Internal Revenue
bulletin

Bulletin No. 2010-18
May 3, 2010

# HIGHLIGHTS OF THIS ISSUE

**These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.**

## INCOME TAX

### Rev. Rul. 2010–12, page 617.

**Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate.** For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for May 2010.

### Notice 2010–37, page 654.

**Renewable electricity production, refined coal production, and Indian coal production; calendar year 2010 inflation adjustment factors and reference prices.** This notice announces the calendar year 2010 inflation adjustment factors and reference prices for the renewable electricity production credit, refined coal production credit, and Indian coal production credit under section 45 of the Code.

## EMPLOYEE PLANS

### T.D. 9479, page 618.

Final regulations under section 9812 of the Code provide guidance on the requirements imposed on group health plans by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), generally prohibiting plans from imposing financial requirements or treatment limitations with respect to mental health or substance use disorder benefits that are more restrictive than those imposed with respect to medical/surgical benefits under the plan.

## EXCISE TAX

### T.D. 9479, page 618.

Final regulations under section 9812 of the Code provide guidance on the requirements imposed on group health plans by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), generally prohibiting plans from imposing financial requirements or treatment limitations with respect to mental health or substance use disorder benefits that are more restrictive than those imposed with respect to medical/surgical benefits under the plan.

## TAX CONVENTIONS

### Announcement 2010–27, page 657.

The competent authorities of the United States and Belgium entered into the following agreement regarding the types of pension plans established in either Contracting State that will be deemed to generally correspond to a pension plan recognized for tax purposes in the other Contracting State as required by paragraphs 7 and 9 of Article 17 (Pensions, Social Security, Annuities, Alimony, and Child Support) of the Convention Between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income, signed at Brussels on November 27, 2006. The Agreement is entered into under paragraph 3 of Article 24 (Mutual Agreement Procedure).

**(Continued on the next page)**

**Finding Lists begin on page ii.**

Department of the Treasury
Internal Revenue Service

# ADMINISTRATIVE

### Notice 2010–30, page 650.

This notice provides an extension of time to pay tax through October 15, 2010, to civilian spouses of servicemembers working in a U.S. territory but claiming a residence or domicile for tax purposes in a state or the District of Columbia pursuant to the Military Spouses Residency Relief Act (MSRRA). In addition, this notice provides procedures for filing claims for refund of federal income taxes to civilian spouses of servicemembers working in a state or the District of Columbia but claiming residence or domicile for tax purposes in a U.S. territory under MSRRA.

### Announcement 2010–33, page 658.

This document provides notice of public hearing on proposed regulations (REG–134235–08, 2010–16 I.R.B. 596) providing guidance to tax return preparers on furnishing an identifying number on tax returns and claims for refund of tax that they prepare. A public hearing is scheduled for May 6, 2010.

# The IRS Mission

Provide America's taxpayers top quality service by helping them understand and meet their tax responsibilities and by applying the tax law with integrity and fairness to all.

# Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

**Part I.—1986 Code.**
This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

**Part II.—Treaties and Tax Legislation.**
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

**Part III.—Administrative, Procedural, and Miscellaneous.**
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

**Part IV.—Items of General Interest.**
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.



For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

# Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

## Section 1274.—Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

*(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)*

**Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate.** For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for May 2010.

## Rev. Rul. 2010–12

This revenue ruling provides various prescribed rates for federal income tax purposes for May 2010 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2010–12 TABLE 1

Applicable Federal Rates (AFR) for May 2010

| | *Period for Compounding* | | | |
|---|---|---|---|---|
| | *Annual* | *Semiannual* | *Quarterly* | *Monthly* |
| *Short-term* | | | | |
| AFR | .79% | .79% | .79% | .79% |
| 110% AFR | .87% | .87% | .87% | .87% |
| 120% AFR | .95% | .95% | .95% | .95% |
| 130% AFR | 1.03% | 1.03% | 1.03% | 1.03% |
| *Mid-term* | | | | |
| AFR | 2.87% | 2.85% | 2.84% | 2.83% |
| 110% AFR | 3.16% | 3.14% | 3.13% | 3.12% |
| 120% AFR | 3.45% | 3.42% | 3.41% | 3.40% |
| 130% AFR | 3.74% | 3.71% | 3.69% | 3.68% |
| 150% AFR | 4.33% | 4.28% | 4.26% | 4.24% |
| 175% AFR | 5.05% | 4.99% | 4.96% | 4.94% |
| *Long-term* | | | | |
| AFR | 4.47% | 4.42% | 4.40% | 4.38% |
| 110% AFR | 4.92% | 4.86% | 4.83% | 4.81% |
| 120% AFR | 5.37% | 5.30% | 5.27% | 5.24% |
| 130% AFR | 5.83% | 5.75% | 5.71% | 5.68% |

REV. RUL. 2010–12 TABLE 2

Adjusted AFR for May 2010

*Period for Compounding*

| | *Annual* | *Semiannual* | *Quarterly* | *Monthly* |
|---|---|---|---|---|
| Short-term adjusted AFR | .66% | .66% | .66% | .66% |
| Mid-term adjusted AFR | 1.88% | 1.87% | 1.87% | 1.86% |
| Long-term adjusted AFR | 3.98% | 3.94% | 3.92% | 3.91% |

REV. RUL. 2010–12 TABLE 3

Rates Under Section 382 for May 2010

| | |
|---|---|
| Adjusted federal long-term rate for the current month | 3.98% |
| Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.) | 4.03% |

REV. RUL. 2010–12 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for May 2010

Note: Under Section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%.

| | |
|---|---|
| Appropriate percentage for the 70% present value low-income housing credit | 7.85% |
| Appropriate percentage for the 30% present value low-income housing credit | 3.36% |

REV. RUL. 2010–12 TABLE 5

Rate Under Section 7520 for May 2010

| | |
|---|---|
| Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest | 3.4% |

## Section 9812.—Parity in Mental Health and Substance Use Disorder Benefits

*26 CFR 54.9812: Parity in mental health and substance use disorder benefits (temporary).*

## T.D. 9479

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

## Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

**AGENCIES:** Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

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

**SUMMARY:** This document contains interim final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and health insurance coverage offered in connection with a group health plan.

**DATES:** *Effective date*. These interim final regulations are effective on April 5, 2010.

*Comment date*. Comments are due on or before May 3, 2010.

*Applicability date*. These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010.

**ADDRESSES:** Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. ***WARNING***: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

*Department of Labor*. Comments to the Department of Labor, identified by RIN 1210–AB30, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Email*: *E-OHPSCA.EBSA@dol.gov*.
- *Mail or Hand Delivery*: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention*: RIN 1210–AB30.

Comments received by the Department of Labor will be posted without change to *www.regulations.gov* and *www.dol.gov/ebsa*, and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

*Department of Health and Human Services*. In commenting, please refer to file code CMS–4140–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the "More Search Options" tab.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–4140–IFC,
P.O. Box 8016,
Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–4140–IFC,
Mail Stop C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Room 445-G, Hubert H.
Humphrey Building,
200 Independence Avenue, SW,
Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
7500 Security Boulevard,
Baltimore, MD 21244–1850

If you intend to deliver your comments to the Baltimore address, please call (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

*Submission of comments on paperwork requirements*. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

*Inspection of Public Comments:* All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

*Internal Revenue Service*. Comments to the IRS, identified by REG–120692–09, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail*: CC:PA:LPD:PR (REG–120692–09), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–120692–09), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9 a.m. to 4 p.m.

**FOR FURTHER INFORMATION CONTACT:** Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Adam Shaw, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (877) 267–2323, extension 61091.

**CUSTOMER SERVICE INFORMATION:** Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, including the mental health parity provisions, may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's website (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers (such as mental health and substance use disorder parity) can be found on the Centers for Medicare & Medicaid Services (CMS) website (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*).

**SUPPLEMENTARY INFORMATION:**

**I. Background**

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted on October 3, 2008 as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008 (Division C of Public Law 110–343).[1] MHPAEA amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code of 1986 (Code). In 1996, Congress enacted the Mental Health Parity Act of 1996 (MHPA 1996), which required parity in aggregate lifetime and annual dollar limits for mental health benefits and medical and surgical benefits. Those mental health parity provisions were codified in section 712 of ERISA, section 2705 of the PHS Act, and section 9812 of the Code, which apply to employment-related group health plans and health insurance coverage offered in connection with a group health plan. The changes made by MHPAEA are codified in these same sections and consist of new requirements as well as amendments to the existing mental health parity provisions. The changes made by MHPAEA are generally effective for plan years beginning after October 3, 2009.

On April 28, 2009, the Departments of the Treasury, Labor, and HHS (collectively, the Departments) published in the **Federal Register** (74 FR 19155) a request for information (RFI) soliciting comments on the requirements of MHPAEA. After consideration of the comments received in response to the RFI, the Departments are publishing these interim final regulations. These regulations generally become applicable to plans and issuers for plan years beginning on or after July 1, 2010.

**II. Overview of the Regulations**

These interim final regulations replace regulations published on December 22, 1997 at 62 FR 66932 implementing MHPA 1996. These regulations also make conforming changes to reflect modifications MHPAEA made to the original MHPA 1996 definitions and provisions regarding parity in aggregate lifetime and annual dollar limits, and incorporate new parity standards.

A. *Meaning of Terms (26 CFR 54.9812–1T(a), 29 CFR 2590.712(a), and 45 CFR 146.136(a))*

The paragraph with the heading "definitions" in the MHPA 1996 regulations has been renamed "meaning of terms" under these regulations because some of the terms added by MHPAEA are not comprehensively defined. The change in heading reflects the fact that if a term is described as including a list of examples, the term may have a broader meaning than the illustrative list of examples.

1. Aggregate Lifetime and Annual Dollar Limits

The word "dollar" has been added to the terms "aggregate lifetime limit" and "annual limit" under the MHPA 1996 regulations to distinguish them from lifetime and annual limits expressed in terms of days or visits which are subject to new requirements under MHPAEA.

2. Coverage Unit

Paragraph (a) in these regulations cross-references the definition of coverage unit in paragraph (c)(1). Paragraph (c)(1) clarifies the term for purposes of the new MHPAEA rules and is discussed later in this preamble.

3. Cumulative Financial Requirements

These regulations add a definition for the term "cumulative financial requirements". Under this definition, a cumulative financial requirement is a financial requirement that typically operates as a threshold amount that, once satisfied, will determine whether, or to what extent, benefits are provided. A common example of a cumulative financial requirement is a deductible that must be satisfied before a plan will start paying for benefits. However, aggregate lifetime and annual dollar limits are excluded from being cumulative financial requirements (because the statutory term financial requirements excludes aggregate lifetime and annual dollar limits).

4. Cumulative Quantitative Treatment Limitations

These regulations add a definition for the term "cumulative quantitative treatment limitations". Similar to the definition for cumulative financial requirements, a cumulative quantitative treatment limitation is defined as a treatment limitation that will determine whether, or to what extent, benefits are provided based on an accumulated amount. A common example of a cumulative quantitative treatment

[1] A technical correction to the effective date for collectively bargained plans was made by Public Law 110–460, enacted on December 23, 2008.

limitation is a visit limit (whether imposed annually or on a lifetime basis).

5. Financial Requirements

These regulations repeat the statutory language that provides the term "financial requirements" includes deductibles, copayments, coinsurance, and out-of-pocket maximums. The statute and these regulations exclude aggregate lifetime and annual dollar limits from the meaning of financial requirements; these limits are subject to separate provisions originally enacted as part of MHPA 1996 that remain in paragraph (b).

6. Medical/Surgical Benefits, Mental Health Benefits, and Substance Use Disorder Benefits

Among the changes enacted by MHPAEA is an expansion of the parity requirements for aggregate lifetime and annual dollar limits to include protections for substance use disorder benefits. Prior law specifically excluded substance abuse or chemical dependency benefits[2] from those requirements. Consequently, these regulations amend the meanings of medical/surgical benefits and mental health benefits (and add a definition for substance use disorder benefits). Under these regulations, medical/surgical benefits are benefits for medical or surgical services, as defined under the terms of the plan or health insurance coverage, but do not include mental health or substance use disorder benefits. Mental health benefits and substance use disorder benefits are benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. These regulations further provide that the plan terms defining whether the benefits are mental health or substance use disorder benefits must be consistent with generally recognized independent standards of current medical practice. This requirement is included to ensure that a plan does not misclassify a benefit in order to avoid complying with the parity requirements.

The word "generally" in the requirement "to be consistent with generally recognized independent standards of current medical practice" is not meant to imply that the standard must be a national standard; it simply means that a standard must be generally accepted in the relevant medical community. There are many different sources that would meet this requirement. For example, a plan may follow the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Diseases (ICD), or a State guideline. All of these would be considered acceptable resources to determine whether benefits for a particular condition are classified as medical/surgical, mental health, or substance use disorder benefits.

7. Treatment Limitations

These regulations repeat the statutory language with respect to the term "treatment limitation" and also distinguish between a quantitative and a nonquantitative treatment limitation. These regulations provide that the parity requirements in the statute apply to both quantitative and nonquantitative treatment limitations. A quantitative treatment limitation is a limitation that is expressed numerically, such as an annual limit of 50 outpatient visits. A nonquantitative treatment limitation is a limitation that is not expressed numerically, but otherwise limits the scope or duration of benefits for treatment. A non-exhaustive list of nonquantitative treatment limitations is included in these regulations in paragraph (c)(4). This list, as well as the application of these regulations to nonquantitative treatment limitations, is further discussed later in this preamble. However, these regulations provide that a permanent exclusion of all benefits for a specific condition or disorder is not a treatment limitation.

B. *Conforming Amendments to Parity Requirements With Respect To Aggregate Lifetime and Annual Dollar Limits (26 CFR 54.9812–1T(b), 29 CFR 2590.712(b), and 45 CFR 146.136(b))*

Paragraph (b) of these regulations addresses the parity requirements with respect to aggregate lifetime and annual dollar limits. The mechanics of these requirements generally remain the same as under the MHPA 1996 regulations, except that MHPAEA expanded the scope of the parity provisions to apply also to substance use disorder benefits. Accordingly, these regulations make conforming changes to reflect this expansion. Certain examples illustrating the application of MHPA 1996 to benefits for substance abuse and chemical dependency were deleted (as they are no longer accurate); other provisions were modified to include references to substance use disorder benefits as within the scope of the parity requirements for aggregate lifetime and annual dollar limits.

C. *Parity Requirements With Respect To Financial Requirements and Treatment Limitations (26 CFR 54.9812–1T(c), 29 CFR 2590.712(c), and 45 CFR 146.136(c))*

Paragraph (c) of these regulations implements the core of MHPAEA's new rules, which require parity with respect to financial requirements and treatment limitations.

1. Clarification of Terms

In addition to the meaning of terms in paragraph (a), paragraph (c)(1) of these regulations clarifies certain terms that have been given specific meanings for purposes of MHPAEA.

a. *Classification of benefits*. Paragraph (c)(1) cross-references the term "classification of benefits" in paragraph (c)(2)(ii). Paragraph (c)(2)(ii) describes the six benefit classifications and their application, which are discussed later in this preamble. These regulations provide that the parity requirements for financial requirements and treatment limitations are applied on a classification-by-classification basis.

b. *Type*. These regulations use the term "type" to refer to financial requirements and treatment limitations of the same nature. Different types include copayments, coinsurance, annual visit limits, and episode visit limits. Plans often apply more than one financial requirement or treatment limitation to benefits. These regulations specify that a financial requirement or treatment limitation must

[2] The terms "substance abuse," "chemical dependency," and "substance use disorder" are variously used to refer to substance use disorders. Although they mean essentially the same thing, the term used in MHPAEA is "substance use disorder".

be compared only to financial requirements or treatment limitations of the same type within a classification. For example, copayments are compared only to other copayments, and annual visit limits are compared only to other annual visit limits; copayments are not compared to coinsurance, and annual visit limits are not compared to episode visit limits.

c. *Level*. A type of financial requirement or treatment limitation may vary in magnitude. For example, a plan may impose a $20 copayment or a $30 copayment depending on the medical/surgical benefit. In these regulations, a "level" of a type of financial requirement or treatment limitation refers to the magnitude (such as the dollar, percentage, day, or visit amount) of the financial requirement or treatment limitation.

d. *Coverage unit*. Plans typically distinguish between coverage for a single participant, for a participant plus a spouse, for a family, and so forth. Coverage unit is the term used in these regulations to refer to how a plan groups individuals for purposes of determining benefits, or premiums or contributions. These regulations provide that the general parity requirement of MHPAEA for financial requirements and treatment limitations is applied separately for each coverage unit.

2. General Parity Requirement for Financial Requirements and Treatment Limitations

The general parity requirement of paragraph (c)(2) of these regulations prohibits a plan (or health insurance coverage) from applying any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification. For this purpose, the general parity requirement of MHPAEA applies separately for each type of financial requirement or treatment limitation (that is, for example, copayments are compared to copayments, and deductibles to deductibles). The test is applied somewhat differently to nonquantitative treatment limitations, as discussed later in this preamble.

a. *Classifications of benefits*. Plans often vary the financial requirements and treatment limitations imposed on benefits based on whether a treatment is provided on an inpatient, outpatient, or emergency basis; whether a provider is a member of the plan's network; or whether the benefit is specifically for a prescription drug. Therefore, determining the predominant financial requirements and treatment limitations for the entire plan without taking these distinctions into account could potentially lead to absurd results. For example, if a plan generally requires a $100 copayment on inpatient medical/surgical benefits and a $10 copayment on outpatient medical/surgical benefits, and most services (as measured by plan costs) are provided on an inpatient basis, the plan theoretically could charge a $100 copayment for outpatient mental health and substance use disorder benefits. Similarly, if most benefits are provided on an outpatient basis, the plan would only be able to charge a $10 copayment for inpatient mental health and substance use disorder benefits. Commenters generally agreed that the statute should be applied within several broad classifications of benefits.

These regulations specify, in paragraph (c)(2)(ii), six classifications of benefits: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. If a plan does not have a network of providers for inpatient or outpatient benefits, all benefits in the classification are characterized as out-of-network. These regulations provide that the parity requirements for financial requirements and treatment limitations are generally applied on a classification-by-classification basis and these are the only classifications used for purposes of satisfying the parity requirements of MHPAEA. Moreover, these classifications must be used for all financial requirements and treatment limitations to the extent that a plan (or health insurance coverage) provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification. Examples illustrate the application of this rule.

Commenters noted that a common plan design imposes lower copayments for treatment from a primary care provider (for example, an internist or a pediatrician) as compared to higher copayments for treatment from a specialist (such as a cardiologist or an orthopedist). Some of these commenters requested that this distinction be permitted in applying the parity requirements by recognizing a separate classification for specialists; others of these commenters opposed allowing this distinction. Some plans (or health insurance coverage) identify a large range of mental health and substance use disorder providers as specialists. Allowing plans to provide less favorable benefits with respect to services by these providers than for services by providers of medical/surgical care that are classified by the plan as primary care providers would undercut the protections that the statute was intended to provide. These regulations, therefore, do not allow the separate classification of generalists and specialists in determining the predominant financial requirement that applies to substantially all medical/surgical benefits.

Under these regulations, if a plan provides any benefits for a mental health condition or substance use disorder, benefits must be provided for that condition or disorder in each classification for which any medical/surgical benefits are provided. This follows from the statutory requirement that any treatment limitations applied to mental health or substance use disorder benefits may be no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits. Treatment limitation is not comprehensively defined under the statute. The statute describes the term as including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, but it is not limited to such types of limits. Indeed, these regulations make a distinction between quantitative treatment limitations (such as day limits, visit limits, frequency of treatment limits) and non-quantitative treatment limitations (such as medical management, formulary design, step therapy). If a plan provides benefits for a mental health condition or substance use disorder in one or more classifications but excludes benefits for that condition or disorder in a classification (such as outpatient, in-network) in which it provides medical/surgical benefits, the

exclusion of benefits in that classification for a mental health condition or substance use disorder otherwise covered under the plan is a treatment limitation. It is a limit, at a minimum, on the type of setting or context in which treatment is offered.

This rule does not require an expansion of the range of mental health conditions or substance use disorders covered under the plan; it merely requires, for those conditions or disorders covered under the plan, that coverage also be provided for them in each classification in which medical/surgical coverage is provided. If a plan does not offer, for instance, any benefits for medical/surgical services on an outpatient basis by an out-of-network provider, then there is no requirement to provide benefits for mental health conditions or substance use disorders on an outpatient, out-of-network basis. Although this rule follows from the general parity requirement added by MHPAEA, the statute includes a specific provision in the case of out-of-network benefits.[3] The rule for out-of-network benefits is stated separately in these regulations to reflect the separate statutory provision, but the application of the general rule requires the same result with respect to all classifications.

These regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meanings may differ from plan to plan. Additionally, State health insurance laws may define these terms. A plan must apply these terms uniformly for both medical/surgical benefits and mental health or substance use disorder benefits. However, the manner in which they apply may differ from plan to plan. For example, a plan may treat a hospital stay of more than 12 hours as inpatient care for medical/surgical benefits; in such case, it must also treat a hospital stay of more than 12 hours as inpatient care for mental health and substance use disorder benefits. However, another plan may treat a hospital stay that includes midnight as inpatient care for medical/surgical benefits; in such a case the plan must also treat a hospital stay that includes midnight as inpatient care for mental health or substance use disorder benefits.

b. *Applying the general parity requirement to financial requirements and quantitative treatment limitations*. Paragraph (c)(3) of these regulations addresses the application of the general parity requirement of MHPAEA to plan financial requirements and quantitative treatment limitations.

(1) *Measuring plan benefits*. In order to apply the substantive rules, these regulations first establish standards for measuring plan benefits. These regulations, similar to the MHPA 1996 regulations, provide that the portion of plan payments subject to a financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year. Also similar to the MHPA 1996 regulations, any reasonable method may be used to determine the dollar amount expected to be paid under the plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.

Some cumulative financial requirements, such as deductibles and out-of-pocket maximums, involve a threshold amount that causes the amount of a plan payment to change. These regulations clarify that, for purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied. For purposes of out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Other threshold requirements are treated similarly.

(2) *"Substantially all"*. The first step of these regulations in applying the general parity requirement of MHPAEA is to determine whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification. Regulations issued under MHPA 1996 interpreted the term "substantially all" to mean at least two-thirds. Under these regulations, a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification if it applies to at least two-thirds of the benefits in that classification. In determining whether a financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification, benefits expressed as subject to a zero level of a type of financial requirement are treated the same as benefits that are not subject to that type of requirement, and benefits expressed as subject to an unlimited quantitative treatment limitation are treated the same as benefits that are not subject to that type of limitation. For example, in the classification of outpatient, in-network medical/surgical benefits, a plan could reduce the normal copayment amount of $15 to $0 for well baby care or routine physical examinations, while a copayment is not imposed on office visits for allergy shots. For purposes of this analysis, both of these benefits are treated as not subject to a copayment.

If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of the medical surgical benefits in a classification, that type of requirement or limitation cannot be applied to mental health or substance use disorder benefits in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical/surgical benefits in a classification, then it is also the predominant level and that is the end of the analysis. However, if the financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification but has multiple levels and no single level applies to at least two-thirds of all medical/surgical benefits in the classification, then additional analysis is required. In such a case, the next step is to determine which level of the financial requirement or quantitative treatment limitation is considered predominant.

(3) *"Predominant"*. MHPAEA provides that a financial requirement or treatment limitation is predominant if it is the most common or frequent of a type of limit or requirement. Under these regulations, the predominant level of a type of financial requirement or quantitative treat-

[3] See sections 9812(a)(5) of the Code, 712(a)(5) of ERISA, 2705(a)(5) of the PHS Act.

ment limitation is the level that applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification. If a single level of a type of financial requirement or quantitative treatment limitation applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification (based on plan costs, as discussed earlier in this preamble), the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits at a level that is more restrictive than the level that has been determined to be predominant.

If no single level applies to more than one-half of medical/surgical benefits subject to a financial requirement or quantitative treatment limitation in a classification, plan payments for multiple levels of the same type of financial requirement or quantitative treatment limitation can be combined by the plan (or health insurance issuer) until the portion of plan payments subject to the financial requirement or quantitative treatment limitation exceeds one-half. For any combination of levels that exceeds one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in a classification, the plan may not apply that particular financial requirement or quantitative treatment limitation to mental health and substance use disorder benefits at a level that is more restrictive than the least restrictive level within the combination. The plan may combine plan payments for the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation. Examples in these regulations illustrate the application of this rule.

These regulations provide an alternative, simpler method for compliance when a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of medical surgical benefits in a classification but no single level applies to more than one-half of the medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in that classification. In such a situation, a plan is permitted to treat the least restrictive level of the financial requirement or quantitative treatment limitation applied to medical/surgical benefits in that classification as the predominant level.

If a plan provides benefits for more than one coverage unit and applies different levels of financial requirements or quantitative treatment limitations to these coverage units within a classification of benefits, determining the predominant level of a particular financial requirement or quantitative treatment limitation must be done separately for each coverage unit. Thus, for example, a plan with different deductibles for self-only and family coverage units would not determine the predominant level of a deductible applied for benefits across both the self-only and family coverage units. Instead, the plan would determine the predominant level of the deductible for self-only coverage independently from the predominant level for family coverage.

c. *Special rule for prescription drug benefits with multiple levels of financial requirements*. These regulations include, in paragraph (c)(3)(iii), a special rule for applying the general parity requirement of MHPAEA to prescription drug benefits. Although applying the general parity requirement to a prescription drug program with a single level of a type of financial requirement would be relatively uncomplicated, the analysis becomes more difficult if different financial requirements are imposed for different tiers of drugs. The placement of a drug in a tier is generally based on factors (such as cost and efficacy) unrelated to whether the drug is usually prescribed for the treatment of a medical/surgical condition or a mental health condition or substance use disorder. To the extent such a program does not distinguish between drugs as medical/surgical benefits or mental health or substance use disorder benefits, requiring the program to make that distinction solely for the purpose of determining the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in a classification might impose significant burdens without ensuring any greater parity for mental health and substance use disorder benefits.

Consequently, these regulations provide that if a plan imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors (such as cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up), determined in accordance with the requirements for nonquantitative treatment limitations, and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or mental health or substance use disorder benefits, the plan satisfies the parity requirements with respect to the prescription drug classification of benefits. The special rule for prescription drugs, in effect, allows a plan or issuer to subdivide the prescription drug classification into tiers and apply the general parity requirement separately to each tier of prescription drug benefits. For any tier, the financial requirements and treatment limitations imposed with respect to the drugs prescribed for medical/surgical conditions are the same as (and thus not more restrictive than) the financial requirements and treatment limitations imposed with respect to the drugs prescribed for mental health conditions and substance use disorders in the tier. Moreover, because the financial requirements and treatment limitations apply to 100 percent of the medical/surgical drug benefits in the tier, they are the predominant financial requirements and treatment limitations that apply to substantially all of the medical/surgical drug benefits in the tier.

d. *Cumulative financial requirements and quantitative treatment limitations, including deductibles*. While financial requirements such as copayments and coinsurance generally apply separately to each covered expense, other financial requirements (in particular, deductibles) accumulate across covered expenses. In the case of deductibles, generally an amount of otherwise covered expenses must be accumulated before the plan pays benefits. Financial requirements and quantitative treatment limitations that determine whether and to what extent benefits are provided based on accumulated amounts are defined in these regulations as cumulative financial requirements and cumulative quantitative treatment limitations.

In response to the RFI, the Departments received a number of comments regarding how to apply the parity requirements to cumulative financial requirements, in particular to deductibles (although some also

referred to out-of-pocket maximums). The comments reflect two opposing views. One view is that a plan can have deductibles that accumulate separately for medical/surgical benefits on the one hand, and mental health or substance use disorder benefits on the other, as long as the level of the two deductibles is the same (separately accumulating deductibles). The opposing view is that expenses for both mental health or substance use disorder benefits and medical/surgical benefits must accumulate to satisfy a single combined deductible before the plan provides either medical/surgical benefits or mental health or substance use disorder benefits (combined deductible).

The provisions of the statute imposing parity on financial requirements and treatment limitations do not specifically address this issue; the language of the statute can be interpreted to support either position. The comments that supported allowing separately accumulating deductibles maintained that it is commonplace for plans to have such deductibles, and that the projected cost of converting systems to permit unified deductibles would be extremely high for the many plans that use a separate managed behavioral health organization (MBHO).[4]

By contrast, comments that supported requiring combined deductibles argued that allowing separately accumulating deductibles undermines a central goal of parity legislation, to affirm that mental health and substance use disorder benefits are integral components of comprehensive health care and generally should not be distinguished from medical/surgical benefits. Distinguishing between the two requires individuals who need both kinds of care to satisfy a deductible that is greater than that required for individuals needing only medical/surgical care. Other comments that supported requiring combined deductibles noted that mental health and substance use disorder benefits typically comprise only 2 to 5 percent of a plan's costs, so that even using identical levels for separately accumulating deductibles imposes a greater barrier to mental health and substance use disorder benefits.

The Departments carefully considered the positions advanced by both groups of comments regarding separately accumulating and combined deductibles. Given that the statutory language does not preclude either interpretation, the Departments' view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, these regulations provide, in paragraph (c)(3)(v), that a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification.[5] Examples in these regulations illustrate the application of this rule.

e. *Application to nonquantitative treatment limitations*. Plans impose a variety of limits affecting the scope or duration of benefits under the plan that are not expressed numerically. Nonetheless, such nonquantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan. These regulations provide an illustrative list of nonquantitative treatment limitations, including medical management standards; prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary, and reasonable amounts; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment.

Paragraph (c)(4) of these regulations generally prohibits the imposition of any nonquantitative treatment limitation to mental health or substance use disorder benefits unless certain requirements are met. Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. However, these requirements allow variations to the extent that recognized clinically appropriate standards of care may permit a difference. These requirements apply to the terms of the plan (or health insurance coverage) both as written and in operation.

The phrase, "applied no more stringently" was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical benefits and to mental health or substance use disorder benefits. Thus, for example, assume a claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve medical/surgical benefits while denying mental health or substance use disorder benefits and recognized clinically appropriate standards of care do not permit such a difference, the processes used in applying the medical necessity standard are considered to be applied more stringently to mental health or substance use disorder benefits. The use of discretion in this manner violates the parity requirements for nonquantitative treatment limitations.

Different types of illnesses or injuries may require different review, as well as different care. The acute versus chronic nature of a condition, the complexity of it or the treatment involved, and other factors may affect the review. Although the processes, strategies, evidentiary stan-

[4] Several commenters stated that the estimated cost to develop interfaces between MBHOs and the entity administering medical/surgical claims would be $420,000-$750,000 per interface, and that in some cases multiple interfaces per MBHO (as many as 40–50) would be necessary. In response to these cost concerns, the Departments performed an independent analysis, which indicated that the initial cost per interface could be as low as $35,000. The Departments' lower estimated cost reflects, in part, the use of less expensive interface systems (for example, batch processing rather than real-time), and the ability to model new interfaces on existing systems used to interface with pharmacy benefit managers and dental insurers. In addition, many MBHOs already have developed interfaces, because their clients requested combined deductibles. This should result in reduced costs, because interface development costs are incremental and should decrease after the first interface is created. For a further discussion of this issue, see section IV. Economic Impact and Paperwork Burden later in this preamble.

[5] This rule in the interim final regulations prohibiting separately accumulating financial requirements and quantitative treatment limitations does not apply with respect to aggregate lifetime and annual dollar limits. The statutory language of MHPA 1996 specifically permitted plans to impose aggregate lifetime or annual dollar limits that distinguish between mental health benefits and medical/surgical benefits. MHPAEA left the language of this statutory provision intact, modifying it only to expand its applicability to include substance use disorder benefits.

dards, and other factors used in applying these limitations must generally be applied in a comparable manner to all benefits, the mere fact of disparate results does not mean that the treatment limitations do not comply with parity.

Examples in these regulations illustrate the operation of the requirements for nonquantitative treatment limitations. Medical management standards are implemented by processes such as preauthorization, concurrent review, retrospective review, case management, and utilization review; the examples feature the application of these requirements to some of these processes. The facts in the examples reflect simple situations for purposes of better illustrating the application of the rules rather than reflecting the realistic, complex facts that would typically be found in a plan. The Departments invite comments on whether additional examples would be helpful to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design.

Commenters asked if the MHPAEA requirements apply when eligibility for mental health and substance use disorder benefits under a major medical program is conditioned on exhausting some limited number of mental health and substance use disorder counseling sessions offered through an employee assistance program (EAP). Generally, the provision of mental health or substance use disorder benefits by an EAP in addition to the benefits offered by a major medical program that otherwise complies with the parity rules would not violate MHPAEA. However, requiring participants to exhaust the EAP benefits — making the EAP a gatekeeper — before an individual is eligible for the major medical program's mental health or substance use disorder benefits is a nonquantitative treatment limitation subject to the parity requirements. Consequently, if similar gatekeeping processes with a similar exhaustion requirement (whether or not through the EAP) are not applied to medical/surgical benefits, the requirement to exhaust mental health or substance use disorder benefits available under the EAP would violate the rule that nonquantitative treatment limitations be applied comparably and not more stringently to mental health and substance use disorder benefits.

The Departments received many comments addressing an issue characterized as "scope of services" or "continuum of care". Some commenters requested, with respect to a mental health condition or substance use disorder that is otherwise covered, that the regulations clarify that a plan is not required to provide benefits for any particular treatment or treatment setting (such as counseling or non-hospital residential treatment) if benefits for the treatment or treatment setting are not provided for medical/surgical conditions. Other commenters requested that the regulations clarify that a participant or beneficiary with a mental health condition or substance use disorder have coverage for the full scope of medically appropriate services to treat the condition or disorder if the plan covers the full scope of medically appropriate services to treat medical/surgical conditions, even if some treatments or treatment settings are not otherwise covered by the plan. Other commenters requested that MHPAEA be interpreted to require that group health plans provide benefits for any evidence-based treatment.

The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions. The Departments also recognize that MHPAEA prohibits plans and issuers from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than those applied to medical/surgical benefits. These regulations do not address the scope of services issue. The Departments invite comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage.

D. *Availability of Plan Information (26 CFR 54.9812–1T(d), 29 CFR 2590.712(d), and 45 CFR 146.136(d))*

MHPAEA includes two new disclosure provisions for group health plans (and health insurance coverage offered in connection with a group health plan). First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. These regulations repeat the statutory language without substantive change. The Departments invite comments on what additional clarifications might be helpful to facilitate compliance with this disclosure requirement for medical necessity criteria.

MHPAEA also provides that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary in accordance with regulations. These regulations clarify that, in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations,[6] which provide (among other things) that such disclosures must be provided automatically and free of charge. In the case of non-Federal governmental and church plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, these regulations provide that compliance with the form and manner of the ERISA claims procedure regulations for group health plans satisfies this disclosure requirement. The Departments invite comments regarding any additional clarifications that would be helpful to facilitate compliance with MHPAEA's disclosure requirements regarding denials of mental health or substance use disorder benefits.

[6] 29 CFR 2560.503–1.

E. *General Applicability Provisions (26 CFR 54.9812–1T(e), 29 CFR 2590.712(e), and 45 CFR 146.136(e))*

Paragraph (e) of these regulations addresses the applicability of these regulations to group health plans and health insurance issuers and clarifies the scope of these regulations.

1. Overview

These regulations make a number of changes to the general applicability provisions in the MHPA 1996 regulations (paragraphs (c) and (d) in those regulations). Amendments made by MHPAEA require some of these changes. For example, the MHPA 1996 rules of construction specifically excluded any plan provisions relating to cost sharing, limits on the number of visits or days of coverage, and requirements relating to medical necessity from the application of the parity requirements for aggregate lifetime and annual dollar limits. MHPAEA replaces these exclusions with a rule providing that the provisions should not be construed as affecting the terms and conditions of the plan or coverage relating to mental health and substance use disorder benefits except as provided in the rules relating to financial requirements and treatment limitations. These regulations make corresponding changes to the MHPA 1996 regulations.

These regulations also (1) establish a new rule with respect to the mental health and substance use disorder parity requirements for the determination of the number of plans that an employer or employee organization maintains, (2) combine what were in the MHPA 1996 regulations separate rules for group health plans and benefit packages, and (3) make additional clarifications.

a. *Group health plans*. In 2004, the Departments issued proposed regulations for a number of issues under Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act, including rules for determining the number of group health plans that an employer or employee organization is considered to maintain for purposes of those provisions.[7] Those proposed regulations generally would have respected the number of plans designated in the instruments governing the employer's or employee organization's arrangements to provide medical care benefits as long as the arrangements were operated pursuant to those instruments as separate plans. The 2004 proposed regulations included an anti-abuse clause, providing that, if a principal purpose of establishing separate plans was to evade any requirement of law, then the separate plans would be considered a single plan to the extent necessary to prevent the evasion.

The Departments recognized that under the 2004 proposed regulations, absent the anti-abuse clause, plan sponsors might attempt to provide mental health (and now substance use disorder) benefits under a plan that is separate from a plan that provides only medical/surgical benefits. Because the mental health (and now substance use disorder) parity requirements apply only to plans that provide both mental health or substance use disorder benefits and medical/surgical benefits, the absence of medical/surgical benefits in a plan providing mental health or substance use disorder benefits would have resulted in, absent the anti-abuse clause, the inapplicability of the parity requirements. The 2004 proposed regulations included the anti-abuse clause to avoid this kind of evasion of the parity requirements. Commenters raised problems of proof with the subjective intent element of the proposed anti-abuse clause. While the 2004 rule remains proposed, these interim final regulations include a rule for determining the number of plans that an employer or employee organization maintains for the mental health and substance use disorder parity requirements that operates irrespective of the intent of a plan sponsor. The rule is that all medical care benefits provided by an employer or employee organization constitute a single group health plan.

MHPAEA left unchanged the rule from MHPA 1996 requiring that the parity requirements be applied separately to each benefit package option under a group health plan. The MHPA 1996 regulations used the term "benefit package" rather than "benefit package option" and clarified that the parity requirements would apply separately to separate benefit packages also in situations in which the participants (or beneficiaries) had no choice between multiple benefit packages, such as where retirees are provided one benefit package and active employees a separate benefit package. Under these regulations, the statutory rule providing that the parity requirements apply separately to separate benefit package options (reflected in paragraph (c) of the MHPA 1996 regulations), the statutory rule providing that the parity requirements apply to a group health plan providing both mental health or substance use disorder benefits and medical/surgical benefits (reflected in paragraph (d) of the MHPA 1996 regulations), and the determination of how many plans an employer or employee organization maintains have been combined as a single rule in paragraph (e)(1).

The new combined rule in these regulations does not use the term benefit package. Instead, it provides that (1) the parity requirements apply to a group health plan offering both medical/surgical benefits and mental health or substance use disorder benefits, (2) the parity requirements apply separately with respect to each combination of medical/surgical coverage and mental health or substance use disorder coverage that any participant (or beneficiary) can simultaneously receive from an employer's or employee organization's arrangement or arrangements to provide medical care benefits, and (3) all such combinations constitute a single group health plan for purposes of the parity requirements. This new combined rule clearly prohibits what might have been formerly viewed as a potential evasion of the parity requirements by allocating mental health or substance use disorder benefits to a plan or benefit package without medical/surgical benefits (when medical/surgical benefits are also otherwise available). For example, if an employer with a single benefit package for medical/surgical benefits also has a separately administered benefit package for mental health and substance use disorder benefits, the parity requirements apply to the combined benefit package and the combined benefit package is considered a single plan for purposes of the parity requirements.

Similarly, if an employer offered three medical/surgical benefit packages, A, B, and C, and a mental health and substance

[7] See 69 FR 78800 (December 30, 2004).

use disorder benefit package, D, that could be combined with each of A, B , and C, then the parity requirements must be satisfied with respect to each of AD, BD, and CD. If the A benefit package had a standard option and a high option, $A_1$ and $A_2$, then the parity requirements would have to be satisfied with respect to each of $A_1D$ and $A_2D$.

b. *Health insurance issuers*. These regulations make a change regarding applicability with respect to health insurance issuers. Both the MHPA 1996 regulations and these regulations apply to an issuer offering health insurance coverage. The MHPA 1996 regulations provide that the health insurance coverage must be for both medical/surgical and mental health benefits in connection with a group health plan; the rule in these regulations provides that the health insurance coverage must be for mental health or substance use disorder benefits in connection with a group health plan subject to MHPAEA under paragraph (e)(1). Thus, under these regulations, an issuer offering health insurance coverage without any medical/surgical benefits is nonetheless subject to the parity requirements if it offers health insurance coverage with mental health or substance use disorder benefits in connection with a group health plan subject to the parity requirements. In addition, under these regulations, the parity requirements do not apply to an issuer offering health insurance coverage to a group health plan not subject to the parity requirements.

c. *Scope*. Paragraph (e)(3) of these regulations provides that nothing in these regulations requires a plan or issuer to provide any mental health or substance use disorder benefits. Moreover, the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder.

2. Interaction with State Insurance Laws

Numerous comments requested guidance on how MHPAEA interacts with State insurance laws requiring parity for, or mandating coverage of, mental health or substance use disorder benefits. Some commenters sought clarification that MHPAEA does not preempt any State insurance law mandating a minimum level of coverage (such as a minimum dollar, day, or visit level) for mental health conditions or substance use disorders. Other commenters suggested that, while MHPAEA does not preempt State insurance parity and mandate laws to the extent that they do not prevent the application of MHPAEA, provisions in the State laws that are more restrictive than the requirements of MHPAEA are preempted.

The preemption provisions of section 731 of ERISA and section 2723 of the PHS Act (added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA. The HIPAA conference report indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)

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

F. *Small Employer Exemption (26 CFR 54.9812–1T(f), 29 CFR 2590.712(f), and 45 CFR 146.136(f))*

Paragraph (f) of these regulations amends the MHPA 1996 regulations to implement the exemption for 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 this purpose, a small employer is generally defined, in connection with a group health plan with respect to a calendar year and a plan year, as an employer who employed an average of not more than 50 employees on business days during the preceding calendar year.

