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Financial Bailout Gives Life to Mental Health Parity Law

The financial bailout bill signed by President Bush includes provisions that will require group health plans to provide greater parity between mental health benefits and benefits for other medical conditions. It also extends these parity requirements to substance abuse benefits.

Background

For years, advocates of greater benefits for the treatment of mental health conditions have been lobbying for legislation to require that group health plans cover such illnesses on the same terms as for any other medical condition. The first mental health parity law, the Mental Health Parity Act of 1996 (MHPA), prohibits group health plans that provide mental health benefits from imposing a lower annual or lifetime dollar limit on these benefits than it imposes on medical/surgical benefits. However, plans are permitted to impose other limits, such as on the number of outpatient visits or hospital stays, even if they do not impose such limits with respect to other medical conditions. MHPA was first slated to expire on September 30, 2001, but has been reenacted every year since then.

Over the past several years, there has been a continued push to provide for complete parity for mental health benefits. The House and Senate finally agreed to compromise legislation, which was signed into law as part of the financial bailout legislation on October 3, 2008.

New Mental Health Parity Law

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) eliminates the sunset provision of MHPA. It also amends ERISA, the Public Health Service Act and the Internal Revenue Code to expand the parity rules enacted under MPHA to prohibit group health plans (both self-funded and insured) from imposing financial requirements or treatment limitations on mental health benefits that are more restrictive than the predominant (most common or frequent) requirements and limitations imposed on medical and surgical benefits. Significantly, these parity provisions also apply to substance use disorder benefits.

Financial requirements include deductibles, copayments, coinsurance and out-of-pocket expenses, but exclude the aggregate lifetime and annual limits that were already subject to MHPA (which the new law makes permanent). Treatment limitations include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

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Out-of-Network Services. The law specifies that if a health plan provides out-of-network coverage for medical and surgical procedures, it must also provide out-of-network coverage for mental health and substance use disorder services.

Medical Necessity and Claims Denial Information. The law requires that the criteria used by a plan in making medical necessity determinations with respect to mental health or substance abuse treatment be made available to current or potential participants or contracting providers upon request. Similarly, if a claim for mental health or substance abuse benefits is denied, the reason for denial must be made available to participants upon request.

Exemptions from Law

MHPAEA only affects those employers who offer mental health or substance abuse benefits. It does not require group health plans to provide these benefits nor does it specify what conditions must be covered.

Small Employer Exemption. Like MHPA, the new law exempts small employers from its provisions. For this purpose, a small employer is an entity that employs at least two and no more than 50 employees on the first day of the plan year (or one employee if permitted under state law).

Cost Exemption. A group health plan may elect to be exempt from the law if compliance causes its total plan costs to increase by more than 2% in the first year of its applicability and more than 1% in subsequent years. To elect this exemption for a year, the plan must –

- provide a written, certified report from a member of the American Academy of Actuaries that the costs have increased by at least the required percentage. This report must be based on at least the first six months of experience in compliance with the new parity rules.
- notify the appropriate federal and state agencies, participants and beneficiaries of the election. This notification must include the number of covered lives, any prior elections, and the actual total costs for medical/surgical/mental health benefits for the current and prior plan year.

Importantly, if the employer meets the requirements to elect the exemption, it will apply only for the following plan year.

> ***BUCK COMMENT.*** *It appears that the exemption will thus be available only in alternate years. For example, if actual experience during 2010 is used to justify a cost exemption in 2011, then actual experience will not be available from 2011 to justify a 2012 exemption. 2012 compliance would be required, which could then be used to justify a 2013 exemption. These requirements greatly limit the ability to use this cost exemption.*

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Effective Date

The new law is to be effective for plan years beginning one year after enactment. Thus, calendar year plans will have to comply beginning with the plan year commencing on January 1, 2010. For collectively-bargained plans, the law will apply for plan years beginning after the later of January 1, 2009 or the date on which the last of the current agreements terminates.

Conclusion

The new parity law will require changes to most group health plans.

Buck's consultants would be pleased to discuss any questions or concerns you may have with the new law and help you implement its provisions.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.

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