisions. (There is no corresponding provision in the Code.) In this regard, the conference report to HIPAA states that the conferees generally intended the narrowest preemption of State laws with regard to health insurance issuers (not group health plans) with respect to the provisions of Part 7 of Subtitle B of Title I of ERISA and Part A of Title XXVII of the PHS Act.<sup>2</sup> Consequently, the conference report to HIPAA states that State laws with regard to health insurance issuers that are broader than federal requirements in certain areas would not "prevent the application of" the provisions of Part 7 of Subtitle B of Title I of ERISA or Part A of Title XXVII of the PHS Act. Further, the conference report to MHPA states that the application of these preemption provisions should permit the operation of any State law or provision that requires more favorable treatment of mental health benefits under health insurance coverage than that required under the MHPA provisions.

Thus, generally, a State law that requires more favorable treatment of mental health benefits under health insurance coverage offered by issuers would not be preempted by the provisions of MHPA and the interim rules.

**B. Overview of MHPA and the Interim Rules**

The MHPA provisions are set forth in section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act. MHPA and the interim rules apply to a group health plan (or health insurance coverage offered by issuers in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits.

The MHPA provisions provide for parity in the application of aggregate lifetime dollar limits, and annual dollar limits, between mental health benefits and medical/surgical benefits. If a group health plan offers two or more benefit packages under the plan, the

<sup>2</sup> However, the preemption is broader for the statutory requirements of section 701 of ERISA and section 2701 of the PHS Act that limit the application of preexisting condition exclusions. Under these broader provisions, State laws cannot "differ" from the preexisting condition exclusion requirements of section 701 of ERISA or section 2701 of the PHS Act except as specifically permitted by section 731(b)(2) of ERISA and section 2723(b)(2) of the PHS Act. These provisions permit a State to impose on health insurance issuers certain stricter limitations relating to preexisting condition exclusions.

requirements of MHPA and the interim rules apply separately to each package. The interim rules make clear that the MHPA requirements apply regardless of whether the mental health benefits are administered separately under the plan. In addition, the interim rules make clear that the MHPA requirements in ERISA and the PHS Act apply both to group health plans and to health insurance issuers offering coverage in connection with a group health plan.

MHPA and the interim rules do not require a group health plan (or health insurance coverage offered in connection with a group health plan) to provide mental health benefits. In addition, MHPA and the interim rules do not affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requirements that patients or providers obtain prior authorization for treatment, and requirements relating to primary care physicians' referrals for treatment) relating to the amount, duration, or scope of mental health benefits under a plan (or coverage) except as specifically provided in regard to parity of aggregate lifetime dollar limits and annual dollar limits.<sup>3</sup>

### 1. Aggregate Lifetime Limits and Annual Limits

Under MHPA and the interim rules, a group health plan (or health insurance coverage offered in connection with a group health plan) providing both medical/surgical benefits and mental health benefits may comply with the MHPA parity requirements in any of the following general ways:

- The plan (or coverage) may comply by not including any aggregate lifetime dollar limit or annual dollar limit on mental health benefits.
- The plan (or coverage) may comply by imposing a single aggregate lifetime or annual dollar limit on both medical/surgical benefits and mental health benefits in a way that does not distinguish between the two.
- The plan (or coverage) may comply by imposing an aggregate lifetime dollar limit or annual dollar limit on mental health benefits that is not less than the aggregate lifetime dollar limit or annual

dollar limit on medical/surgical benefits.

- In the case of a plan (or coverage) under which aggregate lifetime dollar limits or annual dollar limits differ for categories of medical/surgical benefits, the plan (or coverage) may comply by calculating a weighted average aggregate lifetime dollar limit or weighted average annual dollar limit for mental health benefits. The weighted average must be based on a formula in the interim rules that takes into account the limits on different categories of medical/surgical benefits.

In addition, under MHPA and the interim rules, benefits for treatment of substance abuse or chemical dependency may not be counted in applying an aggregate lifetime or annual dollar limit that applies separately to mental health benefits.

### 2. Exemptions from the Requirements of MHPA

#### (a) Small Employer Exemption

The parity requirements under MHPA and the interim rules do not apply to any group health plan (or health insurance coverage offered in connection with a group health plan) for any plan year of a small employer. The term "small employer" is defined as an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.<sup>4</sup>

For purposes of the small employer exemption, all persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Code (26 U.S.C. 414) are treated as one employer. In addition, if an employer was not in existence throughout the preceding calendar year, whether the employer is a small employer is determined on the average number of employees the employer reasonably expects to employ on business days during the current calendar year. Finally, any reference to an employer in the small employer exemption includes a reference to a predecessor of the employer.

#### (b) Increased Cost Exemption

The second exemption from the MHPA requirements applies to group health plans (or health insurance coverage offered in connection with a group health plan) if the application of the MHPA parity requirements described in paragraph (b)(1)(i)<sup>5</sup> results in an increase in the cost under the plan (or coverage) of at least one percent. This exemption is available only if the requirements of paragraph (f) are met. If a plan offers more than one benefit package, the exemption is applied separately to each benefit package. Except as provided in the transition period described in paragraph (h), a plan must implement the parity requirements for the first plan year beginning on or after January 1, 1998, and must continue to comply with the parity requirements until September 30, 2001 (the sunset date in paragraph (i)) unless the plan satisfies the exemption described in paragraph (f). However, the exemption is not effective until 30 days after the notice requirements in paragraph (f)(3) are satisfied.

The interim rules, in paragraph (f)(2), describe the ratio of two terms used to determine if a plan (or coverage) has experienced a cost increase of one percent or more. The first term is the total cost incurred under parity (including both mental health costs and medical/surgical costs). The second term is the total cost incurred under parity reduced by the costs required solely to comply with parity. Costs required solely to comply with parity include mental health claims that would have been denied absent amendments required to comply with parity, the administrative costs related to those claims, and other administrative costs attributable to complying with the parity requirements. Premium payments are not considered in this calculation. The ratio is expressed by the following formula:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

*IE* represents the incurred expenditures during the base period. *CE* represents the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with the parity requirements of paragraph (b)(1)(i). *AE* represents administrative costs related to claims in *CE* and other administrative costs attributable to

<sup>3</sup>In response to the Departments' request for public comments on MHPA published in the **Federal Register** (62 FR 34604), the Equal Employment Opportunity Commission (EEOC) noted that the Americans with Disabilities Act (ADA) prohibits disability-based distinctions (including such distinctions relating to the provision of mental health benefits) in employer-provided health insurance plans unless the plan otherwise falls within the protections of section 501(c) of the ADA. The ADA is within the regulatory jurisdiction of the EEOC.

<sup>4</sup>Section 9831(a) of the Code, section 732(a) of ERISA, and section 2721(a) of the PHS Act provide an exception that applies under the MHPA provisions as well as under provisions added by HIPAA and the Newborns' and Mothers' Health Protection Act of 1996. The exception applies to any group health plan (and health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

<sup>5</sup>Any reference to a particular paragraph in this preamble to the interim rules is a reference to the corresponding paragraphs in each of the Departments' interim rules.

complying with the parity requirements of paragraph (b)(1)(i).

Examples illustrate how the rule is applied in the case of a self-funded plan, a fully insured plan, and a partially insured plan. Moreover, in the case of a partially insured plan in which the partially insured portion is pooled for rating purposes, the costs of the pool should be allocated proportionally among the pool members by reasonable methods, including proportional enrollment. Additional provisions in paragraph (f) describe the baseline for determining those costs that are attributable solely to compliance with the parity requirements, the base period used to calculate whether a plan may claim the exemption, and how long the exemption applies once it is claimed. The base period must begin on the first day in any plan year that the plan

complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

Before a group health plan may claim the one-percent increased cost exemption, it must furnish participants and beneficiaries with a notice of the plan's exemption from the parity requirements that includes the information described in paragraph (f)(3)(i). A plan may satisfy this requirement by providing participants and beneficiaries with a summary of material reductions in covered services or benefits, under 29 CFR 2520.104b-3(d), if it includes all the information required by paragraph (f)(3)(i). However,

this exemption under MHPA is not effective until at least 30 days after the notice is sent to the participants and beneficiaries and the appropriate federal agency even if the notice is incorporated into a summary of material reductions in covered services or benefits.

A group health plan that is not subject to Part 7 of Subtitle B of Title I of ERISA, and a plan subject to Part 7 of Subtitle B of Title I of ERISA that chooses not to incorporate the information in paragraph (f)(3)(i) into a summary of material reductions in covered services or benefits (which must be furnished to participants and beneficiaries and the appropriate federal agency), may use the following model to satisfy the notice requirement under paragraph (f)(3) of the interim rules:

BILLING CODE 4830-01-P; 4510-29-P; 4120-01-P

NOTICE OF GROUP HEALTH PLAN'S EXEMPTION FROM THE MENTAL HEALTH PARITY ACT

**\* DESCRIPTION OF THE ONE PERCENT INCREASED COST EXEMPTION —** This notice is required to be provided to you under the requirements of the Mental Health Parity Act of 1996 (MHPA) because the group health plan identified in Line 1 below is claiming the one percent increased cost exemption from the requirements of MHPA. Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements.

This notice is to inform you that the group health plan identified in Line 1 below is claiming the exemption from the requirements of MHPA. The exemption is effective as of the date identified in Line 4 below. Since benefits under your group health plan may change as of the date identified in Line 4 it is important that you contact your plan administrator or the plan representative identified in Line 5 below to see how your benefits may be affected as a result of your group health plan's election of this exemption from the requirements of MHPA.

Upon submission of this notice by you (or your representative) to the plan administrator or the person identified in Line 5 below, the plan will provide you or your representative, free of charge, a summary of the information upon which the plan's exemption is based.

1. Name of the group health plan and the plan number (PN): \_\_\_\_\_
  
2. Name, address, and telephone number of plan administrator responsible for providing this notice:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. For single-employer plans, the name, address, telephone number, (if different from Line 2) and employer identification number (EIN) of the employer sponsoring the group health plan:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
4. Effective date of the exemption (at least 30 days after the notices are sent): \_\_\_\_\_
  
5. For further information, call: \_\_\_\_\_

To claim the one-percent increased cost exemption, a group health plan that is a church plan (as defined in section 414(e) of the Code) also must furnish to the Department of the Treasury a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health plan subject to Part 7 of Subtitle B of Title I of ERISA also must furnish to the Department of Labor a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). To claim the one percent increased cost exemption, a group health plan that is a nonfederal governmental plan also must furnish to the Department of Health and Human Services a copy of the notice sent to participants and beneficiaries that satisfies the requirements of paragraph (f)(3)(i). In all cases, the exemption is not effective until 30 days after notice has been sent both to participants and beneficiaries and to the appropriate federal agency. Any notice submitted to the Department of Labor or Health and Human Services will be available for public inspection.

The Secretaries have designated the following addresses for delivery of these notices:

For notices to the Department of the Treasury, church plans should mail the notice to: Office of the Assistant Commissioner, Examination, Examination Programs CP:EX:E, 1111 Constitution Avenue, NW., Washington, DC 20224; Attention: MHPA one-percent cost exemption notice.

For notices to the Department of Labor, plans should mail the notice to: Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW., Washington, DC 20210; Attention: MHPA one-percent cost exemption notice.

For notices to the Department of Health and Human Services, plans should mail the notice to: Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: Insurance Standards: Exemptions.

Finally, to claim the one percent increased cost exemption, a plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information

described in paragraph (f)(4). An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) is considered to be a representative. For this purpose, individually identifiable information in the notice may be redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the administrative expenses attributable to complying with the parity requirements. In no event should a summary of information include individually identifiable information.

Civil money penalties as described in regulations at 45 CFR 146.184(d) apply to an issuer or nonfederal governmental plan that fails to satisfy the requirements of paragraph (f).

### *3. MHPA's Effective Date and Sunset Provision*

The MHPA provisions are generally effective for group health plans (and health insurance issuers offering health insurance coverage in connection with a group health plan) for plan years beginning on or after January 1, 1998. MHPA includes a sunset provision under which the MHPA requirements do not apply to benefits for services furnished on or after September 30, 2001.

However, for requirements of this section other than the one-percent increased cost exemption, the interim rules provide a limitation on enforcement actions in paragraph (h)(2). Under that paragraph, no enforcement action can be taken by any of the Secretaries against a group health plan (or issuer) that has sought to comply in good faith with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act with respect to a violation that occurs before the earlier of the first day of the first plan year beginning on or after April 1, 1998, or January 1, 1999. Compliance with the requirements of the interim rules is deemed to be good faith compliance with the requirements of section 9812 of the Code, section 712 of ERISA, and section 2705 of the PHS Act.