G. *Increased Cost Exemption (26 CFR 54.9812–1T(g), 29 CFR 2590.712(g), and 45 CFR 146.136(g))*

Both MHPA 1996 and MHPAEA include an increased cost exemption under which, if certain requirements are met, plans that incur increased costs above a certain threshold as a result of the application of the parity requirements of both these laws can be exempt from the statutory parity requirements. MHPAEA changed the MHPA 1996 increased cost exemption in several ways, including (1) raising the threshold for qualification from one percent to two percent for the first year for which the plan is subject to MHPAEA; (2) requiring certification by qualified and licensed actuaries who are members in good standing of the American Academy of Actuaries; and (3) revising the notice requirements. Under MHPAEA, plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year. Thus, the increased cost exemption may only be claimed for alternating plan years.

These regulations withdraw the MHPA 1996 regulatory guidance on the increased cost exemption and reserve paragraph (g). The Departments intend to issue, in the near future, guidance implementing the new requirements for the increased cost exemption under MHPAEA. The Departments invite comments on implementing the new statutory requirements for the increased cost exemption under MHPAEA, as well as information on how many plans expect to use the exemption.

H. *Sale of Nonparity Health Insurance Coverage (26 CFR 54.9812–1T(h), 29 CFR 2590.712(h), and 45 CFR 146.136(h))*

These regulations make a few changes to what was paragraph (g) in the MHPA 1996 regulations. That paragraph included a paragraph (g)(2) relating to how long the increased cost exemption applies once its requirements have been satisfied. It has been deleted because MHPAEA provides a new rule for how long the increased cost exemption applies. In addition, minor changes have been made to the presenta-

tion in what was paragraph (g)(1) in the MHPA 1996 regulations. Both that paragraph and paragraph (h) in these regulations address the circumstances of health insurance coverage that does not comply with the parity requirements being sold to a group health plan. The MHPA 1996 regulations refer to an issuer selling a policy; these regulations refer to an issuer selling a policy, certificate, or contract of insurance. The longer phrase in these regulations includes health insurance coverage sold in a form that might not always be described by the term "policy" and is the more typical formulation used throughout the regulations under Chapter 100 of the Code, Part 7 of ERISA, and Title XXVII of the PHS Act. An additional change shifts the emphasis by stating the rule in terms of an issuer not being able to sell except in the described circumstances, rather than in terms of an issuer being able to sell only in the described circumstances. Finally, the cross-reference contained in this paragraph to the parity requirements has been conformed to include the new requirements of MHPAEA.

I. *Applicability Dates (26 CFR 54.9812–1T(i), 29 CFR 2590.712(i), and 45 CFR 146.136(i))*

In general, the requirements of these regulations apply for plan years beginning on or after July 1, 2010. There is a special effective date for certain collectively-bargained plans, which provides that, for group health plans maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of these regulations do not apply to the plan (or health insurance coverage offered in connection with the plan) for plan years beginning before the later of either the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008) or July 1, 2010. MHPAEA provides that any plan amendment made pursuant to a collective bargaining agreement solely to conform to the requirements of MHPAEA not be treated as a termination of the agreement.

Many commenters requested guidance on what percentage of employees covered by a plan must be union employees for the plan to be considered a plan maintained pursuant to one or more collective bargaining agreements — some suggesting as low a percentage as 25 percent while others suggested 90 percent. This issue arises in a number of statutes that provide special rules for plans maintained pursuant to collective bargaining agreements. As such, the issue is beyond the scope of these regulations implementing the MHPAEA amendments and is not addressed in them.

Because the statutory MHPAEA provisions are self-implementing and are generally effective for plan years beginning after October 3, 2009, many commenters asked for a good faith compliance period from Departmental enforcement until plans (and health insurance issuers) have time to implement changes consistent with these regulations. For purposes of enforcement, the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of paragraph (i) of these regulations. However, this does not prevent participants or beneficiaries from bringing a private action.

## III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that 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, which include the provisions of MHPAEA.

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

The requirements of MHPAEA are generally effective for all group health plans and for health insurance issuers offering coverage in connection with such plans for plan years beginning after October 3, 2009. Plan administrators and sponsors, issuers, and participants and beneficiaries need guidance on how to comply with the new statutory provisions. As noted earlier, these regulations take into account comments received by the Departments in response to the request for information on MHPAEA published in the **Federal Register** on April 28, 2009 (74 FR 19155). 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.

## IV. Economic Impact and Paperwork Burden

A. *Summary—Department of Labor and Department of Health and Human Services*

As discussed earlier in this preamble, MHPAEA requires group health plans and group health insurance issuers to ensure that financial requirements (*e.g.*, copayments, deductibles) and treatment limitations (*e.g.*, visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits. Under MHPAEA, a financial requirement or treatment limitation is considered to be predominant if it is the most common or frequent of such type of requirement or limitation. Additionally, there can be no separate cost-sharing requirements or treatment limitations applicable only with respect to mental health or substance use disorder benefits. The statute does not mandate coverage for either mental health or substance use disorder bene-

fits. Thus, self-insured plans are free to choose whether to provide mental health or substance use disorder benefits; insured plans may have to provide these benefits under state laws. Either type of plan that provides mental health or substance use disorder benefits must do so in accordance with MHPAEA's parity provisions.

The Departments have crafted these regulations to secure the protections intended by Congress in as economically efficient a manner as possible. Although the Departments are unable to quantify the regulations' economic benefits, they have quantified some of the costs and have provided a qualitative discussion of some of the benefits and costs that may stem from these regulations.

B. *Statement of Need for Regulatory Action*

Congress directed the Departments to issue regulations implementing the MHPAEA provisions. In response to this Congressional directive, these interim final regulations clarify and interpret the MHPAEA provisions under section 712 of ERISA, section 2705 of the PHS Act, and section 9812 of the Code. These regulations are needed to secure and implement MHPAEA's provisions and ensure that the rights provided to participants, beneficiaries, and other individuals under MHPAEA are fully realized. The Departments' assessment of the expected economic effects of these regulations is discussed in detail below.

C. *Executive Order 12866—Department of Labor and Department of Health and Human Services*

Under Executive Order 12866 (58 FR 51735), the Department must determine whether a regulatory action is "significant" and therefore subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. The Departments have determined that this regulatory action is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an effect on the economy of $100 million or more in any one year. Accordingly, the Departments provide the following assessment of its potential costs and benefits. As elaborated below, the Department believes that the benefits of the rule justify its costs.

Table 1, below, summarizes the costs associated with the rule. The estimates are explained in the following sections. Over the ten-year period of 2010 to 2019, the total undiscounted cost of the rule is estimated to be $115 million in 2010 Dollars. Columns E and F display the costs discounted at 3 percent and 7 percent respectively. Column G shows a transfer of $25.6 billion over the ten-year period. All other numbers included in the text are not discounted, except where noted.

TABLE 1.—*Total Costs of Rule (in Millions of 2010 Dollars)*

| Year | General Review (A) | Medical Necessity Disclosure (B) | Single Deductible (C) | Total Undiscounted Costs A+B+C | Total 3% Discounted Costs (E) | Total 7% Discounted Costs (F) | Transfer (undiscounted) (G) |
|---|---|---|---|---|---|---|---|
| 2010 | $27.8 | $1.2 | $39.2 | $68.2 | $68.2 | $68.2 | $2,360.0 |
| 2011 | $0 | $1.2 | $3.9 | $5.2 | $5.0 | $4.8 | $2,400.0 |
| 2012 | $0 | $1.2 | $3.9 | $5.2 | $4.9 | $4.5 | $2,430.0 |
| 2013 | $0 | $1.2 | $3.9 | $5.2 | $4.7 | $4.2 | $2,460.0 |
| 2014 | $0 | $1.2 | $3.9 | $5.2 | $4.6 | $3.9 | $2,510.0 |
| 2015 | $0 | $1.2 | $3.9 | $5.2 | $4.4 | $3.7 | $2,570.0 |
| 2016 | $0 | $1.2 | $3.9 | $5.2 | $4.3 | $3.4 | $2,620.0 |
| 2017 | $0 | $1.2 | $3.9 | $5.2 | $4.2 | $3.2 | $2,680.0 |
| 2018 | $0 | $1.2 | $3.9 | $5.2 | $4.1 | $3.0 | $2,740.0 |
| 2019 | $0 | $1.2 | $3.9 | $5.2 | $4.0 | $2.8 | $2,810.0 |
| | | | **Total** | **$114.6** | **$108.4** | **$101.8** | **$25,600.0** |

Note: The displayed numbers are rounded to the nearest thousand and therefore may not add up to the totals.

The Departments performed a comprehensive, unified analysis to estimate the costs and, to the extent feasible, provide a qualitative assessment of benefits attributable to the regulations for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act. The Departments' assessment and underlying analysis is set forth below.

1. Regulatory Alternatives

Section 6(a)(3)(C)(iii) of Executive Order 12866 requires an economically significant regulation to include an assessment of the costs and benefits of poten-

tially effective and reasonable alternatives to the planned regulation, and an explanation of why the planned regulatory action is preferable to the potential alternatives. As discussed earlier in this preamble, the Departments considered the alternative of whether to require the same separately accumulating deductible for medical/surgical benefits and mental health or substance use disorder benefits or a combined deductible for such benefits.

The language of the statute can be interpreted to support either alternative. The comments that supported allowing separately accumulating deductibles maintained that it is commonplace for plans to have such deductibles, and that the projected cost of converting systems to permit unified deductibles would be extremely high for the many plans that use a separate managed behavioral health organization (MBHO).[8] By contrast, comments that supported requiring combined deductibles argued that allowing separately accumulating deductibles undermines a central goal of parity legislation: to affirm that mental health and substance use disorder benefits are integral components of comprehensive health care and generally should not be distinguished from medical/surgical benefits. Distinguishing between the two requires individuals who need both kinds of care to satisfy a deductible that is greater than that required for individuals needing only medical/surgical care. Other comments that supported requiring combined deductibles noted that mental health and substance use disorder benefits typically comprise only 2 to 5 percent of a plan's costs, so that even using identical levels for separately accumulating deductibles imposes a greater barrier to mental health and substance use disorder benefits.

The Departments carefully considered the alternative of requiring separately accumulating or combined deductibles. Given that the statutory language does not preclude either interpretation, the Departments choose to require combined deductibles, because this position is more consistent with the policy goals that led to the enactment of MHPAEA.

2. Affected Entities and Other Assumptions

The Departments expect MHPAEA to benefit the approximately 111 million participants in 446,400 ERISA-covered employer group health plans, and an estimated 29 million participants in the approximately 20,300 public, non-Federal employer group health plans sponsored by state and local governments.[9] In addition, approximately 460 health insurance issuers providing mental health or substance use disorder benefits in the group health insurance market and at least 120 MBHOs providing mental health or substance use disorder benefits to group health plans are expected to be affected.[10]

3. Benefits

Congress first passed mental health parity legislation in 1996 with the enactment of MHPA 1996.[11] As discussed earlier in this preamble, this law requires health insurance issuers and group health plans that offer mental health benefits to have aggregate annual and lifetime dollar limits on mental health benefits that are no more restrictive than those for all medical/surgical benefits.

The impact of MHPA 1996 was limited, however, because it did not require parity with respect to day limits for inpatient or outpatient care, deductibles, co-payments or coinsurance, substance use disorder benefits, and prescription drug coverage.[12] While a large majority of plans complied with the MHPA 1996 parity requirement regarding annual and lifetime dollar limits, many employer-sponsored group health plans contained plan design features that were more restrictive for mental health benefits than for medical/surgical benefits. For example, data on private insurance arrangements from the pre-MHPAEA era show that after MHPA 1996, the most significant disparities in coverage for mental health substance use treatment involve limits on the number of covered days of inpatient care and the number of outpatient visits. Survey data from the Kaiser/HRET national employer survey shows that 64 percent of covered workers had more restrictive limits on the number of covered hospital days for mental health care and 74 percent had more restrictive limits on outpatient mental health visits. In addition, 22 percent of covered workers had higher cost-sharing imposed on mental health care benefits. Among those workers with more restrictive limits on inpatient days, 77 percent had limits of 30 days or less.[13] For these reasons, as discussed more fully below, the Departments expect that MHPAEA and these regulations will have their greatest impact on people needing the most intensive treatment and financial protection. The Departments do not have an estimate of the number of individuals who have exceeded the treatment limits. However, according to the FEHBP data used to analyze the FEHBP parity directive in the year before its implementation, the 90th percentile of the mental health spending distribution was corresponded to $2,134 in 1999 dollars. Among the people spending at the 90th percentile or higher, 12% had inpatient psychiatric stays and 20% of those above the 90th percentile had a diagnosis of schizophrenia or bipolar disorder, chronic conditions requiring prescription drugs and regular contact with

[8] For a full discussion of the cost considerations involved with these alternatives, see section 4. b., below, Costs associated with cumulative financial requirements and quantitative treatment limitations, including deductibles.

[9] The Departments' estimates of the numbers of affected participants are based on DOL estimates using the 2008 CPS. ERISA plan counts are based on DOL estimates using the 2008 MEP-IC and Census Bureau statistics. The number of state and local government employer-sponsored plans was estimated using 2007 Census data and DOL estimates. Please note that the estimates are based on survey data that is not broken down by the employer size covered by MHPAEA making it difficult to exclude from estimates those participants employed by employers who employed an average of at least 2 but no more than 50 employees on the first day of the plan year.

[10] The Departments' estimate of the number of insurers is based on industry trade association membership. Please note that these estimates could undercount small state regulated insurers.

[11] P.L. 104–204, title VII, 110 Stat. 2874, 2944–50.

[12] GAO/HEHS–00–95, *Implementation of the Mental Health Parity Act.* In the report, GAO found that 87 percent of compliant plans contained at least one more restrictive provision for mental health benefits with the most prevalent being limits on the number of outpatient office visits and hospital day limits. *Id.* at 5.

[13] Barry, Colleen, *et al.* "Design of Mental Health Benefits: Still Unequal After All These Years," *Health Affairs* Vol. 22, Number 5, 2003. Please note that the baseline data from the Kaiser HRET survey cited in this article are weighted by region, firm size and industry to reflect the national composition of employers. So the data cited establishing the baseline reflects the impact of state parity laws. It is important to realize that state parity laws frequently focus on a subset of diagnoses, *e.g.* biologically based disorders, and do not apply to self-funded insurance programs. Thus, in most states only a minority of insurance contracts is affected by state parity laws.

mental health service providers. It is this group that experienced especially large declines in out of pocket payments after FEHBP implemented parity.

Treatment for alcohol abuse disorders showed a similar trend: Surveys indicate that 74 percent of private industry employees were covered by plans that imposed more restrictive limits for inpatient detoxification benefits than medical and surgical benefits, 88 imposed more restrictive limits for inpatient rehabilitation, and 89 percent imposed more restrictive limits for outpatient rehabilitation.[14]

After MHPA 1996, many states also passed mental health parity laws. Research focused on the impacts of parity laws found that similar to MHPA 1996, even the most comprehensive state laws resulted in little or no increase in access to and utilization of mental health services for covered individuals.[15]

To address these issues, Congress amended MHPA 1996 by enacting MHPAEA. One of Congress' primary objectives in enacting MHPAEA was to improve access to mental health and substance use disorder benefits by eliminating discrimination that existed with respect to these benefits after MHPA 1996. Congress' intent in enacting MHPAEA was articulated in a floor statement from Representative Patrick Kennedy (D-RI), one of the chief sponsors of the legislation, who said "[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society."[16] In a similar statement, Representative James Ramstad (R-MN) said, "[i]t's time to end the discrimination against people who need treatment for mental illness and addition. It's time to prohibit health insurers from placing discriminatory barriers on treatment."[17]

The Departments expect that the largest benefit associated with MHPAEA and these regulations will be derived from applying parity to cumulative quantitative treatment limitations such as annual or lifetime day or visit limits (visit limitations). As discussed above, a large percentage of plans imposed visit limitations pre-MHPAEA, and the GAO found that a major shortcoming of MHPA 1996 was its failure to apply parity to visit limitations. Applying parity to visit limitations will help ensure that vulnerable populations — those accessing substantial amounts of mental health and substance use disorder services — have better access to appropriate care. The Departments cannot estimate how large this benefit will be, because sufficient data is not available to estimate the number of covered individuals that had their benefits terminated because they reached their coverage limit. Though difficult to estimate, the number of beneficiaries who have a medical necessity for substantial amount of care are likely to be relatively small. Severe mental health disorders account for 2–3 percent of people in private health insurance plans and a substantially larger share of mental health spending. Evidenced-based treatments for severe and persistent mental illnesses like schizophrenia, bipolar disorder and chronic major depression requires prolonged (possibly lifetime) maintenance treatment that consists of pharmacotherapy, supportive counseling and often rehabilitation services.[18] The most common visit limits under current insurance arrangements are those for 20 visits per year. That means assuming a minimal approach to treatment of one visit per week, people with severe and persistent mental disorders will exhaust their coverage in about five months. This often results in people foregoing outpatient treatment and a higher likelihood of non-adherence to treatment regimes that produce poor outcomes and the potential for increased hospitalization costs.

Increased coverage also should provide enhanced financial protection for this group by reducing out-of-pocket expenses for services that previously were needed but uncovered. This should help prevent bankruptcy and financial distress for these individuals and families and reduce cost-shifting of care to the public sector, both of which occur when covered benefits are exhausted. In addition, increased coverage for those seeking substantial amounts of care potentially could reduce emergency room use by ensuring that benefits for individuals with serious conditions are not terminated. Finally, reduced entry into disability programs may result from having more complete insurance coverage for mental health and substance use disorder treatment.

Since the early 1990s, many health insurers and employers have made use of specialized vendors, known as behavioral health carve-outs to manage their mental health and substance abuse benefits. These vendors have specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers. These vendors are known as behavioral health carve-outs. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is an extensive literature that has examined the cost savings and impacts on quality of these organizations. Researchers[19] have reviewed this literature and estimated reductions in private insurance spending of 20 percent to 48 percent compared to fee-for-service indemnity arrangements. Also, it appears that the rate of utilization of mental health care rises under behavioral health carve out arrangements. The number of people receiving inpatient psychiatric care typically declines as does the average number of outpatient visits per episode.

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[14] Morton, John D. and Patricia Aleman. "Trends in Employer-provided Mental Health and Substance Abuse Benefits." *Monthly Labor Review*, April 2005.

[15] *Id.*, at 9. The state mental health parity laws varied significantly with most of differences related the following areas: the type of mental health mandate, definition of mental illness, the inclusion of substance abuse coverage, small employers' coverage, and cost increase exceptions. Few state laws provide as extensive coverage as MHPAEA, particularly with regard to its prohibition of visit limitations.

[16] 153 *Cong. Rec. S1864–5 (daily ed., February 12, 2007).*

[17] 154 *Cong. Rec. H8619 (daily ed., September 23, 2008).*

[18] See, Lehman AF "Quality of care in mental health: the case of schizophrenia" Health Affairs 18(5): 52–65.

[19] Sturm R, "Tracking changes in behavioral health services: How carve-outs changed care?" Journal of Behavioral Health Services and Research 26(4): 360–371, 1999. Frank RG and Garfield RL; "Managed Behavioral Health Carve-Outs: Past Performance and Future Prospects" *Annual Reviews of Public Health 2007*, 28:11; 1–18. Frank RG and Garfield RL; "Managed Behavioral Health Carve-Outs: Past Performance and Future Prospects" *Annual Reviews of Public Health 2007*, 28:11; 1–18.

The OPM encouraged its insurers to consider carve-out arrangements when implementing the parity directive in 2000 for the FEHBP. This is because of the ability of behavioral health carve-outs to use utilization management tools to control utilization and spending in the face of reductions in cost-sharing and elimination of limits. Thus, parity in a world dominated by behavioral carve-outs has meant increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity.

Another potential benefit associated with MHPAEA and these regulations is that use of mental health and substance use disorder benefits could improve.[20] Untreated or under treated mental health conditions and substance use disorders are detrimental to individuals and the entire economy. Day and visit limits can interfere with appropriate treatment thereby reducing the impact of care for workers seeking treatment. Many people with mental health conditions and substance use disorders are employed and these debilitating conditions have a devastating impact on employee attendance and productivity, which results in lost productivity for employers and lost earnings for employees. For example, studies have shown that the high prevalence of depression and the low productivity it causes have cost employers $31 billion to $51 billion annually in lost productivity in the United States.[21] More days of work loss and work impairment are caused by mental illness than by various other chronic conditions, including diabetes and lower back pain.[22]

Moreover, studies have consistently found that workers who report symptoms of mental disorders have lower earnings than other similarly-situated coworkers. For example, a recent study funded by the National Institutes of Health's National Institute of Mental Health[23] found that mental disorders cost employees at least $193 billion annually in lost earnings alone, a staggering number that probably is a conservative estimate because it did not include the costs associated with people in hospitals and prisons, and included very few participants with autism, schizophrenia and other chronic illnesses that are known to greatly affect a person's ability to work. The study also noted that individuals suffering from depression earn 40 percent less than non-depressed individuals.

