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Mental Health Parity Act Becomes Law: Ramifications for Health Plans

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On Oct. 3 the Emergency Economic Stabilization Act of 2008 (EESA) was signed into law. EESA contains provisions that greatly expand the reach of the Mental Health Parity Act of 1996 (MHPA). The effective date of these amendments to the MHPA is Jan. 1, 2010, for most group health plans.

Mental Health Parity Act History

The MHPA is a federal law that amended the Employee Retirement Income Security Act of 1974 (ERISA), the Internal Revenue Code and the Public Health Security Act to prohibit group health plans from applying lower annual or aggregate lifetime dollar limits to mental health benefits than were applied to surgical and medical benefits.

Under the MHPA, if a group health plan, insurance company or HMO did not impose aggregate lifetime limits on substantially all medical and surgical benefits, it could not impose any limits on mental health benefits offered under the plan. If the plan did include lifetime limits on medical and surgical benefits, then, in general, limits on mental health benefits had to be either greater than or equal to those limits. MHPA did not contain provisions related to substance abuse or chemical dependency.

The MHPA provisions were originally set to expire on or after Sept. 30, 2001; however, they have been ex-

tended by federal legislation many times. EESA eliminated the sunset provision under which these existing requirements would have expired at the end of 2008.

EESA Details

Benefit Equalization

EESA requires parity (or equality) in coverage for mental health and substance use disorder benefits.

The law does not require a group health plan (or the health insurance coverage offered in connection with such plan) to provide mental health and substance use disorder coverage. However, if the plan does provide such benefits, the financial requirements and treatment limitations for mental health or substance use disorder benefits may not be more restrictive than the most frequent financial requirements applied to substantially all medical and surgical benefits covered under the plan.

Financial requirements are defined by EESA as deductibles, copayments, coinsurance and out-of-pocket expenses. In addition, there can be no separate cost-sharing requirements or treatment limitations applicable to only mental health or substance use disorder benefits.

Treatment limitations are generally defined as limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

Disclosure

EESA adds a new disclosure provision to ERISA. The criteria for medical necessity decisions with respect to mental health or substance use disorder under the group health plan must be made available by the plan administrator (or insurance carrier insuring the benefits) upon request to any current or potential participant, beneficiary or contracting provider.

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In addition, the reason for any claim denial or denial of a reimbursement request with respect to mental health or substance use disorder must be made available to a participant or beneficiary upon request or as otherwise required.

Out-of-Network Providers

EESA does not require a group health plan to provide out-of-network coverage. However, if the group health plan provides out-of-network coverage for medical or surgical benefits, then the group health plan must also provide out-of-network coverage for mental health or substance use disorder in a manner that is consistent with the coverage for medical or surgical benefits.

This seems to imply that the financial requirements and treatment limitations for mental health or substance use disorder benefits obtained through an out-of-network provider can be no more restrictive than the general financial requirements applied to substantially all medical and surgical benefits obtained from an out-of-network provider.

In addition, there can be no separate cost-sharing requirements or treatment limitations applicable to mental health or substance use disorder benefits, unless such requirements and limitations apply to medical and surgical benefits obtained from an out-of-network provider.

Group Health Plans to Which the Law Applies

The law only affects group health plans with 51 or more employees in the prior calendar year. EESA does not apply to small employers, defined as employers that employ at least two (or one, in the case of states that permit a small group to include a single individual) but no more than 50 employees on business days during the prior calendar year.

Cost of Compliance

The Congressional Budget Office has estimated that the law will increase premiums by 0.2 percent to 0.4 percent for group health plans. However, many proponents of the law argue that treating mental illness early prevents more expensive care and hospitalization down the road.

Opt Out

There is a voluntary opt-out clause for group health plans (or the health insurance offered in connection

with such plans) if as a result of offering this coverage, the cost of coverage with respect to medical and surgical benefits and mental health and substance abuse disorder benefits rise more than 2 percent in the first year and 1 percent annually thereafter.

A determination regarding the increase in cost must be made by an actuary in a written report. A determination may be performed after the year in question or within six months of that year. If the plan qualifies and chooses to exercise the exemption, it must file for an exemption with the secretary of labor. The actuarial report must be maintained by the plan for six years from the date of the exemption filing. The secretary of labor may audit the books and records of a plan requesting an exemption during the six-year period following the exemption request.

Additional Regulatory Guidance

The regulators are required to publish and widely disseminate guidance with respect to this law and the continued applicability of state law. The Secretaries of Labor, Health and Human Services and Treasury are required to issue regulations regarding EESA within one year of the date of enactment.

What This Means for Your Health Plan

In summary, if your health plan provides more restrictive coverage for mental health care (*i.e.*, depression, schizophrenia or eating disorders) or substance use disorder (*i.e.*, alcohol or drug abuse) than for the most frequent treatment of physical conditions (*i.e.*, cancer, broken bones or heart disease) the plan will need to adjust its benefits to comply with the new law.

If your plan sets limits on hospital inpatient days and outpatient days for mental health or substance abuse, but not substantially for other physical ailments, the plan will need to be amended to provide parity in coverage.

In addition, if your plan has separate cost-sharing requirements or treatment limitations applicable to only mental health or substance use disorder benefits, these will need to be eliminated or applied to all benefits equally.

Finally, if out-of-network coverage is provided, except in the area of mental health or substance abuse, out-of-network coverage must be provided to mental health and substance abuse treatment as well.