With respect to the increased cost exemption, the interim rules provide in paragraph (h)(3) a transition period for compliance with the requirements of

paragraph (f). Under paragraph (h)(3), no enforcement action will be taken against a group health plan (or issuer) that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan has claimed the increased cost exemption under section 9812(c)(2) of the Code, section 712(c)(2) of ERISA, or section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of the interim rules, provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii).

A group health plan satisfies this transition period notice requirement only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination under section 104(b)(2) of ERISA and the regulations thereunder (§ 2520.104b-1(b)(3)). The notice must indicate the plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. In all cases, the notice must include the date; the name of the plan and the plan number; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number (in the case of single-employer plans only); the individual to contact for further information; the signature of the plan administrator; and the date signed. In addition, the notice must be provided at no charge to participants and beneficiaries (or their representatives) within 15 days after receipt of a written or oral request for such notification, but in no event does the notice have to be provided before it has been sent to the applicable federal agency. For this purpose, plans may use the following model:

BILLING CODE 4830-01-P; 4510-29-P; 4210-01-P

NOTICE OF GROUP HEALTH PLAN'S USE OF TRANSITION PERIOD

**\* IMPORTANT — This notice is required to be provided if a group health plan uses the transition period under the requirements of the Mental Health Parity Act (MHPA). Under MHPA, a group health plan offering both medical/surgical and mental health benefits generally can no longer set annual or aggregate lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits. In addition, a plan that does not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits generally may not impose such a limit on mental health benefits. However, a group health plan can claim an exemption from these requirements if the plan's costs increase one percent or more due to the application of MHPA's requirements. Under MHPA, a plan that claims the one percent increased cost exemption prior to the issuance of the MHPA interim regulations based on assumptions inconsistent with the MHPA interim regulations may delay compliance with the parity requirements of MHPA until a date no later than March 31, 1998.**

**This notice is to inform you that the plan is utilizing the MHPA transition period and that the plan is delaying compliance with the parity requirements of MHPA until a time no later than March 31, 1998.**

1. Name of the group health plan and the plan number (PN): \_\_\_\_\_

2. Name, address, and telephone number of plan administrator responsible for providing this notice:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. For single-employer plans, the name, address, telephone number, (if different from Line 2), and employer identification number (EIN) of the employer sponsoring the group health plan:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. For further information, call: \_\_\_\_\_

5. Signature of plan administrator: \_\_\_\_\_ Date: \_\_\_\_\_



The Secretaries have designated the following addresses for delivery of the notices: For notices to the Department of the Treasury, plans should mail the notice to: Office of the Assistant Commissioner, Examination, Examination Programs CP:EX:E, 1111 Constitution Avenue, NW., Washington, DC 20224; Attention: MHPA transition period notice.

For notices to the Department of Labor, plans should mail the notice to: Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5638, 200 Constitution Avenue, NW., Washington, DC 20210; Attention: MHPA transition period notice.

For notices to the Department of Health and Human Services, plans should mail the notice to: Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244-1850; Attention: Insurance Standards: Exemptions.

### C. Interim Rules and Request for Comments

Section 9833 of the Code (formerly section 9806), section 734 of ERISA (formerly section 707), and section 2792 of the PHS Act provide, in part, that the Secretaries of the Treasury, Labor, and Health and Human Services may promulgate any interim final rules as they determine are appropriate to carry out the provisions of Chapter 100 of Subtitle K of the Code, Part 7 of Subtitle B of Title I of ERISA, and Part A of Title XXVII of the PHS Act, including the MHPA provisions.

Under Section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest.

These rules are being adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may not know what steps to take to comply with the MHPA requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover, MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1,

1998. Plan administrators and sponsors, issuers, and participants and beneficiaries, will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997 (62 FR 34604). For the foregoing reasons, the Departments find that the publication of a proposed regulation, for the purpose of notice and public comment thereon, would be impracticable, unnecessary, and contrary to the public interest.

### D. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) requires an agency to publish a regulatory flexibility analysis describing the impact of a proposed rule which the agency determines would have a significant impact on a substantial number of small entities. The RFA requires that the agency present an initial regulatory flexibility analysis and seek public comment on its analysis when the agency publishes a general notice of proposed rulemaking (NPRM) under section 553 of the Administrative Procedures Act (5 U.S.C. 553 *et seq.*) (APA). Under the RFA, small entities include small businesses, non-profit organizations and governmental agencies. For our purposes, under the RFA, States and individuals are not considered small entities. However, small employers and small group health plans are considered small entities.

Since these rules are issued as interim final rules, and not as an NPRM, a formal regulatory flexibility analysis has not been prepared. Nonetheless, in the discussion below on the rule's impact on the regulated community, the Departments present an analysis addressing many of the same issues otherwise required by the RFA, including the likely impact of the interim rule on small entities, and a discussion of regulatory alternatives considered in crafting the rule. The Departments invite interested persons to submit comments for consideration in the development of the final rules implementing the MHPA. Consistent with the RFA, the Departments encourage the public to submit comments that accomplish the stated purpose of the MHPA and minimize the impact on small entities. Specifically, we welcome comments addressing the impact of the MHPA's 1 percent cost exemption for plans and issuers that can demonstrate that implementation of the parity rules would raise their

expenditures by more than one percent. We also welcome comments addressing the operation of the MHPA provision requiring that plans using differential aggregate lifetime or annual limits for various categories of benefits use a weighted average of such differential limits to calculate the overall aggregate lifetime and annual limits for the plan.

### E. Executive Order 12866— Departments of Labor and Health and Human Services

The Office of Management and Budget has determined this rule to be a major rule, as well as an economically significant regulatory action under Section 3(f) of Executive Order 12866. The following analysis fulfills the requirement under the Executive Order to assess the economic impact of major and economically significant regulatory actions.

Executive Order 12866 requires agencies to assess the costs and benefits of available regulatory alternatives, and when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Section 3(f) of the Executive Order 12866 requires agencies to prepare a regulatory impact analysis for any rule which is deemed a "significant regulatory action" according to specified criteria, including whether the rule may have an annual effect on the economy of \$100 million or more or certain other specified effects; or whether the rules raise novel legal or policy issues arising out of the President's priorities.

This analysis was conducted by the Departments of Labor and Health and Human Services. It discusses the economic impact of the MHPA, which this rule implements, with special emphasis on the one percent cost exemption. It quantifies the number of plans and individuals who might be affected by the exemption rule, illustrating the exemption's effect in the context of other statutory MHPA provisions. It separately considers the impact of regulatory discretion exercised by the Departments in connection with this rule.

#### a. Overall Impact of the MHPA

In general, the MHPA may have both direct and indirect effects on group health plans, plan sponsors, and plan participants. Direct effects may include broader coverage of mental health treatments and associated increases in mental health benefit payments. Indirect effects may include the steps employers who sponsor plans may take to reduce

or offset their expenditures attributable to compliance with the MHPA, such as amending, curtailing or dropping mental health benefits or other components of compensation, as well as participants' responses to any expenditure increases that are passed to them.

#### Direct Effects

The most direct effect of the MHPA is broader health insurance coverage for mental health treatment. In many health plans, mental health coverage is more restrictive than medical/surgical coverage due to lower annual and/or lifetime dollar limits, more restrictive limits on visits and stays, and other plan provisions. For example, a recent survey of employee benefit plans by Hay/Huggins illustrates the differences in plan terms and lower dollar limits of mental health services and medical/surgical services. The survey reported that indemnity plans typically impose a lifetime limit of \$50,000 for mental health benefits. On the other hand, medical/surgical benefits of a typical indemnity plan provide a lifetime limit of \$1,000,000.

Requiring fuller coverage of mental health treatment will increase mental health benefit payments and associated plan expenditures. Some of this increase will be paid by plan sponsors, and some will be paid by participants in the form of increased premiums and/or reductions in other compensation. Aside from any increased administrative costs involved, these plan expenditure increases generally represent one side of transfer payments rather than erosion in overall social welfare. In other words, additional plan expenditures arising from the MHPA are balanced by additional benefits paid for mental health services. One result will be that some money that would have been spent on other goods or services will be spent instead on mental health services.

The direct effects of the MHPA will in turn cause other effects due to subsequent responses by affected employers (in their capacity as plan sponsors) and participants.

#### Indirect Effects of the MHPA

There are numerous ways in which plan sponsors affected by the MHPA might react. Some might take no action other than to remove or increase dollar limits on mental health benefits. Others might make other changes to their mental health benefits in order to reduce or offset expenditure increases from compliance with MHPA. The statute explicitly preserves plan sponsors' right to provide no mental health benefits, or to set the "terms and

conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits," except with respect to annual or lifetime dollar limits. Some plan design options would be associated with lower plan expenditure increases from compliance with the MHPA. The statute also provides an "increased cost exemption" under which the statute "shall not apply" if its application "results in an increase in the cost . . . of at least 1 percent" (ERISA Section 712(c)(2)). Plan sponsors' responses to the MHPA may lessen their expenditures associated with compliance; that is, their responses may reduce the amount of transfers arising from the MHPA.

For example, many mental health plans currently have non-dollar limits. According to the U.S. Bureau of Labor Statistics, among full-time participants at private establishments with 100 or more employees in 1993, 55 percent were subject to separate day limits for inpatient mental health treatment, and 43 percent were subject to separate visit limits for outpatient mental health treatment (U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments, 1993*). Plans that impose non-dollar limits on mental health benefits may face smaller expenditure increases from the MHPA.

Many plans currently subject mental health benefits to separate cost sharing provisions. Among full-time participants in medium and large private establishments in 1993, 15 percent were subject to separate coinsurance rates and 4 percent were subject to separate copayment rates for inpatient mental health care, while 53 percent and 18 percent were respectively subject to separate coinsurance and copayment rates for outpatient mental health care. Cost sharing generally affects plan expenditures in two ways. First, by shifting some payments for services to participants, cost sharing directly reduces the expenditures borne by plans. Second, by increasing the price of services faced by participants, cost sharing reduces the quantity of services that participants demand. Because of both of these mechanisms, plans that have more cost sharing for mental health benefits will not be impacted as much by the MHPA as plans that have parity in cost sharing.

Many plans use HMO-style management techniques to control mental health benefit expenditures. Plans that have HMO-style mental health "carve-outs" but no mental

health limits are likely to pay less for mental health benefits than fee-for-service plans with low dollar limits that are impermissible under the MHPA. For example, a FFS plan with utilization review and an annual mental health limit of \$10,000 averages \$6.51 per member per month, while an unlimited "carve out" plan pays \$6.12, according to a Price Waterhouse LLP actuarial model developed for the Departments based on the same data as above.

There are a number of reasons why the permissible plan designs outlined here should have little negative effect on existing mental health coverage. First, the modest expenditure increases necessitated by the MHPA would be unlikely to prompt many major design changes. As noted below, approximately 10 percent of affected plans will face increased expenditures under the MHPA of at least one percent, according to the Price Waterhouse, LLP analysis conducted for the Departments. Only 4 percent of affected plans are expected to be faced with increases from the MHPA of 1.5 percent or more, according to the same analysis. Second, the largest expenditure increases and therefore the most aggressive responses will be associated with plans that have the tightest dollar caps today—that is, with plans that would have provided the most restrictive coverage anyway.

Other effects resulting from the MHPA may include plan sponsors dropping mental health coverage altogether, or dropping or curtailing other health benefits or components of compensation. Such curtailments could include shifting some of the cost of benefits to employees, for example in the form of increased participant premium contributions for health benefits. Participants, in turn, might respond to premium increases by dropping their health benefits or electing less expensive plans. As with plan sponsor amendments to mental health benefits, such responses by plan sponsors and participants are expected to be modest and/or rare, given the generally small direct effects of the MHPA on plan expenditures.

#### b. Review of Quantitative Estimates

The Congressional Budget Office (CBO) estimated that the MHPA's direct effect would be to increase health plan expenditures by 0.4 percent on aggregate. (See Congressional Budget Office, "CBO's Estimates of the Mental Health Parity Amendments to the VA/ HUD Appropriation Bill, as Passed in the Senate," September 10, 1996.) This assumes that plan sponsors make no changes to their plans other than to raise or eliminate dollar limits on mental

health benefits consistent with the MHPA's parity requirements. However, some plan sponsors may make other changes to their plans in order to reduce or offset the impact of the MHPA on their expenditures. For example, some plan sponsors might amend, curtail, or drop mental health benefits or health benefits in general. Taking into account the likely incidence of such plan sponsor responses to the MHPA, CBO estimated that the true aggregate increase in health plan expenditures attributable to the MHPA would only be 0.16 percent.