Although accurately determining cause and effect can be difficult, studies have attempted to estimate the beneficial impact of treating mental disorders. One study found that treating individuals suffering from mental disorders helped close the gap in productivity between those with mental disorders and those who did not have a mental disorder.[24] The finding that treatment can help increase the productivity of those suffering from mental illness suggests that increasing access to treatment of mental disorders could have a beneficial impact on lost productivity cost and lost earnings that stem from untreated and under treated mental health conditions and substance use disorders. The Departments, however, do not have sufficient data to determine whether this result will occur, and, if it does, the extent to which lost productivity cost and lost earnings could improve.

As noted above the combination of reduced cost sharing and the elimination of day and visit limits have the effect of making coverage more complete. The dominant role of managed behavioral health care in the market and the evidence about it success in controlling costs means that the moral hazard problem can be controlled (the evidence on this is discussed in more detail below). The implication is that more complete financial protection can be offered to people without a significant increase in social costs. This implies improved efficiency in the insurance market since more efficient risk spreading would occur without much welfare loss due to moral hazard.

In order to comply with MHPAEA and these regulations, cost-sharing requirements for mental health and substance use disorder benefits cannot be any more restrictive than the predominant cost-sharing requirement applied to substantially all medical/surgical benefits. Because expenditures on mental health and substance use disorder benefits only comprise 3–6 percent of the total benefits covered by a group health plan and 8 percent of overall healthcare costs,[25] the Departments expect that group health plans will lower cost-sharing on mental health and substance use disorder benefits instead of raising cost-sharing on medical/surgical benefits.

MHPAEA and these interim final regulations could have a positive impact on the delivery system of mental health services. Currently, approximately half of mental health care is delivered solely by primary care physicians.[26] This trend is likely due in part to the large discrepancies between

[20] While studies have shown that state parity laws have increased access only marginally, most state laws still allowed disparate treatment limits for mental health conditions and substance use disorders, which limited access for those needing significant amounts of treatment. As discussed above, MHPAEA and these regulations prohibit the imposition of such disparate limits, which could increase access for those individuals. Nine states have treatment limit requirements similar to MHPAEA for mental health benefits, while 10 states have similar requirements for substance abuse disorder benefits.

[21] Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association.* 289, *23*, 3135–3144.

Kessler, R.C., Akiskal, H.S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, H.M.A. *et al.* (2006). "Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers." *American Journal of Psychiatry*, 163, 1561–1568.

[22] Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association.* 289, *23*, 3135–3144.

[23] Kessler, Ronald C., Steven Heeringa, Matthew D. Lakoma, Maria Petukhova, Agnes E. Rupp, Michael Schoenbaum, Philip S. Wang, and Alan M. Zaslavsky. "Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication."
*The American Journal of Psychiatry*; June 2008; 165, 6; Research Library pg. 703.

[24] Hilton, Michael F., Paul A. Schuffham, Judith Sheridan, Catherine M. Clearly, Neria Vecchio, and Harvey A. Whiteford. "The Association Between Mental Disorders and Productivity in Treated and Untreated Employees." *Journal of Occupational and Environmental Medicine*. Volume 51, Number 9, September 2009.

[25] Finch R.A., Phillips K.. Center for Prevention and Health Services. "An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating Designing, and Implementing Behavioral Health Services." National Business Group on Health 2005.

[26] Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., and Kessler, R.C. (2005, June). "Twelve month use of mental health services in the United States." *Archives of General Psychiatry*, 62, 629–640. The study found that 40 percent of people reporting mental health and substance use disorders receive some treatment in a year.

insurance cost-sharing for services delivered by mental health professionals and primary care physicians. Historically, the cost-sharing associated with primary care physician visits is lower than cost-sharing for mental health professional visits. This difference in the relative price encouraged patients suffering from mental illness to visit primary care physicians for mental health-related conditions. If MHPAEA and these regulations result in lowering the relative price of mental health care, more individuals suffering from mental illness could visit and receive care from mental health professionals. One study[27] found that only 12.7 percent of individuals treated in the general medical sector received at least minimally adequate mental health care compared to 48.3 percent of patients treated in the specialty mental health sector.[28] A shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes.[29] The Departments, however, do not have sufficient data to estimate how large this shift in treatment could be or determine whether it will occur.

Mental health and physical health are interrelated, and individuals with poor mental health are more likely to have physical health problems as well. Increased access and utilization of mental health and substance use disorder benefits could result in a reduction of medical/surgical costs for individuals afflicted with mental health conditions and substance use disorders. The decrease in medical/surgical costs could be significant; however, the Departments do not have sufficient data to estimate how large these health care spending offsets could be or determine whether they will occur.

There is disagreement among experts as to whether depression is an important antecedent risk factor for physical illness or whether the causal relationship acts in the opposite direction. Regardless, there is evidence that comorbid depression worsens the prognosis, prolongs recovery and may increase the risk of mortality associated with physical illness. In addition, comorbid depression has been shown to increase the costs of medical care, over and above the costs of treating the depression itself.[30]

The returns on investment from treatment of substance use disorders can be large.[31] Studies in Washington state clinics demonstrated that each dollar invested in inpatient and outpatient substance abuse treatment yielded returns of about 10 and 23 times their initial investments, respectively.[32] California and Oregon state treatment systems demonstrated a sevenfold return in their investments.[33] Other studies show effects ranging from a return of one and a half times the cost in a large study of a treatment clinic in Chicago to a return of 5 times the initial investment for a treatment for mentally ill chemical abusers,[34] resulting in a net benefit of about $85,000 per client for an investment of nearly $20,000.[35]

4. Costs

a. *Cost associated with increased utilization of mental health and substance use disorder benefits*. As discussed in the Benefits section earlier in this preamble, one of Congress' primary objectives in enacting MPHAEA was to eliminate barriers that impede access to and utilization of mental health and substance use disorder benefits. This has raised concerns among some that increased access and utilization of mental health and substance use disorder benefits will result in increases in associated payments and plan expenditures, which could lead to large premium increases that will make mental health and substance use disorder benefits unaffordable. The Departments are uncertain regarding the level of increased costs and premium increases that will result from MHPAEA and these regulations, but there is evidence that any increases will not be large.

One theory for increased costs resulting from parity is based on the fact that cost-sharing for mental health and substance use disorder benefits will decrease. A frequent justification for higher cost-sharing of mental health and substance use disorder benefits is the greater extent of moral hazard for these benefits; individuals will utilize more mental health and substance use disorder benefits at a higher rate when they are not personally required to pay the cost. To support this

[27] Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., and Kessler, R.C. (2005, June). "Twelve month use of mental health services in the United states." *Archives of General Psychiatry*, 62, 629–640.

[28] Another analysis demonstrating poor adherence to evidence-based treatment for mental disorders is:
Wang PS, Berglund P, Kessler RC, *Journal of General Internal Medicine*. 2000; 15:284–292. Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. This study finds that only 57.3 percent of people with major depression receive treatment during a year and less than one-third of those who receive treatment receive effective treatment.

Based on expert opinion, Normand *et al.* rated the likely effectiveness of combinations of general medical visits, specialty visits (with psychotherapy) and drug treatment to demonstrate the correlation between adequate treatment for depression and the probability of remission. For patients with no anti-depressant medication, the probability of remission increased as the number of specialty visits increased from one or less during a year to ten or more. The probability of remission was greater for patients with antidepressant medication and improved with more specialty visits during the year. Normand SLT, Frank RG, McGuire, TG. "Using elicitation techniques to estimate the value of ambulatory treatments for depression." Medical Decision Making, 2001; 22: 245–261.

[29] The Healthcare Effectiveness Data and Information Set report card for 2007 produced by National Center for Quality Assurance shows that for treatment of depression, only 20 percent of patients get appropriate levels of provider contacts; about 45 percent receive appropriate maintenance level medications and 62 percent obtain adequate medication doses and duration during the acute phase of illness.

[30] Conti R, Berndt ER, Frank RG. "Early retirement and DI/SSI applications: exploring the impact of depression", in Culter DM, Wise DA. *Health in Older Ages*: *The causes and consequences of declining disability among the elderly*, (Chicago: National Bureau of Economic Research, 2008).

[31] The Office of National Drug Control Policy has information on effective treatment and cost savings at *www.whitehousedrugpolicy.gov*.

[32] French, M. T., H. J. Salome, A. Krupski, J. R. McKay, D. M. Donovan, A. T. McLellan, and J. Durrell. (2000). "Benefit-cost analysis of residential and outpatient addiction treatment in the State of Washington." *Evaluation Review, 24(6)*, 609–634.

[33] Ettner, S. L., D. Huang, E. Evans, D. R. Ash, M. Hardy, M. Jourabchi, and Y. Hser. (2006). "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself?'" *Health Services Research*, 41(1), 192–213.

[34] French, M.T., K. E. McCollister, S. Sacks, K. McKendrick, & G. De Leon. (2002). "Benefit cost analysis of a modified therapeutic community for mentally ill chemical abusers." *Evaluation and Program Planning*, 25, 137–148.

[35] The returns are the ratio of benefits to costs. Benefits include personal as well as societal benefits including increased employment and reduced crime.

assumption, many have cited the RAND Health Insurance Experiment, conducted in 1977–1982, which demonstrated that individuals are more likely to increase their mental health care usage when their personal cost-sharing for mental health care services fall than they are to increase their physical health care usage when their personal cost-sharing for physical health care services decreases. Because this experiment was conducted nearly thirty years ago, researchers recently tested to determine whether this result held true.[36] Their results indicate that individuals' sensitivity to changes in cost-sharing may have changed significantly over time. These changes are explained at least in part due to the expansion of managed behavioral health care (described earlier). The authors found that individuals' price responsiveness of ambulatory mental health treatment is now slightly lower than physical health treatment. These results indicate that if plans lower the cost-sharing associated with mental health services, costs will not rise as much as would be expected using the results from the RAND Experiment.[37]

When the RAND Experiment was conducted, managed care was not nearly as prevalent as it is today. Health care economists have studied the impact of using cost control techniques associated with managed care to reduce the quantity of mental health and substance use disorder benefits utilized so that lowered cost sharing may result in only a small increase in spending.[38] This research concluded that "comprehensive parity implemented in the context of managed care would have little impact on total spending."[39]

These findings were similar to those of a recent study published in the New England Journal of Medicine examining the Federal Employees Health Benefits Program (FEHBP), which implemented parity for mental health and substance use disorder benefits in 2001.[40] The primary concern has been that the existence of parity in the FEHBP would result in large increases in the use of mental health and substance-abuse services and spending on these services. However, the study concluded that these fears were unfounded and "that parity of coverage of mental health and substance-abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs."[41] The study found average per user declines in out patient cost sharing of between zero and $87 depending on the plan. The reductions were largest for high users of mental health care. The study also found that insurers were not likely to drop out of the FEHBP pool due to the implementation of parity.

The experience of states that have enacted mental health parity laws with appropriate managed care also suggests that minimal increased cost results from implementing parity. One study found that "with the implementation of mental health parity at the same time as managed behavioral health care, many states have discovered that overall health care costs increased minimally and in some cases even were reduced."[42] For example, at least nine states — California, Maine, Maryland, Minnesota, North Carolina, Pennsylvania, Rhode Island, South Carolina, and Vermont — have actually documented experience that implementing mental health parity including cost controls through managed care resulted in lower costs and lowered premiums (or at most, very modest cost increases of less than one percent) within the first year of implementation.[43]

Similarly, the Departments expect medical management and managed care techniques will help control any major cost impact resulting from MHPAEA and these regulations. As discussed earlier in this preamble, these regulations provide that medical management can be applied to mental health and substance use disorder benefits by plans as long as any processes, strategies, evidentiary standards, or other factors used in applying medical management are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying medical management to medical/surgical benefits.

Although the increase in per plan costs associated with parity is not likely to be substantial, there may be plans that decide to drop coverage for mental health and substance use disorder benefits in response to higher costs, or individuals may decide to drop coverage even if it is offered. The Departments do not have an estimate of the number of plans that will drop coverage or the number of individuals that will lose benefits. Currently 98 percent of covered workers have some form of mental health benefits.[44] The lack of coverage for mental health and substance use disorder benefits for these people may lead to many of the typical costs associated with uninsured individuals: lack of access, decreased health, and increased financial burden. The Departments are not able to quantify these costs. Research on the introduction of state parity laws suggests few plans or individ-

[36] Meyerhoefer, Chad D. and Samuel Zuvekas, 2006. "New Estimates of the Demand for Physical and Mental Health Treatment." Agency for Healthcare Research and Quality Working Paper No. 06008

[37] Another paper showing a similar result to the Myerhoefer paper cited above is: Lu CL, Frank, RG and McGuire TG. "Demand Response Under Managed Care." *Contemporary Economic Policy*, 27(1):1–15, 2009.

[38] Barry, Frank, and McGuire. "The Costs of Mental Health Parity: Still an Impediment?" *Health Affairs*, no. 3:623 (2006).

[39] *Id.*

[40] Goldman, *et al.*, "Behavioral Health Insurance Parity for Federal Employees," New England Journal of Medicine (March 30, 2006) Vol. 354, No. 13. In 1999, President Clinton directed the Office of Personnel Management (OPM) to equalize benefits coverage in the FEHBP, and parity was implemented in 2001. Parity under the FEHBP is very similar to MHPAEA. It requires benefits coverage for plan mental health, substance abuse, medical, surgical, and hospital providers to have the same limitations and cost-sharing such as deductibles, coinsurance, and co-pays. When patients use plan providers and follow a treatment regime approved by their plan, all diagnostic categories of mental health and substance abuse conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) are covered.

[41] *Id.*

[42] Melek, Steve, "The Costs of Mental Health Parity," *Health Section News* (March 2005).

[43] Bachman, Ronald, *Mental Health Parity — Just the Facts* (2000).

[44] Kaiser Family Foundation and Health Research & Educational Trust. *Employer Health Benefits 2008 Annual Survey*.

uals will drop insurance coverage due to parity.[45]

b. *Costs associated with cumulative financial requirements and quantitative treatment limitations, including deductibles*. As discussed earlier in this preamble, paragraph (c)(3)(v) of these regulations provide that a group health plan may not apply cumulative financial requirements, such as deductibles, for mental health and substance use disorder benefits in a classification that accumulate separately from any such requirements or limitations established for medical/surgical benefits in the same classification. Some group health plans and health insurance issuers "carve-out" the administration and management of mental health and substance use disorder benefits to MBHOs. These entities obtain cost savings for plan sponsors by providing focused case management and directing care to a broad network of mental and behavioral health specialists (with whom they negotiate lower fees) who ensure that appropriate care for mental health conditions and substance use disorders is provided.[46]

When a group health plan or health insurance issuer uses a carve-out arrangement, at least two entities are involved in separately managing and administering medical/surgical and mental health and substance use disorder benefits.[47] The imposition of a single deductible requires entities providing medical/surgical and mental health and substance use disorder benefits to develop and program a communication network often referred to as an "interface" or an "accumulator" that will allow them to exchange the data necessary to make timely and accurate determinations of when participants have incurred sufficient combined medical/surgical and mental health and substance use disorder expenses to satisfy the single deductible.

Two comments received in response to the RFI indicate that MBHOs would confront significant costs to develop real-time interfaces that could range from $420,000-$750,000 with an additional $40,000-$70,000 required for annual maintenance.[48] The Departments held discussions with the regulated community which indicated that interface development costs may not be as high as stated in the RFI comments. For example, the Departments have learned that MBHOs could develop less costly "batch process" interfaces that exchange data on a daily or weekly basis rather than real-time for as low as approximately $35,000 per interface.[49]

It also appears that some plan sponsors using carve-out arrangements already are implementing a unified, single deductible, and MBHOs have created interfaces to service these clients. For example, the Departments' discussions found that one MBHO already has established 10–15 accumulators, because its plan sponsor clients requested a single deductible. The MBHO reported that another 10–15 accumulators were being implemented for the current benefit year, because plan sponsors wanted to ensure that they were compliant with MHPAEA. This finding suggests that while costly, putting these accumulators in place is not cost prohibitive for the MBHOs and plan sponsors. Moreover, plans and issuers have created and used interfaces with separate pharmacy benefit managers and dental insurers for years. Interface development costs should decrease after the first interface is created. The experience and lessons learned from creating these interfaces should reduce the cost associated with designing and implementing interfaces with MBHOs.

While the RFI comment letters suggested that MBHOs would have to create 40–50 interfaces each, this number most likely only relates to the largest MBHOs. The smallest MBHOs would need to create fewer interfaces. The Departments assume that a significant number of smaller MBHOs exist; therefore, the Departments estimate that, on average, seven interfaces would have to be created per insurer. The Departments acknowledge that there is uncertainty in this estimate due to incomplete information about the MBHO industry.

For purposes of this analysis, the Departments have used an estimated interface development cost of $35,000 per interface, because the Departments were not able to substantiate the higher estimated costs provided in the RFI comment letters, and the propensity of the evidence leads to the conclusion that the cost could be significantly less. Based on the foregoing, the Departments estimate total interface development costs of approximately $39.2 million.[50]

Once the interfaces are created, ongoing annual maintenance costs will be incurred. One industry source suggested that ongoing maintenance costs could be one-tenth of the development costs, and based on this information, the Departments estimate that maintenance cost of $3.9 million will be incurred annually after the interfaces are created.

While the total interface development and maintenance costs are large, a useful measure to examine is the per-participant cost impact. While reliable estimates of the number of participants enrolled in plans utilizing MBHOs are not available, based on the best available information, the Departments estimate that at least 70 million participants are covered by MBHOs. Based on this count, the per-participant first year interface development costs would be $0.60, and the maintenance costs in subsequent years would be less than one cent.

Comments from health insurance issuers have suggested that the costs of

[45] Cseh, Attila. "Labor Market Consequences of State Mental Health Parity Mandates," Forum for Health Economics & Policy, Vol. 11, issue 2, 2008.

[46] Research papers have indicated that carve-out arrangements have reduced the cost of proving mental health and substance use disorder benefits by an estimated 25–40 percent. Frank, Richard G. and Thomas G. McGuire, "Savings from a Carve-Out Program for Mental Health and Substance Abuse in Massachusetts Medicaid" Psychiatric Services 48(9); 1147–1152, 1997; Ma, Ching-to Albert and Thomas G. McGuire, "Costs and Incentives in a Behavioral Health Carve-out. *Health Affairs* March/April 1998.

[47] This can create a coordination issue that has cost implications that otherwise do not exist when a single vendor is used.

[48] RFI comments. MHPAEA RFI comments can be viewed at *http://www.dol.gov/ebsa/regs/cmt-MHPAEA.html*.

[49] An additional undetermined expense would be required to reconcile and make adjustments in instances when two claims are received on the same day satisfying the unified deductible. While this alternative would produce a much lower cost than real-time interfaces, the costs remain significant. A low-end estimate of the first year cost for MBHOs and insurers to create, on average, at least 20 new interfaces would be $700,000 per insurer. There is uncertainty regarding the total cost, because the number of entities that would need to create interfaces is unclear. The Departments are aware of 460 health insurance issuers and at least 120 MBHOs that could be affected.

[50] Please note that using the $420,000 per interface estimate cited in the RFI comment letters would result in total interface development costs of $470 million, with annual maintenance costs of $47 million. Based on this estimate, the per-participant first year interface development costs would be $7, and the annual maintenance costs in subsequent years would be $.06 cents per participant per month.

creating these interfaces would be passed on to participants in the form of higher premiums; however, no independent information has been found to corroborate this assertion.

c. *Compliance review costs*. The Departments expect that group health plans and health insurance issuers will conduct a compliance review to ensure that their plan documents, summary plan descriptions, and any associated policies and procedures comply with the requirements of MHPAEA and these regulations. While the Departments do not know the total number of issuers that will be affected by the regulations, the Departments estimate that there are approximately 460 issuers operating in the group market. In addition, the Departments are aware of at least 120 MBHOs.[51] The Departments believe smaller MBHOs exist but were unable to obtain a count.

The Departments assume that insured plans will rely on the issuers providing coverage to ensure compliance, and that self-insured plans will rely on third-party administrators to ensure compliance. The per-plan compliance costs are expected to be low, because vendors and issuers will be able to spread these costs across multiple client plans. These regulations provide examples illustrating the application of the rules to specific situations, which are intended to reduce the compliance burden.

The Departments assume that the average burden per plan will be one-half hour of a legal professional's time at an hourly labor rate of $120 to conduct the compliance review and make the needed changes to the plan and related documents. This results in a total cost of $27.8 million in the first year. The Departments welcome public comments on this estimate.

d. *Costs associated with MHPAEA disclosures*. MHPAEA and these regulations contain two new disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan that are addressed in paragraph (d) of the rules.

