A Timely Analysis of Legal Developments

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Along with the recent financial rescue legislation signed into law by the President on October 8, 2008, a provision was included requiring group health plans - whether insured or self-insured - that provide mental health and substance use disorders benefits, to provide such benefits in equal measure with the plan's medical and surgical benefits. With an effective date for most calendar year plans of January 1, 2010, employers must carefully examine these new requirements and their group health benefit programs to determine how to meet this new employee benefits challenge.

Equal Mental Health and Substance Use Benefits Realized

By Russell D. Chapman and Andrea Jackson

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("the Act") was signed into law on October 3, 2008, as part of H.R. 1424, the Tax Extender's and Alternative Minimum Tax Relief Act of 2008, a part of the recent massive financial rescue legislation. The long-awaited Act amends current requirements under ERISA, the Public Health Service Act and the Internal Revenue Code for parity in mental health benefits offered under a private group health benefit plan (currently known as the Mental Health Parity Act (MHPA)).

The Act is significant because, for the first time, federal law will require private group health benefit plans to provide mental health and substance use disorder benefits on an equivalent basis to medical and surgical benefits. It will enable plan participants greater access to these types of benefits and will necessitate several plan design decisions on the part of plan sponsors. Primarily, plan sponsors will have to determine whether they can afford to provide mental health and substance use disorder benefits at the heightened levels required by the Act.

The Act defines *mental health benefits* as "benefits with respect to service for mental health conditions, as defined under the terms of the plan and in accordance with Federal and State law" and *substance use disorder benefits* as "benefits with respect to services for substance use disorders, as defined under the plan and in accordance with applicable Federal and State law."

Substantial Changes Required to Group Health Benefit Plan Design

Currently, the MHPA permits a plan sponsor to design a group health benefit plan that contains various restrictions on the access to mental health benefits, including an outright exclusion on the coverage of substance use disorder benefits. Under the Act, mental health and substance use disorder services must be on equal footing or "parity" with other group health benefits; this will require changes to a vast number of existing group health benefit plans.

In order to ensure parity in coverage, the Act imposes several plan design requirements upon group health benefit plans that offer mental health and/or substance use disorder benefits:

- **Financial requirements**: A group health benefit plan that imposes cost-sharing devices such as co-pays or coinsurance for medical and surgical benefits must offer coverage for mental health issues and/or substance use disorders at equal rates. Current group health benefit plans are often designed to impose separate and unequal financial requirements for coverage of mental health benefit services, for example $20 co-pays for a physician visit, but $50 co-pay for a visit to a mental health professional. The Act will prohibit unequal financial requirements such as this, representing a significant change from the current MHPA. However, this provision does not apply to lifetime and annual limits under a group health benefit plan.
- **Treatment requirements**: Group health benefit plans may no longer impose treatment limitations (e.g., number of visits, days of coverage) on mental health and substance use disorder benefits unless they also impose such limits on medical and surgical benefits. For example, a group health benefit plan may not limit coverage of mental health therapy sessions to 20 per year, another significant change from the current MHPA.
- **Coverage requirements**: Group health benefit plans that offer coverage of medical and surgical benefits on an out-of-network basis will also be required to offer coverage for mental health and substance use disorder benefits on an out-of-network basis. No such requirement currently exists under the MHPA.
- **Coverage decision requirements**: Group health benefit plans (or issuers of such coverage) that offer mental health and substance use disorder benefits must make the criteria for medical necessity determinations available to participants and beneficiaries upon request. An explanation of a denial of a payment or reimbursement for such benefits under the plan must be made upon request of the participant and in accordance with forthcoming regulations from the Internal Revenue Service, Health and Human Services and Department of Labor.

Exceptions for Employer Size or Increased Cost

Similar to the requirements of the current MHPA, the Act exempts from its provisions an employer who employs on average at least two (or one in states that permit small groups to include an individual) but not more than 50 employees in the preceding calendar year. This is a significant change from the current MHPA, which determines a small employer based on the number of employees that are employed on the first day of the plan year.

The Act also expands an exemption known as the *increased cost exemption* for a group health benefit plan. A group health benefit plan may apply for this exemption if it can demonstrate that compliance with the parity rules increases the total cost of coverage with respect to all benefits under the group health benefit plan by two percent or more in the first year that the parity rule applies to the plan (or by one percent or more in subsequent plan years). The exemption from the parity rules will apply only for the plan year in which the exemption can be met; therefore annual testing is needed. The total cost of coverage and the percentage of increased costs for all benefits due to compliance with the parity rule under the plan must be determined by a certified and licensed actuary in a written report and must be determined after the group health benefit plan has complied with the Act for the first six months of the plan year in question. Notice of the exemption must be given to the IRS, applicable state agencies, and participants and beneficiaries.

Effective Dates

The Act is effective for plan years beginning one year after the date of enactment, October 3, 2008. For calendar year plans, the Act is effective January 1, 2010. Until that time, the current MHPA requirements will continue to apply to group health benefit plans. The Secretaries of Labor, Treasury and Health and Human Services are directed to promulgate regulations before the first anniversary of the enactment of the Act, but the Act will become effective regardless of whether the regulations have been promulgated.

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A New Direction for Plan Sponsors

The signing of the Act represents the culmination of 12 years of legislative action with respect to parity for mental health and substance use disorder benefits. For employers, the Act may require significant changes in plan design and will likely increase plan costs at a time when employers are already struggling with the high costs of health plan coverage. Because of these stresses, and because the Act does not *require* employers to provide either mental health or substance use disorder benefits, it remains to be seen whether employers will continue to offer one or both of these types of benefits beyond the Act's effective date.

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