Combining these figures with those from an earlier CBO analysis, the Departments calculate that, in dollar terms, the total annual direct impact of the MHPA would be to increase aggregate health plan expenditures by \$1.16 billion, not accounting for plan sponsor responses to reduce that impact. Accounting for those responses, the actual increase in annual aggregate health plan expenditures would be \$464 million. It should be noted that these figures do not account for the MHPA's increased cost exemption, its exemption of firms with 50 or fewer employees, the incidence of managed care plans whose added cost under the MHPA would be smaller than those of managed fee for service plans, or for plans that are separately subject to state requirements equal or greater than the MHPA's. The Departments' estimates, reported below, incorporate these adjustments.

CBO also reports the Joint Committee on Taxation's estimate that the MHPA will reduce federal revenues by \$560 million over six years. CBO explains that most of the 0.16 percent increase in plan expenditures would be shifted back to employees as lower pay, thus eroding the income and payroll tax bases. On an annual basis, the MHPA would increase expenditures for federal annuitants' health benefits by \$30 million, CBO reports. Finally, the MHPA's impact on nonfederal governmental entities would amount to \$50 million, while its impact on the private sector would probably exceed \$100 million, according to CBO.

The CBO estimates were based on a typical fee-for-service indemnity plan with customary management techniques to control expenditures, and not on plans with other types of delivery systems, such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or Point-of-Service (POS) plans. In fact, plans using different delivery systems will face different expenditure increases under the MHPA. For example, HMOs, which typically contract with health care providers at discounted rates and

tightly manage utilization, will face smaller increases under the MHPA.

Coopers & Lybrand (C&L) also estimated the impact of the MHPA (Ronald E. Bachman, "An Actuarial Analysis of S. 2031, The Mental Health Parity Act of 1996," prepared for the American Psychological Association. Coopers & Lybrand LLP, September 1996). C&L estimated that the MHPA would increase plan expenditures by 0.12 percent per plan on average before taking into account any responses by plan sponsors. Taking plans sponsors' responses into account and using the same response assumption as CBO, C&L estimated that plan expenditures would increase by less than 0.05 percent. In dollar terms, these increases would amount to \$348 million and \$139 million respectively.

Unlike CBO, C&L considered four different delivery systems: fee-for-service with standard utilization review on typical medical services, fee-for-service with specialized mental health utilization review, PPO and POS plans with specialized mental health utilization review, and HMO and carve-out mental health plans. Under each delivery system, C&L also considered a variety of annual dollar limits ranging from \$10,000 to unlimited amounts, rather than assuming that all plans in the delivery system provided the same level of benefits.

The Departments performed additional quantitative analysis, generally analogous to CBO's, in the course of assessing the impact of the regulatory discretion reflected in this rule. The additional analysis suggests that the direct impact of the MHPA, not accounting for plan sponsors' responses, would be to increase annual aggregate health plan expenditures by 0.29 percent or \$653 million. Under CBO's assumption regarding plan sponsor responses to reduce the added expenditure, actual added expenditures would amount to \$261 million. The Departments did not attempt to independently quantify such responses. However, the Departments estimate that if all plans eligible for the one percent cost exemption exercise it, the increase in plan expenditures would be reduced from 0.29 percent to 0.14 percent or \$310 million. The Departments' analysis is detailed below.

#### *c. Exercise of Regulatory Discretion*

##### **One Percent Cost Exemption**

The main area in which the agencies exercised regulatory discretion is in connection with the one percent cost increase exemption. Alternative regulatory interpretations can impact

the outcome of the number of plans, firms, policyholders, and covered lives that would be exempted from the MHPA.

The Departments considered options concerning the interpretation of the one-percent cost exemption and how it should be implemented. In general, they considered (1) whether the eligibility for the exemption should be determined retrospectively or prospectively, and what, if any, rules should be established with respect to how eligibility should be determined, (2) whether eligibility should be contingent on affirmative approval from an enforcement agency or simply subject to possible review by such an agency, and (3) whether plan sponsors electing exemptions should be required to notify participants and/or enforcement agencies of this action and/or to disclose to these parties evidence documenting eligibility for the exemption. They also considered the administrability of each option, seeking to balance the costs and benefits to plans and participants, as well as the benefits and burdens of the regulatory scheme on the federal government.

##### **Retro/prospective Determination**

The options considered ranged from a purely retrospective interpretation to a purely prospective one, and included intermediate interpretations that blend these two approaches.

Under a purely retrospective interpretation, the one percent increased cost exemption would be based on actually incurred expenditures increases, measured retrospectively after implementation of the statute. In other words, all plans must comply and provide parity of annual and/or lifetime dollar limits of mental health and medical services for the first year beginning with the start of a plan year on or after January 1, 1998. If during the first year, a plan experiences increases in expenditures equal to one percent or more as a result of complying with the statute, that plan would then be eligible to exercise an exemption from the MHPA for subsequent plan years.

The calculation for determining the percent increase would be based on the ratio of the increase in plan expenditures to the total plan expenditures, that is, both medical and mental health expenditures. For self-insured plans, the numerator would be the actual value of mental health claims paid in excess of the previous plan limits. For example, if the annual mental health limit were \$10,000 and the medical/surgical were \$1,000,000, then the sum of all mental health claims paid in excess of \$10,000 would be included in the numerator of the ratio

used for that plan in calculations related to the one percent exemption. The denominator for self-insured plans would be the total value of medical and mental health claims excluding mental health claims in excess of \$10,000. If the result is an increase of one or more percent, the plan would be exempt from complying with the statute in any other year until the statute sunsets in 2001. Because there is a lag between the time that claims are incurred and the time they are reported, complete data needed for the calculation might not be available until three or six months after the end of the first plan year under the MHPA. With respect to fully insured plans, the calculation would be slightly different. To the extent that different plans' experiences are pooled for purposes of setting premiums, their eligibility for the exemption would depend on their pooled experience under MHPA, rather than on each plan's individual experience.

The purely retrospective interpretation would minimize the availability of the exemption, and therefore might result in both the greatest incidence of parity in lifetime and annual dollar limits and the greatest incidence of other plan actions to reduce or offset the increase in expenditures arising from the MHPA. It would also assure that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience.

Under a purely prospective interpretation, a plan would be eligible for the exemption prospectively if its expected additional expenditures from the MHPA act equaled or exceeded one percent of its expected total expenditures absent the MHPA. A self-insured plan would project these figures, relying on available data and actuarial projection methods. A fully insured plan would compare legitimate premium quotes with and without the exemption to determine if the difference equals or exceeds one percent. The purely prospective interpretation would maximize the availability of the exemption, and therefore might result in both the least incidence of parity in lifetime and annual dollar limits and the least incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA.

Other interpretations were also considered, some closer to a purely retrospective interpretation and others closer to a purely prospective one. For example, one interpretation might allow plans to prospectively determine their eligibility and exercise the exemption,

but only based upon a narrowly constrained analysis of their own prior experience, taking into account only the potential added expenditure from the MHPA associated with participants whose past mental health claims reached or nearly reached MHPA-prohibited dollar limits. Interpretations closer to the purely retrospective view would lessen the availability of the exemption, and therefore might result in both greater incidence of parity in lifetime and annual dollar limits and lesser incidence of other plan actions to reduce or offset expenditure increases arising from the MHPA; those closer to the purely prospective view would do the opposite.

The approach adopted under this rule, referenced above, can be characterized as modified retrospective approach, based on a relatively brief base period. It is intended to assure the accurate measurement of increased costs while minimizing the burden on plan sponsors who wish to exercise the exemption as soon as accurate measurements can be made. It also assures that all plan elections to exercise the one percent increased cost exemption are based on actual experience under the MHPA's parity requirements and not on projections or estimates of such experience. The rule eases compliance burdens by providing a transition period under which certain plans whose plan years begin during the first quarter of 1998 can exercise the exemption until April 1, 1998.

#### Exemption Authority

This rule provides that plans may determine their own eligibility for the exemption and, if eligible, exercise the exemption, without affirmative approval from any enforcement agency.

#### Notification and Disclosure

The Departments also exercised discretion in requiring notice and disclosure in connection with the one percent increased cost exemption. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the workplace. It further requires plans otherwise exercising the exemption to notify participants and the federal government, and to disclose on request to these parties summary documentation of the plans' eligibility for the exemption.

Notifications and disclosures will be of benefit to participants. They will help assure plans' compliance with the MHPA, and will promote participants'

understanding of their and their plans' status under the MHPA. Moreover, by promoting participants' understanding, notifications and disclosures will inform participants' choices among plans and their feedback to plan sponsors, thereby fostering more vigorous competition among plan sponsors and issuers to provide benefits attractive to participants at competitive prices. The cost of these notifications and disclosures is outlined below.

#### Weighted Average Limits

The Departments also exercised discretion in developing rules that specify when plans may impose separate dollar limits on mental health benefits equal to the weighted average of limits imposed on other benefit categories, and in how this weighted average may be calculated. In general, the rules provide that such mental health limits may be imposed if the benefit categories to which separate limits apply account for at least one-third of total plan expenditures and are comparable in scope to mental health benefits. The average is calculated by weighting each applicable limit to reflect its share of total plan expenditures. Any unlimited categories are figured into the average by using in place of a limit a reasonable estimate of the maximum plan expenditure that could possibly be incurred in connection with all such categories, and weighting this estimate to reflect the proportion of total plan expenditures attributable to all such categories.

Alternative rules might have permitted more, fewer, or different plans to impose such limits on mental health benefits, and/or resulted in calculated averages that were higher or lower. For example, if unlimited categories were treated as having infinite limits, then the weighted average of category limits would equal infinity and the option of imposing a weighted average limit on mental health benefits effectively would be foreclosed. In contrast, if limits applicable to benefit categories narrower in scope than mental health benefits could be averaged to arrive at the permissible mental health limit, plans might be able to impose very low limits on very narrow benefit categories, with little effect on coverage of these categories but with the result of a lower permissible mental health benefit limit.

#### d. Impact of Regulatory Discretion

Because the Departments exercised regulatory discretion in connection with the one percent cost exemption, it is necessary to quantify the number of plans eligible for the exemption. This

requires both estimates of the affected universe and estimates of the distribution of impacts within that universe. CBO reported universe estimates but did not estimate the distribution of impacts. C&L provided a distribution but not universe estimates. Thus, neither source provides the necessary basis for estimating the reach of the one percent cost exemption. To address this gap, the Departments, assisted by Price Waterhouse LLP, combined the CBO and C&L analyses with other data to produce relevant national estimates, as follows.

First, the Departments estimated the relevant universe at 3.0 million plans sponsored by 2.8 million employers covering 145 million individuals. To derive these estimates, we tallied the number of group health plan policyholders and dependents by firm size from the Census Bureau's March 1996 Current Population Survey. Census enterprise data provided average firm sizes in each size category, allowing us to estimate the number of employers covering these individuals. KPMG Peat Marwick's 1997 survey provided the average number of plans per firm in each size group, supporting estimates of the number of plans. Data from the Bureau of Labor Statistics' Employee Benefits Survey and the Health and Retirement Study provided a proportionate breakdown of plans and individuals in each firm size group across plan types (HMO, PPO, and fee for service). Likewise, data from KPMG and Foster Higgins surveys were used to divide insured from self-insured plans.

Second, the Departments narrowed the focus to plans affected by the MHPA. Approximately 296,000 plans, sponsored by 136,000 employers and covering 113 million individuals, would be directly affected by the MHPA. This excludes firms with fewer than 50 employees (which are exempt under ERISA Section 712 (c)(1)), plans already covered by state mandates to provide parity in annual and lifetime dollar limits (based on C&L and Hay Huggins reports of the incidence of differential limits—roughly 29,000 plans were excluded here), and insured plans in 13 states that, independent of the MHPA, as of January 1, 1998 will require parity equivalent to or surpassing that required by the MHPA. (Those 13 states are: Indiana, Maryland, Minnesota, Montana, Arkansas, Colorado, Connecticut, Maine, Missouri, New Hampshire, North Carolina, Rhode Island, and Texas.) Some of the plans identified here as affected may not be affected. The MHPA permits self-insured nonfederal governmental plans to opt out of compliance. This includes

roughly 22,000 plans covering about 18 million individuals. It also exempts plans whose costs increase by one percent or more, as enumerated below.