(1) *Medical necessity disclosure*. The first disclosure requires plan administrators to make the plan's medical necessity determination criteria available upon request to potential participants, beneficiaries, or contracting providers. The Departments are unable to estimate with certainty the number of requests that will be received by plan administrators based on this requirement. However, the Departments have assumed that, on average, each plan affected by the rule will receive one request. For purposes of this estimate, the Departments assume that it will take a medically trained clerical staff member five minutes to respond to each request at a labor rate of $26.85 per hour resulting in an annual cost of approximately $1,044,000.[52]

The Departments also estimated the cost to deliver the requested criteria for medical necessity determinations. Many insurers already have the information prepared in electronic form, and the Departments assume that 38 percent[53] of requests will be delivered electronically resulting in a *de minimis* cost. The Departments estimate that the cost associated with distributing the approximately 290,000 requests sent by paper will be approximately $192,000.[54]

(2) *Claims denial disclosure*. MHPAEA and these regulations also provide that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary. The Department of Labor's ERISA claims procedure regulation (29 CFR 2560.503–1) requires, among other things, such disclosures to be provided automatically to participants and beneficiaries free of charge. Although non-ERISA covered plans, such as plans sponsored by state and local governments that are subject to the PHS Act, are not required to comply with the ERISA claims procedure regulation, these regulations provide that such plans (and health insurance coverage offered in connection with such plans) will be deemed to satisfy the MHPAEA claims denial disclosure requirement if they comply with the ERISA claims procedure regulation.

For purposes of this cost analysis, the Departments assume that non-Federal governmental plans will satisfy the safe harbor, because the same third-party administrators and insurers are hired by ERISA- and non-ERISA-covered plans, and these entities provide the same claims denial notifications to participants covered by ERISA- and non-ERISA-covered plans. Therefore, based on the foregoing, the Departments have not included a cost for plans to provide the claims denial disclosures.

5. Transfer resulting for premium increase due to MHPAEA

The evaluation of mental health and substance use disorder parity in the Federal Employees Health Benefit Program (FEHBP) estimated the overall impact of parity on total spending for mental health and substance use disorder services relative to a set of control plans that did not experience any increase in mental health coverage.[55] That evaluation also assessed changes in out-of-pocket spending. The overall results on total mental health and substance use disorder (MH/SUD) spending (health plan spending plus out of pocket spending) showed essentially no significant increase in total MH/SUD spending. The evaluation also showed that in general parity resulted in a statistically significant decrease in out-of-pocket spending. This means that while there was no increase in the total spending on MH/SUD services there was a significant shift in the final responsibility for paying for these services. In other words, health plan spending expanded due to par-

[51] There are about 460 issuers in the group market; this is an average of 1,000 plans per issuers. In addition, there are at least 120 MBHOs.

[52] EBSA estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index (June 2009, Bureau of Labor Statistics).

[53] For purposes of this burden estimate, the Departments assume that 38 percent of the disclosures will be provided through electronic means in accordance with the Department's standards for electronic communication of required information provided under 29 CFR 2520.104b–1(c).

[54] This estimate is based on an average document size of four pages, $.05 cents per page material and printing costs, $.44 cent postage costs.

[55] Goldman, *et al.*, "Behavioral Health Insurance Parity for Federal Employees," New England Journal of Medicine (March 30, 2006) Vol. 354, No. 13.

ity. The magnitude of the change implies an estimated increase in total health care premiums of 0.4 percent.[56] Thus the 0.4 percent increase derived from the FEHBP evaluation is due entirely to a shift in final responsibility for payment.

The Congressional Budget Office[57] estimated the direct and indirect costs to the private and public sector of implementing MHPAEA and similarly found that health insurance premiums would go up by approximately 0.4 percent. The FEHBP estimate contrasts with the CBO estimate, because the CBO estimate appears to include some shift in final payment along with an increase in service utilization.

The Departments estimate that total health care premiums will rise 0.4 percent due to MHPAEA based on data and analysis from the FEHBP evaluation. The premium increase is a transfer from those not using MH/SUD benefits to those who do, because given the size of the estimated impacts and the known changes in coverage from baseline discussed earlier in this Regulatory Impact Analysis, any change in utilization must be very small again suggesting that premium changes were primarily due to a shift in responsibility for final payments for MH/SUD care.

Using data on private health insurance premiums from the National Health Expenditure Projections[58] and data on premiums for individual insurance[59] from the National Association of Insurance Commissioners, the Departments estimate that the dollar amount of the 0.4 percent premium increases attributable to MHPAEA would be approximately $25.6 billion over the ten-year period 2010–2019. The ten-year value using a discount rate of seven percent is $19.0 billion, and it is $22.4 billion using a three percent discount rate. Yearly estimates are reported in Table 1, column G. Due to the magnitude of this transfer, this regulatory action is economically significant pursuant to section 3(f)(1) of Executive Order 12866.

D. *Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services*

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Under Section 553(b) of the Administrative Procedures Act (APA), 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 interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the rule would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. The Departments expect the rules to reduce the compliance burden imposed on plans and insurers by clarifying definitions and terms contained in the statute and providing examples of acceptable methods to comply with specific provisions. The Departments believe that the rule's impact on small entities will be minimized by the fact that MHPAEA does not apply to small employers who have between two and 50 employees.

E. *Special Analyses-Department of the Treasury*

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

F. *Paperwork Reduction Act*

1. Departments of Labor and the Treasury

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)). This 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.

As discussed earlier in this preamble, MHPAEA includes two new disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan. First, the criteria for medical necessity determi-

[56] The estimated .04 percent increase was derived from an authors' final calculation based on data from the report cited in the previous footnote.

[57] Congressional Budget Office Cost Estimate on H.R. 1424-Paul Wellstone Mental Health and Addiction Equity Act of 2007, 21 November 2007.

[58] National Health Expenditures Projections 2008–2018, Centers for Medicare & Medicaid Services, Office of the Actuary, *http://www.cms.hhs.gov/NationalHealthExpendData/*.

[59] The National Health Expenditure estimate of total spending on private health insurance includes premiums for purchases made in the individual market, which is not affected by MHPAEA. Therefore it needs to be subtracted from the total. The NAIC data does not contain information from California; therefore, an adjustment based on the number of lives covered in California and average premiums was used to impute a value for California.

nations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request ("medical necessity disclosure").

MHPAEA also requires the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations ("claims denial notice").

The MHPAEA disclosures are information collection requests (ICRs) subject to the PRA. The Departments are not soliciting comments concerning an ICR pertaining to the claims denial notice, because the Department of Labor's ERISA claims procedure regulation (29 CFR 2560.503–1) requires (among other things) ERISA-covered group health plans to provide such disclosures automatically to participants and beneficiaries free of charge. Although non-ERISA covered plans, such as certain church plan under Treasury/IRS jurisdiction and plans sponsored by state and local governments that are subject to the PHS Act and under HHS jurisdiction (these plans are discussed under the HHS ICR discussion below) are not required to comply with the ERISA claims procedure regulation, these regulations provide that such plans (and health insurance coverage offered in connection with such plans) will be deemed to satisfy the MHPAEA claims denial disclosure requirement if they comply with the ERISA claims procedure regulation. For purposes of this PRA analysis, the Departments assume that non-ERISA plans will satisfy the safe harbor, because the same third-party administrators and insurers are hired by ERISA- and non-ERISA-covered plans, and these entities provide the same claims denial notifications to participants covered by ERISA- and non-ERISA-covered plans. Therefore, the Departments hereby determine that the hour and cost burden associated with the claims denial notice already is accounted for in the ICR for the ERISA claims procedure regulation that is approved under OMB Control Number 1210–0053.

Currently, the Departments are soliciting comments concerning the medical necessity disclosure. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the 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 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, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395–7285 or by email to *oira_submission@omb.eop.gov*. Although comments may be submitted through April 5, 2010, OMB requests that comments be received within 30 days of publication of these interim final regulations to ensure their consideration. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–4745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at reginfo.gov *(http://www.reginfo.gov/public/do/PRAMain)*.

The Departments are unable to estimate with certainty the number of requests for medical necessity criteria disclosures that will be received by plan administrators; however, the Departments have assumed that, on average, each plan affected by the rule will receive one request. The Departments estimate that approximately 93 percent of large plans and all small plans administer claims using service providers; therefore, 5.1 percent of the medical necessity criteria disclosures will be done in-house. For PRA purposes, plans using service providers will report the costs as a cost burden, while plans administering claims in-house will report the burden as an hour burden.

The Departments assume that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of $27 per hour. This results in an annual hour burden of nearly 1,900 hours and an associated equivalent cost of nearly $51,000 for the approximately 23,000 requests done in-house by plans. The remaining 424,000 medical necessity criteria disclosures will be provided through service providers resulting in a cost burden of approximately $950,000.

The Departments also calculated the cost to deliver the requested medical necessity criteria disclosures. Many insurers and plans already may have the information prepared in electronic form, and the Departments assume that 38 percent of requests will be delivered electronically resulting in a *de minimis* cost. The Departments estimate that the cost burden associated with distributing the approximately 277,000 medical necessity criteria disclosures sent by paper will be approximately $177,000.[60] The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR

[60] This estimate is based on an average document size of four pages, $.05 cents per page material and printing costs, $.44 cent postage costs.

unless the ICR has a valid OMB control number.[61]

These paperwork burden estimates are summarized as follows:

*Type of Review*: New collection.

*Agencies*: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury,

*Title*: Notice of Medical Necessity Criteria under the Mental Health Parity and Addition Equity Act of 2008.

*OMB Number*: 1210-NEW; 1545-NEW.

*Affected Public*: Business or other for-profit; not-for-profit institutions.

*Total Respondents*: 446,400.

*Total Responses*: 446,400.

*Frequency of Response*: Occasionally.

*Estimated Total Annual Burden Hours*: 950 hours (Employee Benefits Security Administration); 950 hours (Internal Revenue Service).

*Estimated Total Annual Burden Cost*: $562,500 (Employee Benefits Security Administration); $562,500 (Internal Revenue Service).

2. Department of Health and Human Services

Under the PRA, we are required to provide 30-days 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:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

*ICRs Regarding Parity in Mental Health and Substance Use Disorder Benefits. (45 CFR §146.136(d))*

As discussed above, MHPAEA includes two new disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan. First, the criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available in accordance with regulations by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request ("medical necessity disclosure").

MHPAEA also requires the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations ("claims denial disclosure").

*Medical Necessity Disclosure*

The Department estimates that there are 29.1 million participants covered by 20,300 state and local public plans that are subject to the MHPAEA disclosure requirements that are employed by employers with more than 50 employees.[62]

The Department is unable to estimate with certainty the number of requests for medical necessity criteria disclosures that will be received by plan administrators; however, the Department has assumed that, on average, each plan affected by the rule will receive one request. CMS estimates that approximately 93 percent of large plans administer claims using third party providers. Furthermore the vast majority of all smaller employers usually are fully insured such that issuers will be administering their claims. Therefore 5.1 percent of claims are administered in-house. For plans that use issuers or third party providers the costs are reported as cost burden while for plans that administer claims in-house the burden is reported as an hour burden. For purposes of this estimate, the Department assumes that it will take a medically trained clerical staff member five minutes to respond to each request at a wage rate of $26.85 per hour. This results in an annual hour burden of 86 hours and an associated equivalent cost of about $2,300 for the approximately 1,000 requests handled by plans. The remaining 19,300 claims (94.9 percent) are provided through a third-party provider or an issuer and results in a cost burden of approximately $43,000.

*Claims Denial Disclosure*

MHPAEA requires plans to disclose to participants and beneficiaries upon request the reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits. The Department of Labor's ERISA claims procedure regulation (29 CFR 2560.503–1) requires, among other things, such disclosures to be provided automatically to participants and beneficiaries free of charge. Although non-ERISA covered plans, such as plans sponsored by state and local governments that are subject to the PHS Act, are not required to comply with the ERISA claims procedure regulation, the interim final regulations provide that these plans (and health insurance coverage offered in connection with such plans) will be deemed to satisfy the MHPAEA claims denial disclosure requirement if they comply with the ERISA claims procedure regulation.

Using assumptions similar to those used for the ERISA claims procedure regulation, the Department estimates that there will be approximately 29.7 million claims for mental health or substance use disorder benefits with approximately 4.45 million

[61] 5 CFR 1320.1 through 1320.18.

[62] Non-Federal governmental plans may opt-out of MHPAEA and certain other requirements under Section 2721 of the PHS Act. Since past experience has shown that the number of non-Federal governmental plans that opt-out is small, the impact of the opt-out election should be immaterial on the Department's estimates.

denials that could result in a request for an explanation of reason for denial. The Department has no data on the percent of denials that will result in a request for an explanation, but assumed that ten percent of denials will result in a request for an explanation (445,000 requests).

The Department estimates that a medically trained clerical staff member may require five minutes to respond to each request at a labor rate of $27 per hour. This results in an annual hour burden of nearly 1,900 hours and an associated equivalent cost of nearly $51,000 for the approximately 22,700 requests completed by plans. The remaining 422,300 are provided through an issuer or a third-party provider, which results in a cost burden of approximately $945,000.

In association with the explanation of denial, participants may request a copy of the medical necessity criteria. While the Department does not know how many notices of denial will result in a request for the criteria of medical necessity, the Department assumes that ten percent of those requesting an explanation of the reason for denial will also request the criteria of medical necessity, resulting in 44,500 requests, 2,300 of which will be completed in-house with an hour burden of 190 hours and equivalent cost of $5,000 and 42,000 requests handled by issuers or third-party providers with a cost burden of $95,000.

The Department also calculated the cost to deliver the requested information. Many insurers or plans may already have the information prepared in electronic format, and the Department assumes that requests will be delivered electronically resulting in a *de minimis* cost.[63] The Department estimates that the cost burden associated with distributing the approximately 135,000 disclosures sent by paper will be approximately $86,000.[64] The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.[65]

These paperwork burden estimates are summarized as follows:

*Type of Review*: New collection.

*Agency*: Department of Health and Human Services.

*Title*: Required Disclosures Under the Mental Health Parity and Addition Equity Act of 2008.

*OMB Number*: 0938-NEW.

*Affected Public*: State, Local, or Tribal Governments.

*Respondents*: 20,300.

*Responses*: 510,000.

*Frequency of Response*: Occasionally.

*Estimated Total Annual Burden Hours*: 2,200 hours.

*Estimated Total Annual Burden Cost*: $1,169,000.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, 4140-IFC

Fax: (202) 395–6974; or

Email: *OIRA_submission@omb.eop.gov*

G. *Congressional Review Act*

These regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and have been transmitted to Congress and the Comptroller General for review.

H. *Unfunded Mandates Reform Act*

The Unfunded Mandates Reform Act of 1995 (Public Law 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by state, local and tribal governments or the private sector. These rules are not subject to the Unfunded Mandates Reform Act because they are being issued as 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 MHPAEA.

I. *Federalism Statement—Department of Labor and Department of Health and Human Services*

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States have enacted or will enact laws or take other appropriate action resulting in their meeting or exceeding the federal MHPAEA standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2723 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the

[63] Following the assumption in the ERISA claims regulation, it was assumed 75 percent of the explanation of denials disclosures would be delivered electronically, while it was assumed that 38 percent of non-denial related requests for the medical necessity criteria would be delivered electronically.

[64] This estimate is based on an average document size of four pages, $.05 cents per page material and printing costs, $.44 cent postage costs.

[65] 5 CFR 1320.1 through 1320.18.

MHPAEA requirements are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of MHPAEA. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the MHPAEA requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the federal requirements are unlikely to "prevent the application of"' MHPAEA, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in numerous efforts to consult with and work cooperatively with affected State and local officials. It is expected that the Departments will act in a similar fashion in enforcing the MHPAEA requirements.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to MHPAEA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached regulations in a meaningful and timely manner.

**V. Statutory Authority**

The Department of the Treasury temporary and final regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

* * * * *

Accordingly, 26 CFR Parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

Par. 2. Section 54.9812–1T is revised to read as follows:

*§54.9812 Parity in mental health and substance use disorder benefits (temporary).*

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

*Aggregate lifetime dollar limit* means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan for any coverage unit.

*Annual dollar limit* means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan for any coverage unit.

*Coverage unit* means coverage unit as described in paragraph (c)(1)(iv) of this section.

*Cumulative financial requirements* are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

*Cumulative quantitative treatment limitations* are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

*Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

*Medical/surgical benefits* means benefits for medical or surgical services, as defined under the terms of the plan, but does not include mental health or substance use disorder benefits. Any condition defined by the plan as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

*Mental health benefits* means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any condition defined by the plan as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

*Substance use disorder benefits* means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally rec-

ognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

*Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits*—(1)—*General*—(i) *General parity requirement*. A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(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 (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(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 dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder 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 dollar limit on at least two-thirds of all medical/surgical benefits, it must either—

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

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

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

*Example 1*. (i) *Facts*. A group health plan has no annual limit on medical/surgical benefits and a $10,000 annual limit on mental health and substance use disorder benefits. To comply with the requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Eliminating the plan's annual dollar limit on mental health and substance use disorder benefits;

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

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

(ii) *Conclusion*. In this *Example 1*, each of the three options being considered by the plan sponsor would comply with the requirements of this paragraph (b).

*Example 2*. (i) *Facts*. A plan has a $100,000 annual limit on medical/surgical inpatient benefits and a $50,000 annual limit on medical/surgical outpatient benefits. To comply with the parity requirements of this paragraph (b), the plan sponsor is considering each of the following options:

(A) Imposing a $150,000 annual limit on mental health and substance use disorder benefits; and

(B) Imposing a $100,000 annual limit on mental health and substance use disorder inpatient benefits and a $50,000 annual limit on mental health and substance use disorder outpatient benefits.

(ii) *Conclusion*. In this *Example 2*, each option under consideration by the plan sponsor would comply with the requirements of this section.

(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 an aggregate lifetime or annual dollar 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 dollar limits). Any reasonable method may be used to determine whether the dollar amount 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 (b)(3) of this section*—(i) *In general*. A group health plan that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either—

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

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder 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 dollar 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 dollar 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) *Facts*. 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 dollar limit on any other category of medical/surgical benefits. The plan determines that 40 percent 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 percent of payments for medical/surgical benefits.

(ii) *Conclusion*. In this *Example*, the plan is not described in paragraph (b)(3) of this section because there is not one annual dollar 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 dollar limit. Under this paragraph (b)(6), the plan sponsor can choose either to include no annual dollar limit on mental health or substance use disorder benefits, or to include an annual dollar limit on mental health or substance use disorder benefits that is not less than the weighted average of the annual dollar limits applicable to each category of medical/surgical benefits. In this example, the minimum weighted average annual dollar limit that can be applied to mental health or substance use disorder benefits is $640,000 (40% x $100,000 + 60% x $1,000,000 = $640,000).

(c) *Parity requirements with respect to financial requirements and treatment limitations*—(1) *Clarification of terms*—(i) *Classification of benefits*. When reference is made in this paragraph (c) to a classification of benefits, the term "classification" means a classification as described in paragraph (c)(2)(ii) of this section.

(ii) *Type of financial requirement or treatment limitation*. When reference is made in this paragraph (c) to a type of financial requirement or treatment limitation, the reference to type means its nature. Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. Different types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits. See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.

(iii) *Level of a type of financial requirement or treatment limitation*. When reference is made in this paragraph (c) to a level of a type of financial requirement or treatment limitation, level refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent; different levels of a copayment include $15 and $20; different levels of a deductible include $250 and $500; and different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

(iv) *Coverage unit*. When reference is made in this paragraph (c) to a coverage unit, coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions. For example, different coverage units include self-only, family, and employee-plus-spouse.

(2) *General parity requirement*—(i) *General rule*. A group health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation. The application of the rules of this paragraph (c)(2) to financial requirements and quantitative treatment limitations is addressed in paragraph (c)(3) of this section; the application of the rules of this paragraph (c)(2) to nonquantitative treatment limitations is addressed in paragraph (c)(4) of this section.

(ii) *Classifications of benefits used for applying rules*—(A) *In general*. If a plan provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. In determining the classification in which a particular benefit belongs, a plan must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits. To the extent that a plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, the rules of this paragraph (c) apply separately with respect to that classification for all financial requirements or treatment limitations. The following classifications of benefits are the only classifications used in applying the rules of this paragraph (c):

(*1*) *Inpatient, in-network*. Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan.

(*2*) *Inpatient, out-of-network*. Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan. This classification includes inpatient benefits under a plan that has no network of providers.

(*3*) *Outpatient, in-network*. Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan.

(*4*) *Outpatient, out-of-network*. Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan. This classification includes outpatient benefits under a plan that has no network of providers.

(*5*) *Emergency care*. Benefits for emergency care.

(*6*) *Prescription drugs*. Benefits for prescription drugs. See special rules for multi-tiered prescription drug benefits in paragraph (c)(3)(iii) of this section.

(B) *Application to out-of-network providers*. See paragraph (c)(2)(ii)(A) of this section, under which a plan that provides mental health or substance use disorder benefits in any classification of benefits must provide mental health or substance use disorder benefits in every classification in which medical/surgical benefits are provided, including out-of-network classifications.

(C) *Examples*. The rules of this paragraph (c)(2)(ii) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

*Example 1*. (i) *Facts*. A group health plan offers inpatient and outpatient benefits and does not contract with a network of providers. The plan imposes a $500 deductible on all benefits. For inpatient medical/surgical benefits, the plan imposes a coinsurance requirement. For outpatient medical/surgical benefits, the plan imposes copayments. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 1*, because the plan has no network of providers, all benefits provided are out-of-network. Because inpatient, out-of-network medical/surgical benefits are subject to separate financial requirements from outpatient, out-of-network medical/surgical benefits, the rules of this paragraph (c) apply separately with respect to any financial requirements and treatment limitations, including the deductible, in each classification.

*Example 2*. (i) *Facts*. A plan imposes a $500 deductible on all benefits. The plan has no network of providers. The plan generally imposes a 20 percent coinsurance requirement with respect to all benefits, without distinguishing among inpatient, outpatient, emergency, or prescription drug benefits. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 2*, because the plan does not impose separate financial requirements (or treatment limitations) based on classification, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance across all benefits.

*Example 3*. (i) *Facts*. Same facts as *Example 2*, except the plan exempts emergency care benefits from the 20 percent coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 3*, because the plan imposes separate financial requirements based on classifications, the rules of this paragraph (c) apply with respect to the deductible and the coinsurance separately for—

(A) Benefits in the emergency classification; and

(B) All other benefits.

*Example 4*. (i) *Facts*. Same facts as *Example 2*, except the plan also imposes a preauthorization requirement for all inpatient treatment in order for benefits to be paid. No such requirement applies to outpatient treatment.

(ii) *Conclusion*. In this *Example 4*, because the plan has no network of providers, all benefits provided are out-of-network. Because the plan imposes a separate treatment limitation based on classifications, the rules of this paragraph (c) apply with respect to the deductible and coinsurance separately for—

(A) Inpatient, out-of-network benefits; and

(B) All other benefits.

(3) *Financial requirements and quantitative treatment limitations*—(i) *Determining "substantially all" and "predominant"*—(A) *Substantially all.* For purposes of this paragraph (c), a type of financial requirement or quantitative treatment limitation is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.

(B) *Predominant*—(*1*) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

(*2*) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

(C) *Portion based on plan payments.* For purposes of this paragraph (c), the determination of the portion of medical/surgical benefits in a classification of benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation) is based on the dollar amount of all plan payments for medical/surgical benefits in the classification 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 financial requirement or quantitative treatment limitation).

(D) *Clarifications for certain threshold requirements.* For any deductible, the dollar amount of plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied. For any out-of-pocket maximum, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied. Similar rules apply for any other thresholds at which the rate of plan payment changes.

(E) *Determining the dollar amount of plan payments.* Subject to paragraph (c)(3)(i)(D) of this section, any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation (or subject to any level of a financial requirement or quantitative treatment limitation).

(ii) *Application to different coverage units.* If a plan applies different levels of a financial requirement or quantitative treatment limitation to different coverage units in a classification of medical/surgical benefits, the predominant level that applies to substantially all medical/surgical benefits in the classification is determined separately for each coverage unit.

(iii) *Special rule for multi-tiered prescription drug benefits.* If a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules in paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations) and without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits, the plan satisfies the parity requirements of this paragraph (c) with respect to prescription drug benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

(iv) *Examples*. The rules of paragraphs (c)(3)(i), (c)(3)(ii), and (c)(3)(iii) of this section are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

*Example 1*. (i) *Facts*. For inpatient, out-of-network medical/surgical benefits, a group health plan imposes five levels of coinsurance. Using a reasonable method, the plan projects its payments for the upcoming year as follows:

| Coinsurance rate | 0 % | 10% | 15% | 20% | 30% | Total |
|---|---|---|---|---|---|---|
| Projected payments | $200x | $100x | $450x | $100x | $150x | $1,000x |
| Percent of total plan costs | 20% | 10% | 45% | 10% | 15% | |
| Percent subject to coinsurance level | N/A | 12.5% (100x/800x) | 56.25% (450x/800x) | 12.5% (100x/800x) | 18.75% (150x/800x) | |

The plan projects plan costs of $800x to be subject to coinsurance ($100x + $450x + $100x + $150x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to coinsurance, and 56.25 percent of the benefits subject to coinsurance are projected to be subject to the 15 percent coinsurance level.

(ii) *Conclusion*. In this *Example 1*, the two-thirds threshold of the substantially all standard is met for coinsurance because 80 percent of all inpatient, out-of-network medical/surgical benefits are subject to coinsurance. Moreover, the 15 percent coinsurance is the predominant level because it is applicable to more than one-half of inpatient, out-of-network medical/surgical benefits subject to the coinsurance requirement. The plan may not impose any level of coinsurance with respect to inpatient, out-of-network mental health or substance use disorder benefits that is more restrictive than the 15 percent level of coinsurance.

*Example 2*. (i) *Facts*. For outpatient, in-network medical/surgical benefits, a plan imposes five different copayment levels. Using a reasonable method, the plan projects payments for the upcoming year as follows:

| Copayment amount | $0 | $10 | $15 | $20 | $50 | Total |
|---|---|---|---|---|---|---|
| Projected payments | $200x | $200x | $200x | $300x | $100x | $1,000x |
| Percent of total plan costs | 20% | 20% | 20% | 30% | 10% | |
| Percent subject to copayments | N/A | 25% (200x/800x) | 25% (200x/800x) | 37.5% (300x/800x) | 12.5% (100x/800x) | |

The plan projects plan costs of $800x to be subject to copayments ($200x + $200x +$300x + $100x = $800x). Thus, 80 percent ($800x/$1,000x) of the benefits are projected to be subject to a copayment.

(ii) *Conclusion*. In this *Example 2*, the two-thirds threshold of the substantially all standard is met for copayments because 80 percent of all outpatient, in-network medical/surgical benefits are subject to a copayment. Moreover, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to a copayment (for the $10 copayment, 25 percent; for the $15 copayment, 25 percent; for the $20 copayment, 37.5 percent; and for the $50 copayment, 12.5 percent). The plan can combine any levels of copayment, including the highest levels, to determine the predominant level that can be applied to mental health or substance use disorder benefits. If the plan combines the highest levels of copayment, the combined projected payments for the two highest copayment levels, the $50 copayment and the $20 copayment, are not more than one-half of the outpatient, in-network medical/surgical benefits subject to a copayment because they are exactly one-half ($300x + $100x = $400x; $400x/$800x = 50%). The combined projected payments for the three highest copayment levels — the $50 copayment, the $20 copayment, and the $15 copayment — are more than one-half of the outpatient, in-network medical/surgical benefits subject to the copayments ($100x + $300x + $200x = $600x; $600x/$800x = 75%). Thus, the plan may not impose any copayment on outpatient, in-network mental health or substance use disorder benefits that is more restrictive than the least restrictive copayment in the combination, the $15 copayment.

*Example 3*. (i) *Facts*. A plan imposes a $250 deductible on all medical/surgical benefits for self-only coverage and a $500 deductible on all medical/surgical benefits for family coverage. The plan has no network of providers. For all medical/surgical benefits, the plan imposes a coinsurance requirement. The plan imposes no other financial requirements or treatment limitations.

(ii) *Conclusion*. In this *Example 3*, because the plan has no network of providers, all benefits are provided out-of-network. Because self-only and family coverage are subject to different deductibles, whether the deductible applies to substantially all medical/surgical benefits is determined separately for self-only medical/surgical benefits and family medical/surgical benefits. Because the coinsurance is applied without regard to coverage units, the predominant coinsurance that applies to substantially all medical/surgical benefits is determined without regard to coverage units.

*Example 4*. (i) *Facts*. A plan applies the following financial requirements for prescription drug benefits. The requirements are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits. Moreover, the process for certifying a particular drug as "generic", "preferred brand name", "non-preferred brand name", or "specialty" complies with the rules of paragraph (c)(4)(i) of this section (relating to requirements for nonquantitative treatment limitations).

| | Tier 1 | Tier 2 | Tier 3 | Tier 4 |
|---|---|---|---|---|
| Tier description | Generic drugs | Preferred brand name drugs | Non-preferred brand name drugs (which may have Tier 1 or Tier 2 alternatives) | Specialty drugs |
| Percent paid by plan | 90% | 80% | 60% | 50% |

(ii) *Conclusion*. In this *Example 4*, the financial requirements that apply to prescription drug benefits are applied without regard to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to mental health or substance use disorder benefits; the process for certifying drugs in different tiers complies with paragraph (c)(4) of this section; and the bases for establishing different levels or types of financial requirements are reasonable. The financial requirements applied to prescription drug benefits do not violate the parity requirements of this paragraph (c)(3).

(v) *No separate cumulative financial requirements or cumulative quantitative treatment limitations*. (A) A group health plan may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

(B) The rules of this paragraph (c)(3)(v) are illustrated by the following examples:

*Example 1*. (i) *Facts*. A group health plan imposes a combined annual $500 deductible on all medical/surgical, mental health, and substance use disorder benefits.

(ii) *Conclusion*. In this *Example 1*, the combined annual deductible complies with the requirements of this paragraph (c)(3)(v).

*Example 2*. (i) *Facts*. A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $250 deductible on all mental health and substance use disorder benefits.

(ii) *Conclusion*. In this *Example 2*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

*Example 3*. (i) *Facts*. A plan imposes an annual $300 deductible on all medical/surgical benefits and a separate annual $100 deductible on all mental health or substance use disorder benefits.

(ii) *Conclusion*. In this *Example 3*, the separate annual deductible on mental health and substance use disorder benefits violates the requirements of this paragraph (c)(3)(v).

*Example 4*. (i) *Facts*. A plan generally imposes a combined annual $500 deductible on all benefits (both medical/surgical benefits and mental health and substance use disorder benefits) except prescription drugs. Certain benefits, such as preventive care, are provided without regard to the deductible. The imposition of other types of financial requirements or treatment limitations varies with each classification. Using reasonable methods, the plan projects its payments for medical/surgical benefits in each classification for the upcoming year as follows:

| Classification | Benefits Subject to Deductible | Total Benefits | Percent Subject to Deductible |
|---|---|---|---|
| Inpatient, in-network | $1,800x | $2,000x | 90% |
| Inpatient, out-of-network | $1,000x | $1,000x | 100% |
| Outpatient, in-network | $1,400x | $2,000x | 70% |
| Outpatient, out-of-network | $1,880x | $2,000x | 94% |
| Emergency care | $300x | $500x | 60% |

(ii) *Conclusion*. In this *Example 4*, the two-thirds threshold of the substantially all standard is met with respect to each classification except emergency care because in each of those other classifications at least two-thirds of medical/surgical benefits are subject to the $500 deductible. Moreover, the $500 deductible is the predominant level in each of those other classifications because it is the only level. However, emergency care mental health and substance use disorder benefits cannot be subject to the $500 deductible because it does not apply to substantially all emergency care medical/surgical benefits.

(4) *Nonquantitative treatment limitations*—(i) *General rule*. A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(ii) *Illustrative list of nonquantitative treatment limitations*. Nonquantitative treatment limitations include—

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and

(F) Exclusions based on failure to complete a course of treatment.

(iii) *Examples*. The rules of this paragraph (c)(4) are illustrated by the following examples. In each example, the group health plan is subject to the requirements of this section and provides both medical/surgical benefits and mental health and substance use disorder benefits.

*Example 1*. (i) *Facts*. A group health plan limits benefits to treatment that is medically necessary. The plan requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require it for any inpatient, in-network medical/surgical benefits. The plan conducts retrospective review for inpatient, in-network medical/surgical benefits.

(ii) *Conclusion*. In this *Example 1*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation — medical necessity — applies to both mental health and substance use disorder benefits and to medical/surgical benefits for inpatient, in-network services, the concurrent review process does not apply to medical/surgical benefits. The concurrent review process is not comparable to the retrospective review process. While such a difference might be permissible in certain individual cases based on recognized clinically appropriate standards of care, it is not permissible for distinguishing between all medical/surgical benefits and all mental health or substance use disorder benefits.

*Example 2*. (i) *Facts*. A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits. For mental health and substance use disorder treatments that do not have prior approval, no benefits will be paid; for medical/surgical treatments that do not have prior approval, there will only be a 25 percent reduction in the benefits the plan would otherwise pay.

(ii) *Conclusion*. In this *Example 2*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation — medi-

cal necessity — is applied both to mental health and substance use disorder benefits and to medical/surgical benefits for outpatient, in-network services, the penalty for failure to obtain prior approval for mental health and substance use disorder benefits is not comparable to the penalty for failure to obtain prior approval for medical/surgical benefits.

*Example 3*. (i) *Facts*. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.

(ii) *Conclusion*. In this *Example 3*, the plan complies with the rules of this paragraph (c)(4) because the nonquantitative treatment limitation — medical appropriateness — is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.

*Example 4*. (i) *Facts*. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.

(ii) *Conclusion*. In this *Example 4*, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation — medical appropriateness — is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan's unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.

*Example 5*. (i) *Facts*. An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP. No similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program.

(ii) *Conclusion*. In this *Example 5*, limiting eligibility for mental health and substance use disorder benefits only after EAP benefits are exhausted is a nonquantitative treatment limitation subject to the parity requirements of this paragraph (c). Because no comparable requirement applies to medical/surgical benefits, the requirement may not be applied to mental health or substance use disorder benefits.

(5) *Exemptions*. The rules of this paragraph (c) do not apply if a group health plan satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(d) *Availability of plan information*—(1) *Criteria for medical necessity determinations*. The criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator to any current or potential participant, beneficiary, or contracting provider upon request.

(2) *Reason for denial*. The reason for any denial under a group health plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available by the plan administrator to the participant or beneficiary in accordance with this paragraph (d)(2).

(i) *Plans subject to ERISA*. If a plan is subject to ERISA, it must provide the reason for the claim denial in a form and manner consistent with the requirements of 29 CFR 2560.503–1 for group health plans.

(ii) *Plans not subject to ERISA*. If a plan is not subject to ERISA, upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time and in a reasonable manner. For this purpose, a plan that follows the requirements of 29 CFR 2560.503–1 for group health plans complies with the requirements of this paragraph (d)(2)(ii).

(e) *Applicability*—(1) *Group health plans*. The requirements of this section apply to a group health plan offering medical/surgical benefits and mental health or substance use disorder benefits. If, under an arrangement or arrangements to provide health care benefits by an employer or employee organization (including for this purpose a joint board of trustees of a multiemployer trust affiliated with one or more multiemployer plans), any participant (or beneficiary) can simultaneously receive coverage for medical/surgical benefits and coverage for mental health or substance use disorder benefits, then the requirements of this section (including the exemption provisions in paragraph (g) of this section) apply separately with respect to each combination of medical/surgical benefits and of mental health or substance use disorder benefits that any participant (or beneficiary) can simultaneously receive from that employer's or employee organization's arrangement or arrangements to provide health care benefits, and all such combinations are considered for purposes of this section to be a single group health plan.

(2) *Health insurance issuers*. See 29 CFR 2590.712(e)(2) and 45 CFR 146.136(e)(2), under which a health insurance issuer offering health insurance coverage for mental health or substance use disorder benefits is subject to requirements similar to those applicable to group health plans under this section if the health insurance coverage is offered in connection with a group health plan subject to requirements under 29 CFR 2590.712 or 45 CFR 146.136 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 substance use disorder benefits, and the provision of benefits by a plan for one or more mental health conditions or substance use disorders does not require the plan under this section to provide benefits for any other mental health condition or substance use disorder; or

(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan except as specifically provided in paragraphs (b) and (c) of this section.

(f) *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 (f), 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 (or one in the case of an employer residing in a state that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year. See section 9831(a)(2) and §54.9831–1(b), 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 (f)(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.

(g) *Increased cost exemption*—[Reserved].

(h) *Sale of nonparity health insurance coverage*. See 29 CFR 2590.712(h) and 45 CFR 146.136(h), under which a health insurance issuer may not sell a policy, certificate, or contract of insurance that fails to comply with requirements similar to those under paragraph (b) or (c) of this section, except to a plan for a year for which the plan is exempt from requirements similar to those under paragraph (b) or (c) of this section because the plan meets requirements under paragraph (f) or (g) of 29 CFR 2590.712 or 45 CFR 146.136 similar to those under paragraph (f) or (g) of this section.

(i) *Effective/applicability dates*—(1) *In general*. Except as provided in paragraph (i)(2) of this section, the requirements of this section are applicable for plan years beginning on or after July 1, 2010.

(2) *Special effective date for certain collectively-bargained plans*. For a group health plan maintained pursuant to one or more collective bargaining agreements ratified before October 3, 2008, the requirements of this section do not apply to the plan for plan years beginning before the later of either—

(i) The date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after October 3, 2008); or

(ii) July 1, 2010.

(j) *Expiration date*. This section expires on or before January 29, 2013.

## PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 4. In §602.101, paragraph (b) is amended by adding the following entry in numerical order to the table:

*§602.101 OMB Control numbers*.

* * * * *

(b) * * *

| CFR part or section where Identified and described | Current OMB control No. |
|---|---|
| * * * * * | |
| 54.9812–1T | 1545–2165 |
| * * * * * | |

Steven T. Miller,
*Deputy Commissioner for Services and Enforcement, Internal Revenue Service.*

Approved January 27, 2010.

Michael F. Mundaca,
*Acting Assistant Secretary of the Treasury (Tax Policy).*

(Filed by the Office of the Federal Register on January 29, 2010, 8:45 a.m., and published in the issue of the Federal Register for February 2, 2010, 75 F.R. 5410)

# Part III. Administrative, Procedural, and Miscellaneous

## Transitional Guidance for Taxpayers Claiming Relief Under the Military Spouses Residency Relief Act for Taxable Year 2009

## Notice 2010–30

### I. PURPOSE

This notice grants certain civilian spouses of active duty members of the uniformed services (servicemembers), as defined under 10 U.S.C. § 101(a)(5), an extension of time through October 15, 2010 for paying the amount of tax shown or required to be shown on a federal income tax return for the taxable year that includes November 11, 2009 (this will generally be the calendar year 2009 and is referred to hereinafter as "2009"). This extension is granted with respect to civilian spouses of servicemembers (civilian spouses) who: (1) were away from their residence or domicile (tax residence) in a State or the District of Columbia during 2009 solely to be with a servicemember spouse serving in compliance with military orders at a military duty station in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, or the U.S. Virgin Islands (hereinafter, a "U.S. territory"); and (2) maintained their tax residence in a State or the District of Columbia for 2009 under MSRRA. As discussed in Part III(A)(2) of this notice, the extension to pay tax provided in this notice does not apply to civilian spouses claiming tax residence in a State or the District of Columbia who are (1) federal employees in American Samoa, Guam, or the U.S. Virgin Islands (USVI), or (2) individuals working in Guam or the Northern Mariana Islands (NMI) to whom section 935 applies.

Certain taxpayers who worked in a State or the District of Columbia during 2009 and who claim tax residence in a U.S. territory under MSRRA for 2009 may apply for a refund of federal income taxes that the taxpayer's employer withheld and remitted to the Internal Revenue Service (IRS) or estimated tax payments that the taxpayer paid to the IRS during 2009. This notice provides guidance and procedures for submitting claims for refund of federal income taxes to civilian spouses who: (1) were away from their tax residence in the U.S. territories during 2009 solely to be with a servicemember spouse serving in compliance with military orders at a military duty station in a State or the District of Columbia; and (2) maintained their tax residence in the U.S. territories for 2009 under MSRRA. As discussed in Part III(B)(2), the procedures set forth in this notice do not apply to certain civilian spouses claiming tax residence in Guam, the NMI, or the USVI.

### II. BACKGROUND

MSRRA was signed into law on November 11, 2009 and applies retroactively to 2009 as well as to subsequent taxable years. MSRRA amends the Servicemembers Civil Relief Act, 50 U.S.C. App. § 501 *et seq.*, to provide a civilian spouse with rights similar to those afforded to the servicemember when the civilian spouse accompanies the servicemember serving at a duty station on military orders within one of the 50 States, the District of Columbia, or a U.S. territory.

Although it does not explicitly amend any provision of the Internal Revenue Code (Code), MSRRA nonetheless may have the effect of modifying the application of certain provisions of the Code with respect to federal income tax withholding, source of income, and residency for a civilian spouse who claims relief under the tax provisions of MSRRA and who was employed in a State, the District of Columbia, or a U.S. territory. MSRRA provides in relevant part that a civilian spouse shall neither lose nor acquire tax residence by reason of being absent or present in any tax jurisdiction of the United States (defined in 50 U.S.C. App. §§ 511 and 571 to include the 50 States, the District of Columbia, and a commonwealth, territory, or possession of the United States) solely to be with the servicemember serving in compliance with military orders if the tax residence is the same for the servicemember and civilian spouse. *See* MSRRA, § 3. Accordingly, pursuant to MSRRA, a civilian spouse may maintain tax residence other than where the civilian spouse is physically present while accompanying the servicemember to a military duty station.