Third, the Departments estimated the overall impact of the MHPA as follows: affected plans' potential increases in mental health expenditures under the MHPA equal \$653 million, or 0.29 percent of affected plans' \$226 billion in total expenditures. (The 0.29 percent figure is benchmarked to CBO's estimate that the average cost increase for indemnity plans would be 0.4 percent, but it is adjusted to reflect C&L's assessment of the relative magnitude of cost increases for different plan types. The \$226 billion figure is benchmarked to CBO's \$290 billion universe, but reduced proportionately to reflect the Department's estimate of the proportion of the total universe that is affected by the MHPA.) Under CBO's assumption regarding plan sponsor actions to reduce the added expenditure, actual added expenditures would amount to \$261 million. Expenditures could be smaller still as a result of self-insured nonfederal governmental plans' right to opt out of compliance and the MHPA's one percent increased cost exemption, which are not accounted for in the foregoing estimates. Recall also that these expenditures represent transfer payments and not social costs.

#### One Percent Cost Exemption

The effect of this rule will be to prohibit all covered plans from imposing annual or lifetime dollar limits on mental health benefits that are lower than limits imposed on medical and surgical benefits during at least seven months of the first plan year beginning on or after January 1, 1998. Specifically, after six months, the rule permits plans to exercise an exemption as soon as they document a cost increase of one percent or more and provide 30 days notice to participants and the federal government.

Exactly when a given plan will become eligible to elect the one percent increased cost exemption will depend on the timing of its increased costs and its documentation of those costs. In many cases, plans' increased costs under the MHPA will not equal or exceed one percent until more than the initial six months have elapsed. For example, added costs from the MHPA's provision restricting the use of annual dollar limits on mental health benefits would likely be concentrated late in the plans year, when some participants would otherwise have reached these limits. In addition, plans that utilize this rule's transition period may not be affected by the MHPA's provisions until

after the first three months of the plan year have elapsed. Therefore, these may be less likely to incur added costs of one percent or more until later in the plan year, or until a subsequent plan year (in which they would be affected by the MHPA beginning on the first day of the plan year).

Whether eligible plans wishing to reduce the direct impact of the MHPA will opt to pursue the exemption or opt for alternative responses will depend on each plan's particular circumstances and priorities.

The Departments estimated the number of affected plans with potential increases of at least one percent. Roughly 30,000 plans, or about 10 percent of a plans affected by MHPA, potentially would be eligible for the one-percent increased cost exemption. That is, all else being equal, complying with the MHPA would increase 30,000 plans' expenditures by at least one percent. These plans cover about 5 million policyholders and 11 million individuals. This is the universe potentially affected by the provisions of this rule that address the one percent increased cost exemption.

In assessing the impact of this rule, the Departments considered the economic consequences of its provisions implementing the one percent cost exemption. Several factors are likely to affect the magnitude of those consequences.

First, under any interpretation, only 10 percent of MHPA-affected plans (or 30,000 plans) could become eligible for the exemption, and only some of those would elect to exercise it. The estimated 30,000 plans that would become eligible for the one-percent cost exemption represents the upper limit of the number of plans that would actually exercise the exemption. Many of the potentially eligible plans are likely to forego the exemption in favor of other permitted actions. A survey of 300 large firms conducted by William M. Mercer, Inc., found that fewer than 2 percent intended to pursue the one percent increased cost exemption. Extrapolated to the Departments' estimated plan universe, this suggests that 6,000 plans, or 22 percent of the 30,000 that are potentially eligible, would pursue the exemption.

Second, expenditure increases from the MHPA will generally be modest, even for plans potentially eligible for the one percent cost exemption. Their potential expenditure increase would be \$332 million on a base of \$23 billion in total expenditures, or 1.47 percent overall.

Third, as noted above, plans can be designed in ways that lessen these expenditure increases.

Fourth, the 2,215 self-insured nonfederal governmental plans that might become eligible for the one percent cost exemption are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect. These plans cover 1.8 million individuals, or 16 percent of individuals in potentially eligible plans.

Fifth, the estimates presented in this analysis are conservative; actual expenditures arising from compliance with the MHPA are likely to be less than reported here. In particular, the estimates may understate the reach and cost-effectiveness of managed mental health programs that will exist during the years that the MHPA is in effect (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" *JAMA*, Nov. 12, 1997—Vol. 278 No. 18).

Sixth, because plan expenditure increases under the MHPA (aside from increases in administrative expenses) are transfers, the availability and use of the exemption does not change aggregate social welfare. However, the availability and use of the exemption does affect the size and incidence of transfers across affected parties.

Finally, this rule preserves the availability of most of this savings under the one percent exemption—certain eligible plans are permitted to exercise the exemption after seven months, thereby operating under the exemption for up to 38 of the 45 months during which the MHPA is in effect.

This rule also requires certain notices and disclosures by plans exercising the one percent increased cost exemption. The Departments undertook to estimate the paperwork burdens associated with these provisions, as well as the burden associated with determining whether a plan is eligible for the exemption. These estimates are summarized below.

The estimates reported immediately below are for all plans affected by the notice and disclosure provisions of this rule. The Paperwork Reduction Act (PRA) analysis that follows is presented separately for affected private-sector plans and for plans sponsored by nonfederal governmental employers, which are under the jurisdictions of the Departments of Labor and of Health and Human Services, respectively.

With respect to the notice to participants and beneficiaries and to the federal government by plans exercising the one percent cost exemption, the maximum possible number of such notices is approximately 5.0 million

(reflecting all plans potentially eligible to elect the exemption), while a more likely figure is 1.1 million (reflecting the Mercer survey cited above). Assuming each notice requires 2 minutes of labor at \$11 per hour, plus \$0.50 for postage and materials, total costs would amount to up to \$4.3 million or more probably \$931,000. (These assumptions reflect plans' ability to satisfy this notice requirement through the provisions of a separately required summary of material modifications, as well as availability of a model notice to the government, which together essentially eliminate separate preparation burdens under this requirement and help minimize ongoing burdens.)

With respect to requirement for group health plans to notify the federal government of use of the transition period, and to post these notices in the workplace, only those plans whose plan years begin during the first three months on 1998 and who are potentially eligible for the one percent cost exemption are potentially affected by this provision.

These notices would be filed and posted within 30 days or less of the beginning of the plan year, so all would be filed in 1998. Based on annual reports filed with the Department of Labor, the Departments estimate that 60 percent of all eligible plans, accounting for 72 percent of participants in such plans, begin their plan years during these months. This amounts to 18,000 plans, representing the maximum number of notices that would be filed. Extrapolating from the Mercer survey cited above, about 4,000 of these plans might intend to pursue the exemption, representing a more probable number of notices to be filed. Applying the same per unit cost assumptions as above to the filing and posting of these notices, the cost of these notices would be no more than \$8,000 and more likely \$2,000. These assumptions reflect the availability of a model notice, the use of which eliminates preparation costs and helps minimize ongoing burdens.

With respect to the requirement for plans to disclose on request summary information documenting the plan's eligibility for the one percent increased cost exemption, the number of such disclosures will depend on the volume of requests. One might expect requests to arise most commonly when participants are at or near plans' dollar limits. Hay Huggins estimates for the Congressional Research Service (See Roland Sturm, "How Expensive is Unlimited Mental Health Care Coverage Under Managed Care?" *JAMA*, Nov. 12, 1997—Vol. 278 No. 18) suggest that 0.73 percent of participants on average incur mental health claims of more than

\$10,000—a typical annual limit—in a given year. The Departments adjusted this figure to reflect the estimated relationship between increased expenditures under the MHPA for plans eligible for the one percent increased cost exemption and increased expenditures under the MHPA for all affected plans, concluding that 3.74 percent of participants in plans eligible for the one percent increased cost exemption incur claims of more than \$10,000 in a given year. Assuming that this proportion of participants in plans electing the exemption request disclosures, the maximum number of such disclosure requests would be 186,000, while a more probable figure would be 40,000. Given the same per unit cost assumptions as above, the associated costs would be \$161,000 and \$35,000, respectively.

Finally, with respect to plan determinations of eligibility for the one percent increased cost exemption, the Departments expect that plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no more than 5,346 and more probably 1,142. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans that wish to exercise the exemption is estimated to be 1,770 (including 400 third party administrators, 650 health insurers, 645 HMOs, and 75 Blue Cross Blue Shield organizations). Assuming a start up cost of \$5,000 per affected entity, the total start-up cost associated with determining plans' eligibility to exercise the exemption amounts to \$14.6 million to \$35.6 million, to be amortized over 10 years beginning in 1998.

The estimates of the numbers and costs of notices, disclosures and calculations reported above, and below in connection with the Paperwork Reduction Act, may be high with respect to nonfederal governmental plans. An estimated 2,215 self-insured nonfederal governmental plans might become eligible for the one percent cost exemption. These plans are separately permitted to opt out of the MHPA entirely, thereby exercising an alternative exemption with equivalent effect, and without becoming subject to the calculation, notice, and disclosure requirements. These plans cover 1.8

million individuals, or 16 percent of individuals in potentially eligible plans.

### Weighted Average

The economic impact of the Departments' exercise of discretion in the weighted average rule is also expected to be modest.

First, separate limits for benefit categories other than mental health are not very common. For example, among full-time employees at establishments with 100 or more employees participating in non-HMO group health plans in 1993, only a fraction were subject to separate limits for many major benefit categories. For example, just 14 percent were subject to separate limits for inpatient surgery, just 13 percent were subject to such limits for outpatient surgery, and only about one in four were subject to separate limits for both inpatient and office physician visits (U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments*, 1993). "Separate limits" in this context include not only dollar limits, but also non-dollar limits, such as inpatient day or outpatient visit limits, as well as differential coinsurance rates, copayments, or deductibles. Therefore, the proportion with separate dollar limits that would permit imposition of a weighted average limit on mental health benefits would be even smaller. In addition, such separate limits are even less common in HMOs.

Second, discretion exercised in the weighted average rule affects plans' ability to impose weighted average limits on mental health benefits only at the margin. In other words, compared with the approach set forth in the rule, alternative approaches would have increased or decreased the proportion of plans that are able to impose weighted average limits and the dollar level of calculated averages by only a small amount.

Third, not all plans that are permitted to impose weighted average limits on mental health benefits will elect to do so.

Fourth, some plans that under the rule are not permitted to impose weighted average limits on mental health benefits, under an alternative approach, might have been permitted to impose only a relatively high limit. As such, their expenditure increases from the MHPA might have been nearly the same with a weighted average limit on mental health benefits as with no separate limit on such benefits.

Consider a plan with a \$500,000 annual cap on all inpatient care and a \$250,000 annual cap on all outpatient care, and a \$25,000 annual cap on mental health

benefits. Under the interim rules, such a plan could not impose a weighted average limit on mental health benefits. Any separate limit on mental health care would have to be at least \$750,000, or at least \$500,000 for inpatient care and at least \$250,000 for outpatient care. Had the plan been permitted to impose a weighted average cap, however, it still would have been required to increase its mental health cap from \$25,000 to some amount between \$250,000 and \$500,000, depending on the weights.

Finally, as with the one percent cost exemption and with the MHPA generally, the impact of regulatory discretion in the weighted average rule will be reduced because self-insured nonfederal governmental plans can opt out, the MHPA's added expenditure is modest, plans can be designed in ways that lessen the MHPA's added expenditure, and the estimates presented here are conservative.

### F. Unfunded Mandates Reform Act of 1995

The Unfunded Mandates Reform Act of 1995 (P.L. 104-4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of \$100 million by state, local and tribal governments or the private sector. These rules are not subject to the Unfunded Mandates Reform Act because they are interim final rules. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regulation has been designed to be the least burdensome alternative for state, local and tribal governments, and the private sector, while achieving the objectives of the MHPA.

### G. Small Business Regulatory Enforcement and Fairness Act of 1995

The Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget has determined that this is a major rule for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. Section 801 *et. seq.*) (SBREFA).

The Secretaries have determined that the effective date of these interim final rules is January 1, 1998. Pursuant to Section 808(2) of SBREFA, the Secretaries find, for good cause, that notice and public procedure thereon are impracticable, unnecessary and contrary to the public interest.

These rules are adopted on an interim final basis because the Secretaries have determined that without prompt guidance some members of the regulated community may have difficulty complying with the MHPA

requirements, which may result in an adverse impact on participants and beneficiaries with regard to their mental health benefits under group health plans and the protections provided under MHPA. Moreover, MHPA's requirements will affect the regulated community in the immediate future.