MSRRA also provides that income for services performed by the civilian spouse in a tax jurisdiction of the United States shall not be deemed to be income for services performed or from sources within that tax jurisdiction if the civilian spouse is not a resident or domiciliary of the jurisdiction in which the income is earned because the civilian spouse is in the jurisdiction solely to be with the servicemember serving in compliance with military orders. *See* MSRRA, § 3. Consequently, the civilian spouse claiming the benefits of MSRRA may not be required to pay income taxes to a jurisdiction in which the civilian spouse performs services if that jurisdiction is different from the civilian spouse's chosen tax residence under MSRRA. Instead, the civilian spouse may be required to pay applicable State and local income taxes or U.S. territory taxes in the jurisdiction in which the civilian spouse claims tax residence. In addition, the civilian spouse will be required to pay federal income taxes on income from services if the civilian spouse's chosen tax residence is in a State or the District of Columbia. For example, if a civilian spouse is working in Guam but properly claims tax residence in Virginia under MSRRA, the civilian spouse's income from services would not be considered to be from sources in Guam. Thus, this income would not constitute taxable income for Guam tax purposes. However, the civilian spouse would owe taxes to the IRS and may owe taxes to Virginia.

### III. TRANSITIONAL RELIEF FOR 2009

#### A. *Taxpayers Claiming Tax Residence in a State or the District of Columbia*

##### 1. *In General*

MSRRA was enacted on November 11, 2009, and applies retroactively to 2009. As a result, the IRS recognizes that taxpayers working in a U.S. territory who claim tax residence in a State or the District of Columbia may experience undue hardship in timely paying federal income tax liabilities due the IRS for 2009. This sit-

uation may occur, in particular, if a taxpayer claims tax residence in a State or the District of Columbia and files a 2009 federal income tax return with the IRS, but the taxpayer's employer withheld income tax for 2009 that was remitted to a U.S. territory tax administration, and/or the taxpayer made estimated tax payments to a U.S. territory tax administration. (As discussed in Part III(A)(2), this situation generally should not arise for (1) federal employees in American Samoa, Guam, or the USVI, or (2) individuals working in Guam or the NMI to whom section 935 of the Code applies.) Accordingly, withheld amounts and estimated tax payments that should have been paid to the IRS were actually paid to the territory. The IRS recognizes that a taxpayer in this situation, in order to recover amounts erroneously paid to a U.S. territory, may need to file a claim for refund or credit of amounts withheld by the taxpayer's employer or estimated tax payments that the taxpayer remitted to the U.S. territory tax administration during 2009.

Furthermore, a civilian spouse should be aware that to the extent that a Form W–2, *Wage and Tax Statement* (or its equivalent), issued to the taxpayer by an employer indicates income tax withholding paid to a tax administration of a U.S. territory for 2009, such amount should not be claimed as a payment on a federal income tax return (*e.g.*, Form 1040, Line 61) if such withholding amount has not been paid or treated as paid to the IRS. In such a case, the amount owed as shown on a tax return filed with the IRS will be higher than if such withholding amounts had been paid to the IRS.

**a.** ***Applicable Provisions of the Code***

Section 6651(a) of the Code imposes a penalty on any failure to pay (on or before the due date for payment, including extensions) any amount shown as tax on any return. In general, individuals must pay income tax by April 15. Section 6161 of the Code authorizes the Secretary of the Treasury or his delegate to grant taxpayers reasonable extensions of time (generally not to exceed 6 months) to pay the amount of tax shown or required to be shown on any return. However, section 6601 of the Code imposes interest on any amount of tax not paid by the due date, determined without regard to any extension of time for payment or any installment agreement entered into under section 6159 of the Code, from such due date to the date the tax is paid.

Section 6654(a) of the Code provides for an addition to tax in the case of an underpayment of estimated tax by an individual. An underpayment of estimated tax is the excess of the required quarterly estimated tax payment over the amount actually paid on or before the due date for the payment. Section 6654(e)(3)(A) of the Code provides that the addition to tax shall not be imposed to the extent that the Secretary or his delegate determines that the imposition of such addition to tax would be against equity and good conscience due to unusual circumstances.

**b.** ***Procedures for Relief***

Pursuant to section 6161 of the Code, the IRS is providing to certain taxpayers an extension of time through October 15, 2010 for paying the amount of tax shown or required to be shown on a federal income tax return for 2009. This extension is being provided to taxpayers who: (i) worked in a U.S. territory; (ii) claim tax residence in a State or the District of Columbia under MSRRA; and (iii) are not (1) federal employees in American Samoa, Guam, or the USVI, or (2) individuals working in Guam or the NMI to whom section 935 applies. Additionally, pursuant to section 6654(e)(3)(A) of the Code, the IRS has determined that with respect to such taxpayers, applying the addition to tax under section 6654(a) is against equity and good conscience due to unusual circumstances. However, interest on the amount of tax must be paid for the period from the time the tax is due, without regard to such extension (generally, April 15), until the date the tax is paid.

Taxpayers should be aware that the extension of time to pay provided in this notice is ***not*** an extension of time to file a return. To obtain an automatic extension of time to file, a taxpayer should file IRS Form 4868.

To qualify for the extension of time to pay under this notice, taxpayers must follow these procedures:

- Taxpayers must mark "MSRRA" in red ink on the top of their returns and include with their returns a copy of the Form(s) W–2, or its equivalent, that they received from their employers in the U.S. territory where they worked during 2009.
- Taxpayers must also attach the following declaration:

  "I am claiming _____ as my residence or domicile under the Military Spouses Residency Relief Act ("MSRRA"). Under penalties of perjury, I declare that I am qualified for relief under MSRRA because I am present in _____ solely to accompany my spouse who is a servicemember serving in compliance with military orders, and my claimed residence or domicile is the same as my spouse's residence or domicile."
- The declaration must be signed and dated by the taxpayer. Neither a stamped signature nor a faxed signature is permitted.
- Taxpayers must mail their returns to the IRS Service Center to which the return would be mailed if the taxpayer lived in the jurisdiction claimed as the taxpayer's tax residence under MSRRA. The address for the appropriate IRS Service Center may be found in the instructions to IRS Form 1040. For example, if a civilian spouse works in Puerto Rico but claims tax residence in Virginia under MSRRA, the civilian spouse should mail the federal income tax return to the IRS Service Center in Kansas City, Missouri. Taxpayers may use private delivery services designated by the IRS to mail their returns, as provided in the instructions to IRS Form 1040.

**2.** ***Exceptions***

**a.** ***Taxpayers Employed by the U.S. Federal Government in American Samoa, Guam, or the USVI***

The relief provided in Part III(A)(1)(b) does not apply to a federal employee claiming tax residence under MSRRA in a State or the District of Columbia but who was working in American Samoa, Guam, or the USVI in 2009. In this case, the taxpayer's federal agency employer withheld income taxes and remitted amounts withheld to the IRS during 2009. As a result, the taxpayer does not need the relief provided in Part III(A)(1)(b). Instead, the

taxpayer should file an income tax return with the IRS and may claim as a payment on that federal income tax return (*e.g.*, Form 1040, Line 61) the amount reported as income tax withholding paid to the IRS on the Form W–2, or its equivalent, issued to the taxpayer by the federal agency employer.

**b.** ***Certain Other Taxpayers Present in Guam or the NMI***

The relief provided in Part III(A)(1)(b) also does not apply to a civilian spouse working in Guam or the NMI to whom section 935 applies. In that case, the civilian spouse does not need to file a claim for refund with Guam or the NMI because the civilian spouse may treat amounts paid to Guam or the NMI as paid to the IRS. Section 935 applies to a civilian spouse claiming tax residence in a State or the District of Columbia under MSRRA if the civilian spouse is a U.S. citizen or resident alien and has income from sources in Guam or the NMI (other than income from services performed in Guam or the NMI). A resident alien is a person with a green card or who meets the substantial presence test, which generally means that the person is present in the United States for a specified number of days. If section 935 applies, the taxpayer may treat amounts withheld and paid to the relevant U.S. territory as paid to the IRS. *See* Treas. Reg. § 1.935–1(c)(1)(ii)(A). The taxpayer should file an income tax return with the IRS and pay any tax due by the relevant due date.

**B.** ***Taxpayers Claiming Tax Residence in a U.S. territory***

Circumstances similar to those described in Part III(A)(1) may arise for a civilian spouse who is present in a State or the District of Columbia but who claims tax residence under MSRRA in one of the U.S. territories. In that case, the civilian spouse may be required to file a 2009 income tax return with the relevant U.S. territory tax administration, but the civilian spouse's employer withheld income tax for 2009 that was remitted to the IRS, and/or the civilian spouse made estimated tax payments to the IRS. Thus, taxes that should have been paid to the U.S. territory tax administration were actually paid to the IRS.

As described in more detail in Parts III(B)(1) and (2), the federal income tax treatment of taxpayers in this situation may depend in part on whether the taxpayer is treated under section 937 as a *bona fide* resident of the U.S. territory in which the taxpayer claims tax residence under MSRRA. Under Treas. Reg. § 1.937–1(b)(2), a servicemember who qualified as a *bona fide* resident of a U.S. territory in a prior taxable year is deemed to satisfy the requirements for *bona fide* residence in such U.S. territory for a subsequent taxable year if the servicemember is otherwise unable to satisfy such requirements during such subsequent year by reason of being absent from the U.S. territory or present in a State or the District of Columbia solely in compliance with military orders. The IRS and the Department of Treasury intend to issue regulations under section 937 to provide a civilian spouse with treatment similar to that provided to the servicemember spouse for purposes of section 937. In particular, the regulations will provide that a civilian spouse who claims tax residence under MSRRA in a U.S. territory but is present in a State or the District of Columbia qualifies as a *bona fide* resident of such U.S. territory under section 937 of the Code if the civilian spouse satisfies the following requirements: (1) the civilian spouse qualified as a *bona fide* resident of the U.S. territory in a prior taxable year, and (2) the civilian spouse is unable to satisfy the requirements for *bona fide* residence in the U.S. territory in a subsequent taxable year by reason of being present in a State or the District Columbia solely to be with the servicemember spouse who is serving in compliance with military orders. For general rules regarding *bona fide* residence in a U.S. territory, please refer to IRS Publication 570.

**1.** ***American Samoa and Puerto Rico***

Section 931 of the Code provides that, in the case of a *bona fide* resident of American Samoa, income derived from sources within American Samoa is not included in gross income for U.S. federal income tax purposes (except amounts paid for services performed as an employee of the United States or any agency thereof). A civilian spouse who claims tax residence in American Samoa under MSRRA and is a *bona fide* resident of American Samoa, but who had income taxes withheld and paid to the IRS during 2009 with respect to services performed by the taxpayer in a State or the District of Columbia, may therefore be entitled to claim a refund of these withheld amounts because the income from such services may be deemed to be from sources in American Samoa.

Similar rules apply in the case of Puerto Rico. Specifically, section 933 generally provides that gross income for U.S. federal income tax purposes does not include income of a *bona fide* resident of Puerto Rico from sources within Puerto Rico (except amounts received for services performed as an employee of the United States or any agency thereof). A civilian spouse who claims tax residence in Puerto Rico under MSRRA and is a *bona fide* resident of Puerto Rico, but who had income taxes withheld and paid to the IRS during 2009 with respect to services performed by the taxpayer in a State or the District of Columbia, may therefore be entitled to claim a refund of income taxes withheld and paid to the IRS.

**a.** ***Procedures for Taxpayers Claiming Tax Residence in American Samoa or Puerto Rico Who Are Not Federal Employees***

Taxpayers who worked in a State or the District of Columbia during 2009 but were not employees of the U.S. federal government, who claim tax residence in American Samoa or Puerto Rico for 2009 under MSRRA, and who claim a refund of federal income taxes should follow these procedures.

- Complete the appropriate Form 1040 and mark "MSRRA" in red ink on the top of the return;
- Attach the statement signed under penalties of perjury described in Part III(A)(1)(b), verifying the taxpayer's eligibility for relief under MSRRA; and
- Mail the Form 1040 and attached statement to the IRS Service Center indicated in the instructions to the Form 1040, based on the location in which the taxpayer lives at the end of the year. (For example, if the taxpayer lives and works in Virginia but claims tax residence in Guam under MSRRA, the taxpayer should mail the required forms

and statements to the IRS Service Center in Kansas City, Missouri.) Taxpayers may use private delivery services designated by the IRS to mail their returns, as provided in the instructions to IRS Form 1040.

Taxpayers claiming tax residence in American Samoa or Puerto Rico under MSRRA may be required to pay taxes to American Samoa or Puerto Rico, as the case may be, on their income from services. Taxpayers should contact the appropriate U.S territory tax administration for further information regarding their tax obligations in that U.S. territory, including whether any relief may be available for late filings and payments. See Part IV below for contact information for the U.S. territory tax administrations.

**b.** ***Procedures for Taxpayers Claiming Tax Residence in American Samoa or Puerto Rico Who Are Federal Employees***

Taxpayers claiming tax residence in American Samoa or Puerto Rico under MSRRA who are federal employees should file a return with the relevant U.S. territory tax administration and file a federal income tax return with the IRS. These taxpayers should report income from federal employment as income from sources in American Samoa or Puerto Rico on their federal income tax returns.

Taxpayers should contact the appropriate U.S territory tax administration for further information regarding their tax obligations in that U.S. territory, including whether any relief may be available for late filings and payments. See Part IV below for contact information for the U.S. territory tax administrations.

**2.** ***Guam, the NMI, and the USVI***

Under section 932(c) of the Code, an individual who is a *bona fide* resident of the USVI for the entire taxable year (or a person who files a joint return with such an individual) must file an income tax return for the taxable year with the USVI. For purposes of the territorial income tax of the USVI (that is, "mirrored" sections of the Code), a *bona fide* resident of USVI may take income tax paid to the United States into account as payments to the USVI under mirrored sections 31 (tax withheld on wages), 6315 (payments of estimated income tax), and 6402(b) (credits against estimated tax). *See* Treas. Reg. § 1.932–1(g)(2)(ii)(A). As a result, a civilian spouse who claims tax residence in the USVI under MSRRA and is a *bona fide* resident of the USVI should file an income tax return with the USVI and may treat amounts paid to the IRS in 2009 as paid to the USVI on the taxpayer's return.

Section 935(b) of the Code provides in relevant part that, with respect to a taxpayer who is (i) a *bona fide* resident of Guam or the NMI, (ii) a citizen of Guam or the NMI (but not otherwise a U.S. citizen and not a resident of the United States), or (iii) an individual who files a joint return for a taxable year with an individual described in (i) or (ii) if the individual described in (i) or (ii) has the greater adjusted gross income, the taxpayer shall file an income tax return with Guam or the NMI, as the case may be. Under section 935(c)(3), an individual is relieved of liability for income tax to the jurisdiction other than the jurisdiction with which the individual is required to file under section 935(b). In applying the territorial income tax of Guam or the NMI (under "mirrored" sections of the Code), a *bona fide* resident or citizen of Guam or the NMI may take income tax paid to the United States into account under mirrored sections 31 (tax withheld on wages), 6315 (payments of estimated income tax), and 6402(b) (credits against estimated tax), as payments to the relevant U.S. territory. *See* Treas. Reg. § 1.935–1(c)(1)(ii)(A). Consequently, a civilian spouse who claims tax residence in Guam or the NMI under MSRRA and is a *bona fide* resident or citizen of Guam or the NMI should file an income tax return with the relevant U.S. territory and may treat amounts paid to the IRS in 2009 as paid to the U.S. territory.

**C.** ***Other Guidance***

In the case of taxpayers described in Part III(A)(1) and III(B)(1) of this notice, the IRS and tax administrations of the U.S. territories may determine by agreement or otherwise to coordinate relief for taxpayers claiming the benefits of MSRRA. The IRS and U.S. territories will issue additional guidance if coordinated procedures become available. Taxpayers claiming the benefits of MSRRA should continue to use the procedures set forth in this notice until the IRS issues further guidance.

Taxpayers who have already filed 2009 federal income tax returns and were not aware of the procedures provided in this notice and taxpayers who have any questions regarding the relief or procedures in this notice, may call 1(800) 829–1040 or (215) 516–2000 (not a toll-free call) for assistance.

State, local, and U.S. territory tax administrations may establish their own procedures for the implementation of the taxation provisions of MSRRA. However, such procedures are beyond the scope of this notice.

## IV. CONTACT INFORMATION FOR U.S. TERRITORY TAX ADMINISTRATIONS

Taxpayers may direct questions regarding U.S. territory taxes and claims for refund to the following:

**American Samoa**

Tax Division
Government of American Samoa
Pago Pago, American Samoa 96799

Phone number: 684–633–4181
Fax Number: 684–633–1513

**The Northern Mariana Islands**

Department of Finance
Division of Revenue and Taxation
Commonwealth of the Northern Mariana Islands
P.O. Box 5234 CHRB
Saipan, MP 96950

Phone number: 670–664–1000
Fax Number: 670–664–1015

**Guam**

Department of Revenue and Taxation
Government of Guam
P.O. Box 23607
GMF, GU 96921

Phone number: 671–635–1840 or 671–635–1841
Fax Number: 671–633–2643

**Puerto Rico**

Departamento de Hacienda
Negociado de Asistencia Contributiva
P.O. Box 9024140
San Juan, Puerto Rico 00902–4140

Phone number: 787–721–2020,
extension 3611,
or 1–800–981–9236 (toll-free within Puerto Rico but outside San Juan)

**U.S. Virgin Islands**

Virgin Islands Bureau of Internal Revenue
9601 Estate Thomas
Charlotte Amalie
St. Thomas, VI 00802

Phone number: 340–715–1040
Fax Number: 340–714–9341 and
340–714–9345

**V. EFFECTIVE DATE**

The relief provided in Part III(A)(1)(b) and the procedures in Part III(B)(1) of this notice are effective for taxable years that include November 11, 2009.

The regulations under section 937 providing a civilian spouse with treatment similar to that provided to the servicemember spouse for purposes of section 937 will be effective for taxable years that include November 11, 2009 and subsequent years.

**VI. PAPERWORK REDUCTION ACT**

The collection of information contained in this notice has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. § 3507) under control number 1545–2169.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

The collections of information in this notice are in Part III(A)(1) and III(B)(1). This information will be used to verify a taxpayer's eligibility for relief under the taxation provisions of MSRRA. The collection of information is required to obtain a benefit. The likely respondents are individuals.

The estimated total annual reporting burden is 6,200 hours. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of paperwork. The estimated number of respondents is 6,200. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Internal Revenue Service, Tax Products Coordinating Committee, SE:W:CAR:MP:T:T:SP, 1111 Constitution Avenue, NW, IR–6526, Washington, DC 20224.

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.

**VII. DRAFTING INFORMATION**

The principal author of this notice is Rosy L. Lor of the Office of Associate Chief Counsel (International). For further information regarding this notice, contact Rosy L. Lor at (202) 435–5262 (not a toll-free call).

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## Credit for Renewable Electricity Production, Refined Coal Production, and Indian Coal Production, and Publication of Inflation Adjustment Factors and Reference Prices for Calendar Year 2010

## Notice 2010–37

This notice publishes the inflation adjustment factors and reference prices for calendar year 2010 for the renewable electricity production credit, the refined coal production credit, and the Indian coal production credit under § 45 of the Internal Revenue Code. The 2010 inflation adjustment factors and reference prices are used in determining the availability of the credits. The 2010 inflation adjustment factors and reference prices apply to calendar year 2010 sales of kilowatt-hours of electricity produced in the United States or a possession thereof from qualified energy resources and to calendar year 2010 sales of refined coal and Indian coal produced in the United States or a possession thereof.

BACKGROUND

Section 45(a) provides that the renewable electricity production credit for any tax year is an amount equal to the product of 1.5 cents multiplied by the kilowatt hours of specified electricity produced by the taxpayer and sold to an unrelated person during the tax year. This electricity must be produced from qualified energy resources and at a qualified facility during the 10-year period beginning on the date the facility was originally placed in service.

Section 45(b)(1) provides that the amount of the credit determined under § 45(a) is reduced by an amount which bears the same ratio to the amount of the credit as (A) the amount by which the reference price for the calendar year in which the sale occurs exceeds 8 cents, bears to (B) 3 cents. Under § 45(b)(2), the 1.5 cent amount in § 45(a), the 8 cent amount in § 45(b)(1), the $4.375 amount in § 45(e)(8)(A), and in § 45(e)(8)(B)(i), the $2.00 amount in § 45(e)(8)(D)(ii)(I), the reference price of fuel used as feedstock (within the meaning of § 45(c)(7)(A)) in 2002 are each adjusted by multiplying the amount by the inflation adjustment factor for the calendar year in which the sale occurs. If any amount as increased under the preceding sentence is not a multiple of 0.1 cent, the amount is rounded to the nearest multiple of 0.1 cent.

Section 45(c)(1) defines qualified energy resources as wind, closed-loop biomass, open-loop biomass, geothermal energy, solar energy, small irrigation power, municipal solid waste, qualified hydropower production, marine and hydrokinetic renewable energy.