MHPA's requirements are effective for all group health plans, and for health insurance issuers offering coverage in connection with such plans for plan years beginning on or after January 1, 1998. Plan administrators and sponsors, issuers and participants and beneficiaries will need guidance on the new statutory provisions before MHPA's effective date. As noted earlier, these interim rules take into account comments received by the Departments, in response to the request for public comments on MHPA published in the **Federal Register** on June 26, 1997. 62 FR 34604. For the foregoing reasons, the Departments find that notice and public comment would be impracticable, unnecessary and contrary to the public interest.

### H. Paperwork Reduction Act—The Department of Labor and the Department of the Treasury

The Department of Labor and the Department of the Treasury have submitted this emergency processing public information collection request (ICR), consisting of three distinct ICRs to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35). The Departments have asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

These regulations contain three distinct ICRs. The first ICR is a notice to participants and beneficiaries and to the federal government of the plan's election of the exemption from the MHPA's provisions due to an increase in cost under the plan of at least one percent attributable to compliance with these provisions. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and beneficiaries of the plan's exemption from these parity requirements. Before the one percent increased cost exemption is effective, the plan must also notify the federal government. For this purpose, the group health plan may either send

the Department of Labor a copy of the summary of material reductions in covered services or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan (or coverage) may use the Departments' model notice in this interim final rule which has been developed for this purpose.

The second ICR is a summary of the information used to calculate the plan's increased costs under the MHPA for purposes of electing the one percent increased cost exemption, which the plan must make available to participants and beneficiaries, on request at no charge.

The third ICR is a notice of a group health plan's use of the transition period. The rule requires plans exercising the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions to notify the federal government, and to post a copy of this notice at the workplace.

*1. Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption*

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption. A copy of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the **Federal Register** the control numbers assigned to these ICRs by OMB. The

publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

*Dates:* Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

*Addressee:* Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that participants and beneficiaries, and the federal government, will receive notice of a plan's election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information

are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

**I. Background**

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a plan electing this exemption to notify participants and beneficiaries and the federal government of the plan's election of the exemption. This ICR covers this notification requirement.

**II. Current Actions**

Under 29 CFR 2590.712(f)(3) (i) and (ii), and 26 CFR 54.9812-1T a group health plan electing the one percent exemption is obligated to provide a written notice of that election to participants and beneficiaries and to the federal government of the plan's election of the exemption. A plan may satisfy this requirement by providing



participants and beneficiaries with a notice of material reductions in covered service or benefits, under the Department of Labor's regulations at 29 CFR section 2520.104b-3(d), that includes the information in paragraph (f)(3)(i) of this interim final rule regarding issuing a notice to participants and beneficiaries of the plan's exemption from these parity requirements. To satisfy the requirement to notify the federal government, a group health plan may either send the Department a copy of the summary of material reductions in covered services

or benefits sent to participants and beneficiaries, containing the plan number and the plan sponsor's employer identification number, or the plan may use the Department's model notice in this interim final rule which has been developed for this purpose. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

*Type of Review:* New.

*Agencies:* U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

*Title:* Notice to Participants and Beneficiaries and the Federal Government of Electing One Percent Increased Cost Exemption.

*OMB Number:* XXXXXXXX

*Affected Public:* Individuals or households; Business or other for-profit; Not-for-profit institutions; Group health plans.

*Frequency:* On occasion.

*Burden:*

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998 .....	.....	.....	.....	.....	.....
1999 .....	5,612 to 25,446.	813,505 to 3.8MM.	2 .....	6,324 to 29,605.	\$705,037 to \$3.3MM
2000 .....	.....	.....	.....	.....	.....
Totals .....	5,612 to 25,446.	813,505 to 3.8MM.	2 .....	6,324 to 29,605.	\$705,037 to \$3.3MM

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

**2. Calculation and Disclosure of Documentation of Eligibility for Exemption**

**i. Department of Labor**

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Documentation of Eligibility for Exemption. A copy of the proposed ICR can be obtained by contacting the

employee listed below in the contact section of the notice.

*Information collection:* Affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the **Federal Register** the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

*Dates:* Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and

- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

*Addressee:* Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

**ii. Department of the Treasury**

The collection of information is in Section 54.9812-1T. This information is required by the interim final rules so that participants will be informed about their rights under MHPA, and so that participants and beneficiaries may receive a summary of the information upon which the plan based its election of the one percent increased cost exemption. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be

retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

**I. Background**

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires plans wishing to elect this exemption to calculate their increased costs according to certain rules. It further requires plans electing this exemption to disclose to participants and beneficiaries (or their representatives), on request, and at no charge, a summary of the information upon which the exemption was based. This ICR covers this disclosure requirement.

**II. Current Actions:**

Under 29 CFR 2590.712(f)(2) and 26 CFR 54.9812-1T, a group health plan wishing to elect the one percent exemption must calculate their increased costs according to certain rules. Under 29 CFR 2590.712(f)(4) and 26 CFR 54.9812-1T, a group health plan electing the one percent exemption is obligated to disclose to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based.

*Type of Review:* New.

*Agencies:* U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

*Title:* Calculation and Disclosure of Documentation of Eligibility for Exemption.

*OMB Number:* XXXXXXXX.

*Affected Public:* Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

*Frequency:* On occasion.

*Calculation burden:* It is expected that plans wishing to exercise the one percent increased cost exemption or their service providers will revise their automated claim record systems to facilitate calculation of the plans' increased costs attributable to the MHPA. The number of plans performing such functions in-house that might wish to exercise the exemption is estimated to be no more than 4,489 and probably 958. The number of service providers (including health insurance issuers and third party administrators) that will perform this function for plans using service providers that wish to exercise the exemption is estimated to be 1,770. Assuming a cost of \$5,000 per affected entity, the total cost associated with determining plans' eligibility to exercise the exemption amounts to \$12.5 million to \$30.1 million, to be amortized over 10 years beginning in 1998.

*Disclosure burden:* In addition to the calculation burden, plans wishing to elect the one percent increased cost exemption will incur a burden in connection with disclosure requests from participants, as detailed below.

Year	Total respondents (range)	Total responses (range)	Average time per response (minutes)	Burden hours (range)	Cost (range)
1998 .....	.....	.....	.....	.....	.....
1999 .....	5,612 to 25,466.	30,188 to 140,412.	2 .....	235 to 1,101.	\$26,163 to \$121,690
2000 .....	5,612 to 25,466.	30,188 to 140,412.	2 .....	235 to 1,101.	\$26,163 to \$121,690
Totals .....	5,612 to 25,466.	60,377 to 280,824.	2 .....	470 to 2,201.	\$52,326 to \$243,381

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

**3. Notice of Group Health Plan's Use of Transition Period, and Posting Thereof**

**i. Department of Labor**

The Department of Labor, as part of its continuing effort to reduce paperwork

and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in

the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed collection of information, Notice of Group Health Plan's Use of Transition Period. A copy

of the proposed ICR can be obtained by contacting the employee listed below in the contact section of the notice.

Information collection: affected parties are not required to comply with the ICRs in these rules until the Department of Labor publishes in the **Federal Register** the control numbers assigned to these ICRs by OMB. The publication of the control numbers notifies the public that OMB has approved these ICRs under the Paperwork Reduction Act of 1995. The Department has asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

**Dates:** Written comments must be submitted to the office listed in the addressee section below on or before February 20, 1998. The Department of Labor is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

**Addressee:** Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N-5647, Washington, D.C. 20210. Telephone: 202-219-4782 (this is not a toll-free number). Fax: 202-219-4745.

ii. Department of the Treasury

The collection of information is in Section 54.9812-1T. This information is

required by the interim final rules so that participants will be informed about their rights under MHPA, and so that plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rules' transition provisions will notify the federal government and post the notice in the workplace. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are required to obtain the benefit of the exemption.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received on or before February 20, 1998. In light of the request for OMB clearance by the effective date of the MHPA, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the

application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

**I. Background**

MHPA generally requires that group health plans provide parity in the application of dollar limits to mental health and medical/surgical benefits. The statute exempts plans from this requirement if its application results in an increase in the cost under the plan or coverage of at least one percent. This regulation requires a notice of group health plan's use of transition period, under which plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions must notify the federal government and to post a copy of the notice in the workplace. This ICR covers this notification requirement.

**II. Current Actions**

Under 29 CFR 2590.712(h)(3)(ii) and 26 CFR 54.9812-1T, group health plans electing the one percent increased cost exemption during all or part of the first quarter of 1998 under the rule's transition provisions must notify the federal government. Based on past experience, the staff believes that most of the materials required to be issued under this notice procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

**Type of Review:** New.

**Agencies:** U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

**Title:** Notice of Group Health Plan's Use of Transition Period.

**OMB Number:**

**Affected Public:** Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

**Frequency:** On occasion.

**Burden:**

Year	Total respondents (range)	Total responses (range)	Average time per response (minutes)	Burden hours (range)	Cost (range)
1998 .....	3,348 to 15,193.	3,348 to 15,193.	2 .....	19 to 89 ...	\$1,514 to \$6,910
1999 .....	.....	.....	.....	.....	.....
2000 .....	.....	.....	.....	.....	.....

Year	Total respondents (range)	Total responses (range)	Average time per response (minutes)	Burden hours (range)	Cost (range)
Totals .....	3,348 to 15,193.	3,348 to 15,193.	2 .....	19 to 89 ...	\$1,514 to \$6,910

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of the ICRs; they will also become a matter of public record.

**I. Paperwork Reduction Act—  
Department of Health and Human Services**

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the

information collection requirements discussed below.

Section 146.136 of this document contains three distinct information collection requirements, as summarized below:

*Type of Information Request:* New collection.

*Title of Information Collection:* Mental Health Parity Act of 1996; Information Collection Requirements Contained in 45 CFR 146.136; HCFA-2891-IFC.

*Form Number:* HCFA-R-223 (OMB approval #: 0938-XXXX).

*Use:* The information collection requirements contained in this interim final rule will help ensure that sponsors and administrators of group health plans notify the required individuals/entities of a plan's exemption from the MHPA parity requirements and make the data used to calculate the exemption available to affected individuals and entities.

*Frequency:* On occasion.

*Affected Public:* States, businesses or other for profit, not-for-profit institutions, Federal Government, individuals or households.

*Notification Requirements:* Nonfederal governmental plans, not exempt from the parity requirements by reason of an opt out under regulations at 45 CFR 146.180, must furnish participants and beneficiaries with a notice of the plan's exemption from the

parity requirements based on increased costs. A plan may satisfy this requirement by providing participants and beneficiaries with a notice of material reductions in covered services or benefits, under 29 CFR 2520.104b-3(d), that includes the information in paragraph (f)(3)(i). Even though a plan generally is not required to furnish a material reduction in covered services or benefits for 60 days, in no case will the exemption be effective until 30 days after the notice is sent to participants and beneficiaries. For this purpose, a plan that does not furnish the summary of material reductions in covered services or benefits may satisfy its notice requirements by using the model exemption notice described above in this preamble.

In addition, the nonfederal governmental plan (or issuer providing coverage to such a plan) must also furnish to the Department of Health and Human Services a notice similar to the notice sent to participants and beneficiaries before the exemption is effective. For this purpose, the plan may either send the Department the summary of material reductions in covered services or benefits sent to participants and beneficiaries, or the plan (or issuer) may use the model described above. In all cases, the exemption is not effective until 30 days after notice has been sent.

*Burden:*

Year	Total respondents (range)	Total responses (range)	Average time per response range (minutes)	Burden hours (range)	Cost (range)
1998 .....	.....	.....	.....	.....	.....
1999 .....	890 to 4,092.	261,000 to 1.2 MM.	2 .....	2,133 to 9,975.	\$226,000 to \$1.1 MM
2000 .....	.....	.....	.....	.....	.....
Total .....	890 to 4,092.	261,000 to 1.2 MM.	2 .....	2,133 to 9,975.	\$226,000 to \$1.1 MM

*Availability of documentation:* Nonfederal governmental plans that take the exemption, or issuers that provide coverage for such plans, must make available to participants and beneficiaries, on request and at no

charge, a summary of the data used to calculate the exemption of this section. The summary of data must include the incurred expenditures (including identification of the portion of the total representing claims and the portion of

the total representing administrative expenses), the base period, the claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with parity, and the

administrative expenses attributable to complying with the parity requirements.

*Burden:*

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998 .....	.....	.....	.....	.....	.....
1999 .....	890 to 4,092.	9,700 to 45,300.	2 .....	79 to 372	\$8,400 to \$39,300
2000 .....	890 to 4,092.	9,700 to 45,300.	2 .....	79 to 372	\$8,400 to \$39,300
Total .....	890 to 4,092.	19,400 to 90,600.	2 .....	158 to 744	\$16,800 to \$78,600

Plans that take the exemption will incur start up costs for preparing to issue the information they must disclose. We estimate the start up costs for nonfederal governmental plans that take this exemption to range from \$2.1 million to \$5.5 million.

*Notice of Use of Transition Period:* With respect to the increased cost exemption, the interim rules provide in paragraph (g)(3) a transition period for compliance with the requirements of paragraph (f). Under paragraph (g)(3), no enforcement action shall be taken against a nonfederal governmental plan

that is subject to the MHPA requirements prior to April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f), provided that the plan is amended to comply with the parity requirements no later than March 31, 1998 and the plan complies with certain notice requirements. A nonfederal governmental plan satisfies the notice requirements only if such plan provides notice to the Department of Health and Human Services of the

plan's intent to use the transition period by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event can the notice be provided later than March 31, 1998. Such notice shall include the name of the plan; the name, address, and telephone number of the plan sponsor or plan administrator; the employer identification number; and the plan number. In addition, such notice must be provided at no charge to participants within 30 days after receipt of a written request for such notification.

*Burden:*

Year	Total respondents (range)	Total responses (range)	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1998 .....	531 to 2,441.	531 to 2,441.	2 .....	4 to 17 .....	\$250 to \$1,151
1999 .....	— .....	— .....	— .....	— .....	—
2000 .....	— .....	— .....	— .....	— .....	—
Total .....	531 to 2,441.	531 to 2,441.	2 .....	4 to 17 .....	\$250 to \$1,151

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in § 146.136. These requirements are not effective until they have been approved by OMB.

If you comment on any of these information collection and recordkeeping requirements, please mail copies directly to the following: Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2-26-17, 7500 Security Boulevard, Baltimore, MD 21244-1850. ATTN: John Burke HCFA-2891-IFC.

We have submitted a copy of this rule to OMB for its review of these information collections. A notice will be

published in the **Federal Register** when approval is obtained. Interested persons are invited to send comments regarding this burden or any other aspect of these collections of information. If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following addresses:

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20530, Attn: Allison Herron Eydt, HCFA Desk Officer. DATED:

Gerald B. Lindrew, Deputy Director, Pension and Welfare Benefits Administration, Office of Policy and Research

**Statutory Authority**

The Department of the Treasury temporary rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and the Taxpayer Relief Act of 1997 (Pub. L. 105-34, 111 Stat. 788).

The Department of Labor interim final rule is adopted pursuant to the authority contained in sections 107, 209, 505, 701-703, 711, 712, and 731-734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171-1173, 1181, 1182, and 1191-1194), as amended by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944), and Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

The Department of Health and Human Services interim final rule is adopted pursuant to the authority contained in sections 2701, 2702, 2705, 2711, 2712, 2713, 2721, 2722, 2723, and 2792 of the PHS Act (42 U.S.C. 300gg, 300gg-1, 300gg-5, 300gg-11, 300gg-12, 300gg-13, 300gg-21, 300gg-22, 300gg-23, and 300gg-92), as established by HIPAA (Pub. L. 104-191, 110 Stat. 1936) and MHPA (Pub. L. 104-204, 110 Stat. 2944).

**List of Subjects**

*26 CFR Part 54*

Excise taxes, Health insurance, Pensions, Reporting and recordkeeping requirements.

*29 CFR Part 2590*

Employee benefit plans, Employee Retirement Income Security Act, Health care, Health insurance, Reporting and recordkeeping requirements.

*45 CFR Part 146*

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

**Adoption of Amendments to the Regulations**

*Internal Revenue Service*

26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

**PART 54—PENSION EXCISE TAXES**

**Paragraph 1.** The authority citation for part 54 is amended by revising the entries for sections 54.9801-1T through 54.9801-6T and 54.9802-1T, by removing the entries for sections 54.9804-1T, and 54.9806-1T, and by adding entries for sections 54.9812-1T, 54.9831-1T, and 54.9833-1T to read in part as follows:

- Authority:** 26 U.S.C. 7805 \* \* \*
- Section 54.9801-1T also issued under 26 U.S.C. 9833.
  - Section 54.9801-2T also issued under 26 U.S.C. 9833.
  - Section 54.9801-3T also issued under 26 U.S.C. 9833.
  - Section 54.9801-4T also issued under 26 U.S.C. 9833.
  - Section 54.9801-5T also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.
  - Section 54.9801-6T also issued under 26 U.S.C. 9833.
  - Section 54.9802-1T also issued under 26 U.S.C. 9833.
  - Section 54.9812-1T also issued under 26 U.S.C. 9833.
  - Section 54.9831-1T also issued under 26 U.S.C. 9833.
  - Section 54.9833-1T also issued under 26 U.S.C. 9833.

**Par. 2.** In § 54.9801-1T, paragraph (a) is revised to read as follows:

**§ 54.9801-1T Basis and scope (temporary).**

(a) *Statutory basis.* Sections 54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9812-1T, 54.9831-1T and 54.9833-1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

**Par. 3.** Section 54.9801-2T is amended by:

1. Revising the introductory text.
2. Revising the definition of *excepted benefits*.
3. Revising the definition of *health insurance coverage*.

The revisions read as follows:

**§ 54.9801-2T Definitions (temporary).**

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801-1T through 54.9801-6T, 54.9802-1T, 54.9812-1T, 54.9831-1T, and 54.9833-1T.

*Excepted benefits* means the benefits described as excepted in § 54.9831-1T(b).

*Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in § 54.9831-1T(b)(2) are not treated as benefits consisting of medical care.

**Par. 4.** In § 54.9801-4T, paragraph (a)(2) is revised to read as follows:

**§ 54.9801-4T Rules relating to creditable coverage (temporary).**

- (a) \* \* \*
- (2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 54.9831-1T).

**Par. 5.** In § 54.9801-5T, the first sentence of paragraph (a)(3)(vi) is revised to read as follows:

**§ 54.9801-5T Certification and disclosure of previous coverage (temporary).**

- (a) \* \* \*
- (3) \* \* \*
- (vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted

benefits described in § 54.9831-1T. \* \* \*

**§ 54.9804-1T [Redesignated as § 54.9831-1T]**

**Par. 6.** Section 54.9804-1T is redesignated as § 54.9831-1T and amended by revising paragraph (b)(1) to read as follows:

**§ 54.9831-1T Special rules relating to group health plans (temporary).**

(b) *Excepted benefits—(1) In general.* The requirements of §§ 54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9812-1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

**§ 54.9806-1T [Redesignated as § 54.9833-1T]**

**Par. 7.** Section 54.9806-1T is redesignated as § 54.9833-1T and amended by:

1. Revising paragraph (a)(1).
2. Revising the first sentence of paragraph (a)(2).

The revisions read as follows:

**§ 54.9833-1T Effective dates (temporary).**

(a) *General effective dates—(1) Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K and §§ 54.9801-1T through 54.9806-1T, 54.9802-1T, and 54.9831-1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K and §§ 54.9801-1T through 54.9801-6T, 54.9802-1T, and 54.9831-1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). \* \* \*

**Par. 8.** Section 54.9812-1T is added to read as follows:

**§ 54.9812-1T Parity in the application of certain limits to mental health benefits (temporary).**

(a) *Definitions.* For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

*Aggregate lifetime limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Annual limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Medical/surgical benefits* means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health benefits.

*Mental health benefits* means benefits for mental health services, as defined under the terms of the plan, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1) In general—(i) General parity requirement.* A group health plan that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b) (2), (3), or (6) of this section.

(ii) Exception. The rule in paragraph (b)(1)(i) of this section does not apply if a plan satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

**Example 1.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 2.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 3.** (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 4.** (i) Prior to the effective date of the mental health parity provisions, a group

health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits.

Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to

determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section*—(i) *In general.* A group health plan that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

**Example.** (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/

surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is  $\$640,000 (40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000)$ .

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability*—(1) *Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* See 29 CFR 2590.712(d)(2) and 45 CFR 146.136(d)(2), which provide that health insurance issuers offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan are subject to rules similar to those applicable to group health plans under this section.

(3) *Scope.* This section does not—

(i) Require a group health plan to provide any mental health benefits; or  
(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption*—(1) *In general.* The requirements of this section do not apply to a group health plan for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a

plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 9831(a) and § 54.9831-1T(a), which provide that this section (and certain other sections) does not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption*—(1) *In general.* A group health plan is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase*—(i) *Ratio.* A group health plan satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan results in an increase in the cost under the plan of at least one percent.



The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures.* *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have

participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

**Example 1.** (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 - (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan (\$1,100,000/\$1,050,000 = 1.04762).

**Example 2.** (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

**Example 3.** (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base

period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000.

The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan (\$3,300,000/\$3,273,000 = 1.00825).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the

information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

**Example.** (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies.* A group health plan that is a church plan (as defined in section 414(e)) claiming the exemption of this paragraph (f) for any benefit package must provide notice in accordance with the requirement of this paragraph (f)(3)(ii). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies. For any other group health plan, see 29 CFR 2590.712(f)(3)(ii)(B).

(4) *Availability of documentation.* The plan must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* See 29 CFR 2590.712(g)(1) and 45 CFR 146.136(g)(1) for rules limiting the right of an issuer to sell a policy without parity (as described in 29 CFR 2590.712(b) and 45 CFR 146.136(b)) to a plan that meets the requirements of 29 CFR 2590.712 (e) or (f) and 45 CFR 146.136 (e) or (f).

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 9812, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or

(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 9812.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

**Example 1.** (i) A group health plan has a plan year that is the calendar year. The plan complies with section 9812 in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

**Example 2.** (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 9812 in good faith, and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 9812(c)(2) based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of the Employee Retirement Income Security Act of 1974, and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan (as defined in section 414(e)), the applicable federal agency is the Department of the Treasury. For a group health plan that is not a church plan, see 29 CFR 2590.712(h)(3)(ii). The notice must include—

(I) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset*. This section does not apply to benefits for services furnished on or after September 30, 2001.

Dated: December 16, 1997.

**Michael P. Dolan,**

*Deputy Commissioner of Internal Revenue.*

Approved: December 16, 1997.

**Donald C. Lubick,**

*Acting Assistant Secretary of the Treasury.*

## **Pension and Welfare Benefits Administration**

### *29 CFR Chapter XXV*

29 CFR Part 2590 is amended as follows:

### **PART 2590—RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS**

1. The authority citation for Part 2590 is revised to read as follows:

**Authority:** Secs. 107, 209, 505, 701–703, 711, 712, and 731–734 of ERISA (29 U.S.C. 1027, 1059, 1135, 1171–1173, 1181, 1182, and 1191–1194), as amended by Pub. L. 104–191, 110 Stat. 1936 and Pub. L. 104–204, 110 Stat. 2944; and Secretary of Labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

#### **Subpart B—Other Requirements**

2. Section 2590.712 is revised to read as follows:

#### **§ 2590.712 Parity in the application of certain limits to mental health benefits.**

(a) *Definitions*. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

*Aggregate lifetime limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in

connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Annual limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such a plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Medical/surgical benefits* means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

*Mental health benefits* means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits—(1)—general—(i) General parity requirement*. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), (3), or (6) of this section.

(ii) *Exception*. The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits*. If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits*. If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health

benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples*. The rules of paragraphs (b)(2) and (3) of this section are illustrated by the following examples:

**Example 1.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 2.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 3.** (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 4.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical

annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will

constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or (3) of this section—(i) In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or (3) of this section, must either—

(A) Impose no aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) Impose an aggregate lifetime or annual limit on mental health benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Example.* The rules of this paragraph (b)(6) are illustrated by the following example:

**Example.** (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not

described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is \$640,000 (40% x \$100,000 + 60% x \$1,000,000 = \$640,000).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group

health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See section 732(a) of the Act and § 2590.732(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase—(i) Ratio.* A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section; and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) of this section is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures.* *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to

September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104–204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

**EXAMPLE 1.** (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30, 1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000 – (\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ( $\$1,100,000 / \$1,050,000 = 1.04762$ ).

**EXAMPLE 2.** (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one-percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph

(f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

**EXAMPLE 3.** (i) A partially insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ( $\$3,300,000/\$3,273,000 = 1.00825$ ).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one-percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption;

(2) The name and telephone number of the individual to contact for further information;

(3) The plan name and plan number (PN);

(4) The plan administrator's name, address, and telephone number;

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN);

(6) The effective date of the exemption;

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's claim of the exemption; and

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) of this section by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C) of this section) with a summary of material reductions in covered services or benefits required under § 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

**Example.** (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in

section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Nonfederal governmental plans.* A group health plan that is a nonfederal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements of this section. In no event should the summary of information

include any individually identifiable information.