Section 45(d)(1) defines a qualified facility using wind to produce electricity as any facility owned by the taxpayer that is originally placed in service after December 31, 1993, and before January 1, 2013. See § 45(e)(7) for rules relating to the inapplicability of the credit to electricity sold to utilities under certain contracts.

Section 45(d)(2)(A) defines a qualified facility using closed-loop biomass to produce electricity as any facility (i) owned by the taxpayer that is originally placed in service after December 31, 1992, and before January 1, 2014, or (ii) owned by the taxpayer which before January 1, 2014, is originally placed in service and modified to use closed-loop biomass to co-fire with coal, with other biomass, or with both, but only if the modification is approved under the Biomass Power for Rural Development Programs or is part of a pilot project of the Commodity Credit Corporation as described in 65 Fed. Reg. 63052. Section 45(d)(2)(C) provides that in the case of a qualified facility described in § 45(d)(2)(A)(ii), (i) the 10-year period referred to in § 45(a) is treated as beginning no earlier than the date of enactment of § 45(d)(2)(B)(i); and (ii) if the owner of the facility is not the producer of the electricity, the person eligible for the credit allowable under § 45(a) is the lessee or the operator of the facility.

Section 45(d)(3)(A) defines a qualified facility using open-loop biomass to produce electricity as any facility owned by the taxpayer which (i) in the case of a facility using agricultural livestock waste nutrients, (I) is originally placed in service after the date of enactment of § 45(d)(3)(A)(i)(I) and before January 1, 2014, and (II) the nameplate capacity rating of which is not less than 150 kilowatts; and (ii) in the case of any other facility, is originally placed in service before January 1, 2014. In the case of any facility described in § 45(d)(3)(A), if the owner of the facility is not the producer of the electricity, § 45(d)(3)(C) provides that the person eligible for the credit allowable under § 45(a) is the lessee or the operator of the facility.

Section 45(d)(4) defines a qualified facility using geothermal or solar energy to produce electricity as any facility owned by the taxpayer which is originally placed in service after the date of enactment of § 45(d)(4) and before January 1, 2014 (January 1, 2006, in the case of a facility using solar energy). A qualified facility using geothermal or solar energy does not include any property described in § 48(a)(3) the basis of which is taken into account by the taxpayer for purposes of determining the energy credit under § 48.

Section 45(d)(5) defines a qualified facility using small irrigation power to produce electricity as any facility owned by the taxpayer which is originally placed in service after the date of enactment of § 45(d)(5) and before October 3, 2008.

Section 45(d)(6) defines a qualified facility using gas derived from the biodegradation of municipal solid waste to produce electricity as any facility owned by the taxpayer which is originally placed in service after the date of enactment of § 45(d)(6) and before January 1, 2014.

Section 45(d)(7) defines a qualified facility (other than a facility described in paragraph (6)) that burns municipal solid waste to produce electricity as any facility owned by the taxpayer which is originally placed in service after the date of enactment of § 45(d)(7) and before January 1, 2014. A qualified facility burning municipal solid waste includes a new unit placed in service in connection with a facility placed in service on or before the date of enactment of § 45(d)(7), but only to the extent of the increased amount of electricity produced at the facility by reason of such new unit.

Section 45(d)(8) provides in the case of a facility that produces refined coal, the term "refined coal production facility" means (i) with respect to a facility producing steel industry fuel, any facility (or any modification to a facility) which is placed in service before January 1, 2010, and (ii) with respect to any other facility producing refined coal, and facilty placed in service after the date of the enactment of the American Jobs Creation Act of 2004 and before January 1, 2010.

Section 45(d)(9) defines a qualified facility producing qualified hydroelectric production described in § 45(c)(8) as (A) any facility producing incremental hydropower production, but only to the extent of its incremental hydropower production attributable to efficiency improvements or additions to capacity described in § 45(c)(8)(B) placed in service after the date of enactment of § 45(d)(9) and before January 1, 2014, and (B) any other facility placed in service after the date of enactment of § 45(d)(9) and before January 1, 2014. Section 45(d)(9)(C) provides that in the case of a qualified facility described in § 45(d)(9)(A), the 10-year period referred to in § 45(a) is treated as beginning on the date the efficiency improvements or additions to capacity are placed in service.

Section 45(d)(10) provides in the case of a facility that produces Indian coal, the term "Indian coal production facility" means a facility which is placed in service before January 1, 2009.

Section 45(d)(11) provides in the case of a facility producing electricity from marine and hydrokinetic renewable energy, the term "qualified facility" means any facility owned by the taxpayer which (i) has a nameplate capacity rating of at least 150 kilowatts, and (ii) which is originally placed in service on or after the date of the enactment of this paragraph and before Janaury 1, 2012.

Section 45(e)(8)(A) provides that the refined coal production credit is an amount equal to $4.375 per ton of qualified refined coal (i) produced by the taxpayer at a refined coal production facility during the 10-year period beginning on the date the facility was originally placed in service, and (ii) sold by the taxpayer (I) to an unrelated person and (II) during the 10-year period and the tax year. Section 45(e)(8)(B) provides that the amount of credit determined under § 45(e)(8)(A) is reduced by an amount which bears the same ratio to the amount of the increase as (i) the amount by which the reference price of fuel used as feedstock (within the meaning of § 45(c)(7)(A)) for the calendar year in which the sale occurs exceeds an amount equal to 1.7 multiplied by the reference price for such fuel in 2002, bears to (ii) $8.75. Section 45(e)(8)(D)(ii)(I) provides that in the case of a taxpayer who produces steel industry fuel, subparagraph (A) shall be applied by substituting "2.00 per barrel-of-oil equivalent" for $4.375 per ton." Section 45(e)(8)(D)(ii)(II) provides that in lieu of the 10-yeasr period referred to in clauses (i) and (ii)(II) of subparagraph (A), the credit period shall be the period beginning in the later of the date such facility was originally placed-in-service, or October 1, 2008, and ending on the later of December 31, 2009, or the date which is 1 year after the date such facility or the modifications described in clause (iii) were placed in service. Section 45(e)(8)(D)(ii)(III) provides that subparagraph (B) (dealing with the phaseout of the credit) will not apply.

Section 45(e)(10)(A) provides in the case of a producer of Indian coal, the credit determined under section 45 for any taxable year shall be increased by an amount

equal to the applicable dollar amount per ton of Indian coal (i) produced by the taxpayer at an Indian coal production facility during the 7-year period beginning on January 1, 2006, and (ii) sold by the taxpayer (I) to an unrelated person, and (II) during such 7-year period and such taxable year.

Section 45(e)(10)(B)(i) defines "applicable dollar amount" for any taxable year as (I) $1.50 in the case of calendar years 2006 through 2009, and (II) $2.00 in the case of calendar years beginning after 2009.

Section 45(e)(2)(A) requires the Secretary to determine and publish in the Federal Register each calendar year the inflation adjustment factor and the reference price for the calendar year. The inflation adjustment factors and the reference prices for the 2010 calendar year were published in the Federal Register on April 1, 2010 (75 Fed. Reg.16576).

Section 45(e)(2)(B) defines the inflation adjustment factor for a calendar year as the fraction the numerator of which is the GDP implicit price deflator for the preceding calendar year and the denominator of which is the GDP implicit price deflator for the calendar year 1992. The term "GDP implicit price deflator" means the most recent revision of the implicit price deflator for the gross domestic product as computed and published by the Department of Commerce before March 15 of the calendar year.

Section 45(e)(2)(C) provides that the reference price is the Secretary's determination of the annual average contract price per kilowatt hour of electricity generated from the same qualified energy resource and sold in the previous year in the United States. Only contracts entered into after December 31, 1989, are taken into account.

Under § 45(e)(8)(C), the determination of the reference price for fuel used as feedstock within the meaning of § 45(c)(7)(A) is made according to rules similar to the rules under § 45(e)(2)(C).

Under section 45(e)(10)(B)(ii), in the case of any calendar year after 2006, each of the dollar amounts under section 45(e)(10)(B)(i) shall be equal to the product of such dollar amount and the inflation adjustment factor determined under section 45(e)(2)(B) for the calendar year, except that section 45(e)(2)(B) shall be applied by substituting 2005 for 1992.

## INFLATION ADJUSTMENT FACTORS AND REFERENCE PRICES

The inflation adjustment factor for calendar year 2010 for qualified energy resources and refined coal is 1.4342. The inflation adjustment factor for Indian coal is 1.0976. The reference price for calendar year 2010 for facilities producing electricity from wind (based upon information provided by the Department of Energy) is 4.22 cents per kilowatt hour. The reference prices for fuel used as feedstock within the meaning of § 45(c)(7)(A), relating to refined coal production (based upon information provided by the Department of Energy) are $31.90 per ton for calendar year 2002 and $54.74 per ton for calendar year 2010. The reference prices for facilities producing electricity from closed-loop biomass, open-loop biomass, geothermal energy, solar energy, small irrigation power, municipal solid waste, qualified hydropower production, marine and hydrokinetic energy have not been determined for calendar year 2010.

## PHASE-OUT CALCULATION

Because the 2010 reference price for electricity produced from wind does not exceed 8 cents multiplied by the inflation adjustment factor, the phaseout of the credit provided in § 45(b)(1) does not apply to such electricity sold during calendar year 2010. Because the 2010 reference price of fuel used as feedstock for refined coal does not exceed the $31.90 reference price of such fuel in 2002 multiplied by the inflation adjustment factor and 1.7, the phaseout of credit provided in § 45(e)(8)(B) does not apply to refined coal sold during calendar year 2010. Further, for electricity produced from closed-loop biomass, open-loop biomass, geothermal energy, solar energy, small irrigation power, municipal solid waste, qualified hydropower production, marine and hydrokinetic energy, the phaseout of credit provided in § 45(b)(1) does not apply to such electricity sold during calendar year 2010.

## CREDIT AMOUNT BY QUALIFIED ENERGY RESOURCE AND FACILITY, REFINED COAL, AND INDIAN COAL

As required by § 45(b)(2), the 1.5 cent amount in § 45(a)(1), the 8 cent amount in § 45(b)(1), the $4.375 amount in § 45(e)(8)(A) and the $2.00 amount in § 45(e)(8)(D) are each adjusted by multiplying such amount by the inflation adjustment factor for the calendar year in which the sale occurs. If any amount as increased under the preceding sentence is not a multiple of 0.1 cent, such amount is rounded to the nearest multiple of 0.1 cent. In the case of electricity produced in open-loop biomass facilities, small irrigation power facilities, landfill gas facilities, trash combustion facilities, qualified hydropower facilities, marine and hydrokinetic renewable energy, § 45(b)(4)(A) requires the amount in effect under § 45(a)(1) (before rounding to the nearest 0.1 cent) to be reduced by one-half. Under the calculation required by § 45(b)(2), the credit for renewable electricity production for calendar year 2010 under § 45(a) is 2.2 cents per kilowatt hour on the sale of electricity produced from the qualified energy resources of wind, closed-loop biomass, geothermal energy, and solar energy, and 1.1 cent per kilowatt hour on the sale of electricity produced in open-loop biomass facilities, small irrigation power facilities, landfill gas facilities, trash combustion facilities, qualified hydropower facilities, marine and hydrokinetic energy facilities. Under the calculation required by § 45(b)(2), the credit for refined coal production for calendar year 2010 under section 45(e)(8)(A) is $6.27 per ton on the sale of qualified refined coal. The credit for steel industry fuel is $2.87 per barrel-of-oil equivalent of steel industry fuel sold. The credit for Indian coal production for calendar year 2010 under § 45(e)(10)(B) is $2.2 per ton on the sale of Indian coal.

## DRAFTING AND CONTACT INFORMATION

The principal author of this notice is Philip Tiegerman of the Office of Associate Chief Counsel (Passthroughs and Special Industries). For further information regarding this notice, contact Mr. Tiegerman at (202) 622–3110 (not a toll-free call).

# Part IV. Items of General Interest

## US-Belgium Agreement on Pension Plans under Treaty Article 17

## Announcement 2010–27

The following is a copy of the Competent Authority Agreement entered into by the competent authorities of the United States of America and Belgium with respect to the types of pension plans established in either Contracting State that will be deemed to generally correspond to a pension plan recognized for tax purposes in the other Contracting State as required by paragraphs 7 and 9 of Article 17 (Pensions, Social Security, Annuities, Alimony, and Child Support) of the Convention Between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income signed at Brussels on November 27, 2006.

The text of the Competent Authority Agreement is as follows:

**COMPETENT AUTHORITY AGREEMENT**

The competent authorities of the United States and Belgium hereby enter into the following agreement (the "Agreement") regarding the types of pension plans established in either Contracting State that will be deemed to generally correspond to a pension plan recognized for tax purposes in the other Contracting State as required by paragraphs 7 and 9 of Article 17 (Pensions, Social Security, Annuities, Alimony, and Child Support) of the Convention Between the Government of the United States of America and the Government of the Kingdom of Belgium for the Avoidance of Double Taxation and the Prevention of Fiscal Evasion with Respect to Taxes on Income signed at Brussels on November 27, 2006 (the "Treaty"). The Agreement is entered into under paragraph 3 of Article 24 (Mutual Agreement Procedure).

The competent authorities agree as follows:

1. *Belgian Pensions*
   For purposes of paragraphs 7 and 9 of Article 17, the following types of pension plans established in Belgium will be deemed to generally correspond to a pension plan recognized for tax purposes in the United States:
   a. a qualified complementary retirement benefit arrangement for purposes of Article 52, 3°, b, of the Code of Income Taxes (Code des Impôts sur les revenues 1992),
   b. a qualified complementary retirement benefit arrangement for purposes of Article 52, 7° bis, of the Code on Income taxes (Code des Impôts sur les revenues 1992),
   c. a qualified complementary retirement benefit arrangement for purposes of Article 59, of the Code of Income Taxes (Code des Impôts sur les revenues 1992),
   d. a qualified complementary retirement benefit arrangement for purposes of Article 145–1, 1°, of the Code of Income Taxes (Code des Impôts sur les revenues 1992), and
   e. a qualified complementary retirement benefit arrangement for purposes of Article 145–3, of the Code of Income Taxes (Code des Impôts sur les revenues 1992).
2. *US Pensions*
   For purposes of paragraphs 7 and 9 of Article 17, the following types of pension plans established in the United States will be deemed to generally correspond to a pension plan recognized for tax purposes in Belgium:
   a. a qualified plan under section 401(a) of the Internal Revenue Code (including a Code section 401(k) arrangement),
   b. an individual retirement plan (including an individual retirement plan that is part of a simplified employee pension plan that satisfies Code section 408(k)), an individual retirement account, an individual retirement annuity, a Code section 408(p) account, and a Roth IRA under Code section 408A,
   c. a Code section 403(a) qualified annuity plan,
   d. a Code section 403(b) plan,
   e. a Code section 457(b) plan, and
   f. the Thrift Savings Plan (Code section 7701(j)).

The listing above is not intended to be exclusive. Any U.S. or Belgian pension plan of a type not mentioned above, including any type of plan established pursuant to legislation enacted after the date of signature of this Agreement, or any participant in a type of plan not mentioned above, may ask the competent authority of the other Contracting State for a determination that the plan generally corresponds to a pension plan recognized for tax purposes in that other State.

Agreed to by the undersigned competent authorities on January 14, 2010:

| /s/ | 1-14-2010 |
|---|---|
| Douglas W. O'Donnell | Date |
| U.S. Competent Authority | |

| /s/ | 11-20-2009 |
|---|---|
| Sandra Knaepen | Date |
| Belgian Competent Authority | |

## Furnishing Identifying Number of Tax Return Preparer; Hearing

## Announcement 2010–33

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of public hearing on proposed rulemaking.

SUMMARY: This document provides notice of public hearing on a notice of proposed rulemaking (REG–134235–08, 2010–16 I.R.B. 596) providing guidance to tax return preparers on furnishing an identifying number on tax returns and claims for refund of tax that they prepare.

DATES: The public hearing is being held on Thursday, May 6, 2010, at 1:30 p.m. The IRS must receive outlines of the topics to be discussed at the hearing by Thursday, April 29, 2010.

ADDRESSES: The public hearing is being held in room 2615, Internal Revenue Building, 1111 Constitution Avenue, NW, Washington, DC. Send submissions to: CC:PA:LPD:PR (REG–134235–08), room 5203, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered Monday through Friday between the hours of 8 a.m. and 4 p.m. to CC:PA:LPD:PR (REG–134235–08), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington, DC. Alternatively, taxpayers may submit electronic outlines of oral comments via the Federal eRulemaking Portal at *http://www.regulations.gov*.

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Stuart Murray at (202) 622–4940 (not a toll-free number); concerning submissions of comments, the hearing, and/or to be placed on the building access list to attend the hearing, Richard A. Hurst at *Richard.A.Hurst@irscounsel.treas.gov*.

SUPPLEMENTARY INFORMATION: The subject of the public hearing is the notice of proposed rulemaking (REG–134235–08) that was published in the **Federal Register** on Friday, March 26, 2010 (75 FR 14539).

Persons, who wish to present oral comments at the hearing that submitted written comments, must submit an outline of the topics to be discussed and the amount of time to be devoted to each topic (signed original and eight (8) copies) by Thursday, April 29, 2010.

A period of 10 minutes is allotted to each person for presenting oral comments. After the deadline for receiving outlines has passed, the IRS will prepare an agenda containing the schedule of speakers. Copies of the agenda will be made available, free of charge, at the hearing or in the Freedom of Information Reading Room (FOIA RR) (Room 1621) which is located at the 11th and Pennsylvania Avenue NW entrance, 1111 Constitution Avenue, NW, Washington, DC.

Because of access restrictions, the IRS will not admit visitors beyond the immediate entrance area more than 30 minutes before the hearing starts. For information about having your name placed on the building access list to attend the hearing, see the FOR FURTHER INFORMATION CONTACT section of this document.

Approved February 18, 2010.

LaNita Van Dyke,
*Chief, Publications and Regulations Branch, Legal Processing Division, Associate Chief Counsel (Procedure and Administration).*

(Filed by the Office of the Federal Register on April 21, 2010, 8:45 a.m., and published in the issue of the Federal Register for April 22, 2010, 75 F.R. 20941)

# Definition of Terms

*Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:*

*Amplified* describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

*Clarified* is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

*Distinguished* describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

*Modified* is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

*Obsoleted* describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

*Revoked* describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

*Superseded* describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

*Supplemented* is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

*Suspended* is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

# Abbreviations

*The following abbreviations in current use and formerly used will appear in material published in the Bulletin.*

*A*—Individual.
*Acq.*—Acquiescence.
*B*—Individual.
*BE*—Beneficiary.
*BK*—Bank.
*B.T.A.*—Board of Tax Appeals.
*C*—Individual.
*C.B.*—Cumulative Bulletin.
*CFR*—Code of Federal Regulations.
*CI*—City.
*COOP*—Cooperative.
*Ct.D.*—Court Decision.
*CY*—County.
*D*—Decedent.
*DC*—Dummy Corporation.
*DE*—Donee.
*Del. Order*—Delegation Order.
*DISC*—Domestic International Sales Corporation.
*DR*—Donor.
*E*—Estate.
*EE*—Employee.
*E.O.*—Executive Order.
*ER*—Employer.
*ERISA*—Employee Retirement Income Security Act.
*EX*—Executor.
*F*—Fiduciary.
*FC*—Foreign Country.
*FICA*—Federal Insurance Contributions Act.
*FISC*—Foreign International Sales Company.
*FPH*—Foreign Personal Holding Company.
*F.R.*—Federal Register.
*FUTA*—Federal Unemployment Tax Act.
*FX*—Foreign corporation.
*G.C.M.*—Chief Counsel's Memorandum.
*GE*—Grantee.
*GP*—General Partner.
*GR*—Grantor.
*IC*—Insurance Company.
*I.R.B.*—Internal Revenue Bulletin.
*LE*—Lessee.
*LP*—Limited Partner.
*LR*—Lessor.
*M*—Minor.
*Nonacq.*—Nonacquiescence.
*O*—Organization.
*P*—Parent Corporation.
*PHC*—Personal Holding Company.
*PO*—Possession of the U.S.
*PR*—Partner.
*PRS*—Partnership.
*PTE*—Prohibited Transaction Exemption.
*Pub. L.*—Public Law.
*REIT*—Real Estate Investment Trust.
*Rev. Proc.*—Revenue Procedure.
*Rev. Rul.*—Revenue Ruling.
*S*—Subsidiary.
*S.P.R.*—Statement of Procedural Rules.
*Stat.*—Statutes at Large.
*T*—Target Corporation.
*T.C.*—Tax Court.
*T.D.* —Treasury Decision.
*TFE*—Transferee.
*TFR*—Transferor.
*T.I.R.*—Technical Information Release.
*TP*—Taxpayer.
*TR*—Trust.
*TT*—Trustee.
*U.S.C.*—United States Code.
*X*—Corporation.
*Y*—Corporation.
*Z* —Corporation.

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[1] A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2009–27 through 2009–52 is in Internal Revenue Bulletin 2009–52, dated December 28, 2009.

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