(g) *Special rules for group health insurance coverage*—(1) *Sale of nonparity policies*. An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraphs (e) or (f) of this section.

(2) *Duration of exemption*. After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates*—(1) *In general*. The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions*. (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 712 of the Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or  
(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 712 of Part 7 of Subtitle B of Title I of ERISA.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

**Example 1.** (i) A group health plan has a plan year that is the calendar year. The plan complies with section 712 of Part 7 of Subtitle B of Title I of ERISA in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

**Example 2.** (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 712 of the Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption*—(i) *In general*. No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost

exemption under section 712(c)(2) of Part 7 of Subtitle B of Title I of ERISA based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period*. (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts such notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset*. This section does not apply to benefits for services furnished on or after September 30, 2001.

Signed at Washington, DC, this 16th day of December, 1997.

**Olena Berg,**

*Assistant Secretary, Pension Welfare Benefits Administration, U.S. Department of Labor.*

## Health Care Financing Administration

### 45 CFR Subtitle A, Subchapter B

45 CFR Part 146 is amended as follows:

## PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

1. The authority citation for Part 146 is revised to read as follows:

**Authority:** Secs. 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92).

2. A new Subpart C is added to Part 146 to read as follows:

### Subpart C—Requirements Related to Benefits

#### § 146.136 Parity in the application of certain limits to mental health benefits.

(a) *Definitions*. For purposes of this section, except where the context clearly indicates otherwise, the following definitions apply:

*Aggregate lifetime limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Annual limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a plan (or group health insurance coverage offered in connection with such plan) for an individual (or for a group of individuals considered a single unit in applying this dollar limitation, such as a family or an employee plus spouse).

*Medical/surgical benefits* means benefits for medical or surgical services, as defined under the terms of the plan or group health insurance coverage, but does not include mental health benefits.

*Mental health benefits* means benefits for mental health services, as defined under the terms of the plan or group health insurance coverage, but does not include benefits for treatment of substance abuse or chemical dependency.

(b) *Requirements regarding limits on benefits*—(1) *In general*—(i) *General parity requirement*. A group health plan (or health insurance coverage offered by an issuer in connection with a group

health plan) that provides both medical/surgical benefits and mental health benefits must comply with paragraph (b)(2), paragraph (b)(3), or paragraph (b)(6) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan, or coverage, satisfies the requirements of paragraph (e) or paragraph (f) of this section.

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or group health insurance coverage) does not include an aggregate lifetime or annual limit on any medical/surgical benefits or includes aggregate lifetime or annual limits that apply to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual limit, respectively, on mental health benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or group health insurance coverage) includes an aggregate lifetime or annual limit on at least two-thirds of all medical/surgical benefits, it must either—

(i) Apply the aggregate lifetime or annual limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health benefits in a manner that does not distinguish between the medical/surgical and mental health benefits; or

(ii) Not include an aggregate lifetime or annual limit on mental health benefits that is less than the aggregate lifetime or annual limit, respectively, on the medical/surgical benefits.

(4) *Examples.* The rules of paragraphs (b) (2) and (3) of this section are illustrated by the following examples:

**Example 1.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had no annual limit on medical/surgical benefits and had a \$10,000 annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual limit on mental health benefits;

(B) Replacing the plan's previous annual limit on mental health benefits with a \$500,000 annual limit on all benefits (including medical/surgical and mental health benefits); and

(C) Replacing the plan's previous annual limit on mental health benefits with a \$250,000 annual limit on medical/surgical benefits and a \$250,000 annual limit on mental health benefits.

(ii) In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 2.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had a \$100,000 annual limit on medical/surgical inpatient benefits, a \$50,000 annual limit on medical/surgical outpatient benefits, and a \$100,000 annual limit on all mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Replacing the plan's previous annual limit on mental health benefits with a \$150,000 annual limit on mental health benefits; and

(B) Replacing the plan's previous annual limit on mental health benefits with a \$100,000 annual limit on mental health inpatient benefits and a \$50,000 annual limit on mental health outpatient benefits.

(ii) In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 3.** (i) A group health plan that is subject to the requirements of this section has no aggregate lifetime or annual limit for either medical/surgical benefits or mental health benefits. While the plan provides medical/surgical benefits with respect to both network and out-of-network providers, it does not provide mental health benefits with respect to out-of-network providers.

(ii) In this *Example 3*, the plan complies with the requirements of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

**Example 4.** (i) Prior to the effective date of the mental health parity provisions, a group health plan had an annual limit on medical/surgical benefits and a separate but identical annual limit on mental health benefits. The plan included benefits for treatment of substance abuse and chemical dependency in its definition of mental health benefits. Accordingly, claims paid for treatment of substance abuse and chemical dependency were counted in applying the annual limit on mental health benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Making no change in the plan so that claims paid for treatment of substance abuse and chemical dependency continue to count in applying the annual limit on mental health benefits;

(B) Amending the plan to count claims paid for treatment of substance abuse and chemical dependency in applying the annual limit on medical/surgical benefits (rather than counting those claims in applying the annual limit on mental health benefits);

(C) Amending the plan to provide a new category of benefits for treatment of chemical dependency and substance abuse that is subject to a separate, lower limit and under which claims paid for treatment of substance abuse and chemical dependency are counted only in applying the annual limit on this separate category; and

(D) Amending the plan to eliminate distinctions between medical/surgical benefits and mental health benefits and

establishing an overall limit on benefits offered under the plan under which claims paid for treatment of substance abuse and chemical dependency are counted with medical/surgical benefits and mental health benefits in applying the overall limit.

(ii) In this *Example 4*, the group health plan is described in paragraph (b)(3) of this section. Because mental health benefits are defined in paragraph (a) of this section as excluding benefits for treatment of substance abuse and chemical dependency, the inclusion of benefits for treatment of substance abuse and chemical dependency in applying an aggregate lifetime limit or annual limit on mental health benefits under option (A) of this *Example 4* would not comply with the requirements of paragraph (b)(3) of this section. However, options (B), (C), and (D) of this *Example 4* would comply with the requirements of paragraph (b)(3) of this section because they offer parity in the dollar limits placed on medical/surgical and mental health benefits.

(5) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to a limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual limits). Any reasonable method may be used to determine whether the dollar amounts expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(6) *Plan not described in paragraph (b)(2) or paragraph (b)(3) of this section—(i) In general.* A group health plan (or group health insurance coverage) that is not described in paragraph (b)(2) or paragraph (b)(3) of this section, must either impose—

(A) No aggregate lifetime or annual limit, as appropriate, on mental health benefits; or

(B) An aggregate lifetime or annual limit on mental health benefits that is no less than an average limit for medical/surgical benefits calculated in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment, or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(6)(i)(B). In addition, for purposes of determining



weighted averages, any benefits that are not within a category that is subject to a separately-designated limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.

(ii) *Weighting.* For purposes of this paragraph (b)(6), the weighting applicable to any category of medical/surgical benefits is determined in the manner set forth in paragraph (b)(5) of this section for determining one-third or two-thirds of all medical/surgical benefits.

(iii) *Examples.* The rules of this paragraph (b)(6) are illustrated by the following example:

**Example.** (i) A group health plan that is subject to the requirements of this section includes a \$100,000 annual limit on medical/surgical benefits related to cardio-pulmonary diseases. The plan does not include an annual limit on any other category of medical/surgical benefits. The plan determines that 40% of the dollar amount of plan payments for medical/surgical benefits are related to cardio-pulmonary diseases. The plan determines that \$1,000,000 is a reasonable estimate of the upper limit on the dollar amount that the plan may incur with respect to the other 60% of payments for medical/surgical benefits.

(ii) In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual limit that applies to at least two-thirds of all medical/surgical benefits. Further, the plan is not described in paragraph (b)(2) of this section because more than one-third of all medical/surgical benefits are subject to an annual limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual limit on mental health benefits, or to include an annual limit on mental health benefits that is not less than the weighted average of the annual limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual limit that can be applied to mental health benefits is  $\$640,000$  ( $40\% \times \$100,000 + 60\% \times \$1,000,000 = \$640,000$ ).

(c) *Rule in the case of separate benefit packages.* If a group health plan offers two or more benefit packages, the requirements of this section, including the exemption provisions in paragraph (f) of this section, apply separately to each benefit package. Examples of a group health plan that offers two or more benefit packages include a group health plan that offers employees a choice between indemnity coverage or HMO coverage, and a group health plan that provides one benefit package for retirees and a different benefit package for current employees.

(d) *Applicability—(1) Group health plans.* The requirements of this section

apply to a group health plan offering both medical/surgical benefits and mental health benefits regardless of whether the mental health benefits are administered separately under the plan.

(2) *Health insurance issuers.* The requirements of this section apply to a health insurance issuer offering health insurance coverage for both medical/surgical benefits and mental health benefits in connection with a group health plan.

(3) *Scope.* This section does not—

(i) Require a group health plan (or health insurance issuer offering coverage in connection with a group health plan) to provide any mental health benefits; or

(ii) Affect the terms and conditions (including cost sharing, limits on the number of visits or days of coverage, requirements relating to medical necessity, requiring prior authorization for treatment, or requiring primary care physicians' referrals for treatment) relating to the amount, duration, or scope of the mental health benefits under the plan (or coverage) except as specifically provided in paragraph (b) of this section.

(e) *Small employer exemption—(1) In general.* The requirements of this section do not apply to a group health plan (or health insurance issuer offering coverage in connection with a group health plan) for a plan year of a small employer. For purposes of this paragraph (e), the term *small employer* means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. See regulations at § 146.145(a), which provide that this section (and certain other sections) does not apply to any group health plan (and health insurance issuer offering coverage in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) *Rules in determining employer size.* For purposes of paragraph (e)(1) of this section—

(i) All persons treated as a single employer under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. 414) are treated as one employer;

(ii) If an employer was not in existence throughout the preceding calendar year, whether it is a small employer is determined based on the average number of employees the employer reasonably expects to employ

on business days during the current calendar year; and

(iii) Any reference to an employer for purposes of the small employer exemption includes a reference to a predecessor of the employer.

(f) *Increased cost exemption—(1) In general.* A group health plan (or health insurance coverage offered in connection with a group health plan) is not subject to the requirements of this section if the requirements of this paragraph (f) are satisfied. If a plan offers more than one benefit package, this paragraph (f) applies separately to each benefit package. Except as provided in paragraph (h) of this section, a plan must comply with the requirements of paragraph (b)(1)(i) of this section for the first plan year beginning on or after January 1, 1998, and must continue to comply with the requirements of paragraph (b)(1)(i) of this section until the plan satisfies the requirements in this paragraph (f). In no event is the exemption of this paragraph (f) effective until 30 days after the notice requirements in paragraph (f)(3) of this section are satisfied. If the requirements of this paragraph (f) are satisfied with respect to a plan, the exemption continues in effect (at the plan's discretion) until September 30, 2001, even if the plan subsequently purchases a different policy from the same or a different issuer and regardless of any other changes to the plan's benefit structure.

(2) *Calculation of the one-percent increase—(i) Ratio.* A group health plan (or group health insurance coverage) satisfies the requirements of this paragraph (f)(2) if the application of paragraph (b)(1)(i) of this section to the plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least one percent. The application of paragraph (b)(1)(i) of this section results in an increased cost of at least one percent under a group health plan (or for such coverage) only if the ratio below equals or exceeds 1.01000. The ratio is determined as follows:

(A) The incurred expenditures during the base period, divided by,

(B) The incurred expenditures during the base period, reduced by—

(1) The claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section, and

(2) Administrative expenses attributable to complying with the requirements of this section.

(ii) *Formula.* The ratio of paragraph (f)(2)(i) is expressed mathematically as follows:

$$\frac{IE}{IE - (CE + AE)} \geq 1.01000$$

(A) *IE* means the incurred expenditures during the base period.

(B) *CE* means the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section.

(C) *AE* means administrative costs related to claims in *CE* and other administrative costs attributable to complying with the requirements of this section.

(iii) *Incurred expenditures.* *Incurred expenditures* means actual claims incurred during the base period and reported within two months following the base period, and administrative costs for all benefits under the group health plan, including mental health benefits and medical/surgical benefits, during the base period. Incurred expenditures do not include premiums.

(iv) *Base period.* *Base period* means the period used to calculate whether the plan may claim the one-percent increased cost exemption in this paragraph (f). The base period must begin on the first day in any plan year that the plan complies with the requirements of paragraph (b)(1)(i) of this section and must extend for a period of at least six consecutive calendar months. However, in no event may the base period begin prior to September 26, 1996 (the date of enactment of the Mental Health Parity Act (Pub. L. 104-204, 110 Stat. 2944)).

(v) *Rating pools.* For plans that are combined in a pool for rating purposes, the calculation under this paragraph (f)(2) for each plan in the pool for the base period is based on the incurred expenditures of the pool, whether or not all the plans in the pool have participated in the pool for the entire base period. (However, only the plans that have complied with paragraph (b)(1)(i) of this section for at least six months as a member of the pool satisfy the requirements of this paragraph (f)(2).) Otherwise, the calculation under this paragraph (f)(2) for each plan is calculated by the plan administrator (or issuer) based on the incurred expenditures of the plan.

(vi) *Examples.* The rules of this paragraph (f)(2) are illustrated by the following examples:

**Example 1.** (i) A group health plan has a plan year that is the calendar year. The plan satisfies the requirements of paragraph (b)(1)(i) of this section as of January 1, 1998. On September 15, 1998, the plan determines that \$1,000,000 in claims have been incurred during the period between January 1, 1998 and June 30, 1998 and reported by August 30,

1998. The plan also determines that \$100,000 in administrative costs have been incurred for all benefits under the group health plan, including mental health benefits. Thus, the plan determines that its incurred expenditures for the base period are \$1,100,000. The plan also determines that the claims incurred during the base period that would have been denied under the terms of the plan absent plan amendments required to comply with this section are \$40,000 and that administrative expenses attributable to complying with the requirements of this section are \$10,000. Thus, the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$1,050,000 (\$1,100,000—(\$40,000 + \$10,000) = \$1,050,000).

(ii) In this *Example 1*, the plan satisfies the requirements of this paragraph (f)(2) because the application of this section results in an increased cost of at least one percent under the terms of the plan ( $\$1,100,000/\$1,050,000 = 1.04762$ ).

**Example 2.** (i) A health insurance issuer sells a group health insurance policy that is rated on a pooled-basis and is sold to 30 group health plans. One of the group health plans inquires whether it qualifies for the one percent increased cost exemption. The issuer performs the calculation for the pool as a whole and determines that the application of this section results in an increased cost of 0.500 percent (for a ratio under this paragraph (f)(2) of 1.00500) for the pool. The issuer informs the requesting plan and the other plans in the pool of the calculation.

(ii) In this *Example 2*, none of the plans satisfy the requirements of this paragraph (f)(2) and a plan that purchases a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section. In addition, an issuer that issues to any of the plans in the pool a policy not complying with the requirements of paragraph (b)(1)(i) of this section violates the requirements of this section.

**Example 3.** (i) A partially-insured plan is collecting the information to determine whether it qualifies for the exemption. The plan administrator determines the incurred expenses for the base period for the self-funded portion of the plan to be \$2,000,000 and the administrative expenses for the base period for the self-funded portion to be \$200,000. For the insured portion of the plan, the plan administrator requests data from the insurer. For the insured portion of the plan, the plan's own incurred expenses for the base period are \$1,000,000 and the administrative expenses for the base period are \$100,000. The plan administrator determines that under the self-funded portion of the plan, the claims incurred for the base period that would have been denied under the terms of the plan absent the amendment are \$0 because the self-funded portion does not cover mental health benefits and the plan's administrative costs attributable to complying with the requirements of this section are \$1,000. The issuer determines that under the insured portion of the plan, the claims incurred for the base period that would have been denied under the terms of

the plan absent the amendment are \$25,000 and the administrative costs attributable to complying with the requirements of this section are \$1,000. Thus, the total incurred expenditures for the plan for the base period are \$3,300,000 (\$2,000,000 + \$200,000 + \$1,000,000 + \$100,000 = \$3,300,000) and the total amount of expenditures for the base period had the plan not been amended to comply with the requirements of paragraph (b)(1)(i) of this section are \$3,273,000 (\$3,300,000 - (\$0 + \$1,000 + \$25,000 + \$1,000) = \$3,273,000).

(ii) In this *Example 3*, the plan does not satisfy the requirements of this paragraph (f)(2) because the application of this section does not result in an increased cost of at least one percent under the terms of the plan ( $\$3,300,000/\$3,273,000 = 1.00825$ ).

(3) *Notice of exemption—(i) Participants and beneficiaries—(A) In general.* A group health plan must notify participants and beneficiaries of the plan's decision to claim the one percent increased cost exemption. The notice must include the following information:

(1) A statement that the plan is exempt from the requirements of this section and a description of the basis for the exemption.

(2) The name and telephone number of the individual to contact for further information.

(3) The plan name and plan number (PN).

(4) The plan administrator's name, address, and telephone number.

(5) For single-employer plans, the plan sponsor's name, address, and telephone number (if different from paragraph (f)(3)(i)(A)(3) of this section) and the plan sponsor's employer identification number (EIN).

(6) The effective date of such exemption.

(7) The ability of participants and beneficiaries to contact the plan administrator to see how benefits may be affected as a result of the plan's election of the exemption.

(8) The availability, upon request and free of charge, of a summary of the information required under paragraph (f)(4) of this section.

(B) *Use of summary of material reductions in covered services or benefits.* A plan may satisfy the requirements of paragraph (f)(3)(i)(A) by providing participants and beneficiaries (in accordance with paragraph (f)(3)(i)(C)) with a summary of material reductions in covered services or benefits consistent with Department of Labor regulations at 29 CFR 2520.104b-3(d) that also includes the information of this paragraph (f)(3)(i). However, in all cases, the exemption is not effective until 30 days after notice has been sent.

(C) *Delivery.* The notice described in this paragraph (f)(3)(i) is required to be

provided to all participants and beneficiaries. The notice may be furnished by any method of delivery that satisfies the requirements of section 104(b)(1) of ERISA (29 U.S.C. 1024(b)(1)) (e.g., first-class mail). If the notice is provided to the participant at the participant's last known address, then the requirements of this paragraph (f)(3)(i) are satisfied with respect to the participant and all beneficiaries residing at that address. If a beneficiary's last known address is different from the participant's last known address, a separate notice is required to be provided to the beneficiary at the beneficiary's last known address.

(D) *Example.* The rules of this paragraph (f)(3)(i) are illustrated by the following example:

**Example.** (i) A group health plan has a plan year that is the calendar year and has an open enrollment period every November 1 through November 30. The plan determines on September 15 that it satisfies the requirements of paragraph (f)(2) of this section. As part of its open enrollment materials, the plan mails, on October 15, to all participants and beneficiaries a notice satisfying the requirements of this paragraph (f)(3)(i).

(ii) In this *Example*, the plan has sent the notice in a manner that complies with this paragraph (f)(3)(i).

(ii) *Federal agencies—(A) Church plans.* A church plan (as defined in section 414(e) of the Internal Revenue Code) claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of the Treasury. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(B) *Group health plans subject to Part 7 of Subtitle B of Title I of ERISA.* A group health plan subject to Part 7 of Subtitle B of Title I of ERISA, and claiming the exemption of this paragraph (f) for any benefit package, must provide notice to the Department of Labor. This requirement is satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(C) *Non-Federal governmental plans.* A group health plan that is a non-Federal governmental plan claiming the exemption of this paragraph (f) for any benefit package must provide notice to the Department of Health and Human Services (HHS). This requirement is

satisfied if the plan sends a copy, to the address designated by the Secretary in generally applicable guidance, of the notice described in paragraph (f)(3)(i) of this section identifying the benefit package to which the exemption applies.

(4) *Availability of documentation.* The plan (or issuer) must make available to participants and beneficiaries (or their representatives), on request and at no charge, a summary of the information on which the exemption was based. An individual who is not a participant or beneficiary and who presents a notice described in paragraph (f)(3)(i) of this section is considered to be a representative. A representative may request the summary of information by providing the plan a copy of the notice provided to the participant under paragraph (f)(3)(i) of this section with any individually identifiable information redacted. The summary of information must include the incurred expenditures, the base period, the dollar amount of claims incurred during the base period that would have been denied under the terms of the plan absent amendments required to comply with paragraph (b)(1)(i) of this section, the administrative costs related to those claims, and other administrative costs attributable to complying with the requirements for the exemption. In no event should the summary of information include any individually identifiable information.

(g) *Special rules for group health insurance coverage—(1) Sale of nonparity policies.* An issuer may sell a policy without parity (as described in paragraph (b) of this section) only to a plan that meets the requirements of paragraph (e) or paragraph (f) of this section.

(2) *Duration of exemption.* After a plan meets the requirements of paragraph (f) of this section, the plan may change issuers without having to meet the requirements of paragraph (f) of this section again before September 30, 2001.

(h) *Effective dates—(1) In general.* The requirements of this section are applicable for plan years beginning on or after January 1, 1998.

(2) *Limitation on actions.* (i) Except as provided in paragraph (h)(3) of this section, no enforcement action is to be taken by the Secretary against a group health plan that has sought to comply in good faith with the requirements of section 2705 of the PHS Act, with respect to a violation that occurs before the earlier of—

(A) The first day of the first plan year beginning on or after April 1, 1998; or  
(B) January 1, 1999.

(ii) Compliance with the requirements of this section is deemed to be good faith compliance with the requirements of section 2705 of the PHS Act.

(iii) The rules of this paragraph (h)(2) are illustrated by the following examples:

**Example 1.** (i) A group health plan has a plan year that is the calendar year. The plan complies with section 2705 of the PHS Act in good faith using assumptions inconsistent with paragraph (b)(6) of this section relating to weighted averages for categories of benefits.

(ii) In this *Example 1*, no enforcement action may be taken against the plan with respect to a violation resulting solely from those assumptions and occurring before January 1, 1999.

**Example 2.** (i) A group health plan has a plan year that is the calendar year. For the entire 1998 plan year, the plan applies a \$1,000,000 annual limit on medical/surgical benefits and a \$100,000 annual limit on mental health benefits.

(ii) In this *Example 2*, the plan has not sought to comply with the requirements of section 2705 of the PHS Act in good faith and this paragraph (h)(2) does not apply.

(3) *Transition period for increased cost exemption—(i) In general.* No enforcement action will be taken against a group health plan that is subject to the requirements of this section based on a violation of this section that occurs before April 1, 1998 solely because the plan claims the increased cost exemption under section 2705(c)(2) of the PHS Act based on assumptions inconsistent with the rules under paragraph (f) of this section, provided that a plan amendment that complies with the requirements of paragraph (b)(1)(i) of this section is adopted and effective no later than March 31, 1998 and the plan complies with the notice requirements in paragraph (h)(3)(ii) of this section.

(ii) *Notice of plan's use of transition period.* (A) A group health plan satisfies the requirements of this paragraph (h)(3)(ii) only if the plan provides notice to the applicable federal agency and posts the notice at the location(s) where documents must be made available for examination by participants and beneficiaries under section 104(b)(2) of ERISA and the regulations thereunder (29 CFR 2520.104b-1(b)(3)). The notice must indicate the plan's decision to use the transition period in paragraph (h)(3)(i) of this section by 30 days after the first day of the plan year beginning on or after January 1, 1998, but in no event later than March 31, 1998. For a group health plan that is a church plan, the applicable federal agency is the Department of the Treasury. For a group

health plan that is subject to Part 7 of Subtitle B of Title I of ERISA, the applicable federal agency is the Department of Labor. For a group health plan that is a nonfederal governmental plan, the applicable federal agency is the Department of Health and Human Services. The notice must include—

(1) The name of the plan and the plan number (PN);

(2) The name, address, and telephone number of the plan administrator;

(3) For single-employer plans, the name, address, and telephone number of the plan sponsor (if different from the plan administrator) and the plan

sponsor's employer identification number (EIN);

(4) The name and telephone number of the individual to contact for further information; and

(5) The signature of the plan administrator and the date of the signature.

(B) The notice must be provided at no charge to participants or their representative within 15 days after receipt of a written or oral request for such notification, but in no event before the notice has been sent to the applicable federal agency.

(i) *Sunset*. This section does not apply to benefits for services furnished on or after September 30, 2001.

Dated: December 16, 1997.

**Nancy-Ann Min DeParle,**

*Administrator, Health Care Financing Administration.*

Dated: December 16, 1997.

**Donna E. Shalala,**

*Secretary, Department of Health and Human Services.*

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