CLIENT ACTION BULLETIN

October 13, 2008 **CAB 08-20R**

Mental Health Parity, Other Health-Related Requirements Enacted

SUMMARY

After more than a decade of failed efforts, Congress has approved a bill that includes provisions to require employer-sponsored health plans to provide true parity for mental health benefits. The parity provisions are tucked into the "Emergency Economic Stabilization Act" (H.R.1424) – the so-called "bailout" bill aimed at stemming the current financial crisis. The President signed the measure on Oct. 3 (P.L.110-343).

Separately, employers need to be aware of two other health-related items of interest: a bill that is about to become law that extends coverage for dependent college students on medical leaves of absence; and a law that modifies the prohibitions on employment discrimination on the basis of an individual's disability.

DISCUSSION

Mental Health and Substance Use Disorder Benefits Parity

Effective for plan years beginning on or after Oct. 3, 2009, group health plans and insurance that offer mental health or substance use disorder benefits must provide such benefits on a par with the plans' medical and surgical benefits. (For most plans, the effective date will be Jan. 1, 2010.) By amending the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code, the new law extends the parity requirement to all employer-sponsored arrangements. An exemption applies, however, to employers with fewer than 51 workers, although state laws – including those that recognize a "group" of one employee – may apply. In addition, an employer may qualify for a year-by-year exemption based on the actual costs of providing the required benefits. A later effective date may apply to plans under a collective bargaining agreement.

Key issues covered by the new requirement include:

- *Scope of benefits* – The definitions of "mental health" and "substance use disorder" benefits are to be determined by the plan and in accordance with applicable federal or state laws. Thus, self-insured plans (under ERISA) remain free to define the benefits covered, while insured plans (under the PHSA) must look to any applicable state laws for the benefits that must be covered. Plans are permitted to use utilization review and other authorization or medical management practices, and may determine the criteria for medical necessity and appropriateness.
- *Financial requirements* – Plan participants may not be required to pay more in deductibles, copayments, coinsurance, and out-of-pocket expenses for mental health and substance use disorder benefits than those imposed for the plan's most common or frequent type of medical/surgical benefit. Under a prior law, plans have been prohibited from imposing annual or lifetime limits for mental health benefits if no limits apply to medical/surgical benefits; the new law does not modify this requirement.
- *Treatment limits* – The law requires that plans not impose any limits on the frequency of treatment, the number of visits, the days of coverage, or other similar limits for mental health/substance use disorder benefits that are more restrictive than those imposed on medical/surgical benefits.
- *Network parity* – If a plan offers out-of-network medical/surgical benefits, it must also do so for mental health/substance use disorder benefits.
- *Notification and disclosure* – The plan administrator must disclose any medical necessity determination criteria to any current or potential plan participant, beneficiary, or contracting provider upon request. The reason for any denial of reimbursement or payment for services also must be made available to participants and beneficiaries.

- *Cost exemption* – A plan sponsor that can demonstrate that its actual costs of coverage for the mental health/substance use disorder benefits exceed 2% of the plan's total costs in the first plan year that the new requirement applies (and 1% in subsequent years) may qualify for a one-year exemption the following year. To demonstrate the costs, the plan must obtain an actuarial certification, using data from the first six months of a plan year. Plans qualifying for and electing the cost exemption must notify the appropriate federal agencies (Departments of Labor, Health and Human Services, and Treasury), the appropriate state agencies, and plan participants and beneficiaries of the election. The federal agencies are authorized to audit the records of a group health plan or health insurance issuer relating to an exemption.
- *Penalties* – Plan sponsors or insurers face penalties of up to $100 per day per beneficiary for a failure to comply with the parity requirement, and plan participants may bring civil suit to obtain covered benefits.

Continued Health Plan Coverage for College Students and "Disability" Changes

Two other health-related items of interest to employers are:

- "Michelle's Law" (H.R.2851), which amends ERISA, the PHSA, and the tax code, requires group health plans and insurance to extend coverage for dependent college students who lose coverage due to their less-than-full-time student status because of medical reasons. The extended coverage period is the lesser of: one year after the first day of the medically necessary leave of absence; or until the date on which the plan would otherwise terminate such coverage. Under the bill, the student's attending physician must submit to the plan or insurer a certification stating that the dependent is suffering from a severe illness or injury and that the leave of absence is medically necessary. The bill – named after a student who, against medical advice, attended school full time while undergoing colon cancer treatment in order to retain healthcare coverage – will be effective in plan years beginning one year after it is signed into law and will apply to medically necessary leaves of absence beginning during such plan years. The President is expected to sign the bill soon.
- "The ADA Amendments Act of 2008" (S.3406, signed into law (P.L.110-325) on Sept. 25, 2008) modifies the Americans with Disabilities Act (ADA) to prohibit employment discrimination against individuals on the basis of a disability. The new law overturns recent U.S. Supreme Court rulings that narrowed the definition of "disability." The law redefines "disability" by providing new meanings for "major life activities" and "being regarded as having such an impairment." The amendments to the ADA (along with conforming amendments to the Rehabilitation Act of 1973) are effective on Jan. 1, 2009.

ACTION

Employers that sponsor health benefit plans for their employees should review their plans in light of the new laws. In many cases, contracts with healthcare providers, insurers, and administrators will have to be revised to ensure compliance. Communication materials provided to plan participants may have to be updated, and changes to administrative systems may be necessary. In addition, employment practices – hiring and job duty accommodations in particular – should take into account the requirements of the ADA amendments.

With regard specifically to the mental health/substance use disorder benefits parity requirements, plan sponsors may wish to consider practices to manage costs and/or plan redesigns that assess benefit features across the entire health plan. Whether or not plan sponsors desire seeking a cost exemption, they may want to consider analyzing costs by benefit type as part of an overall healthcare cost assessment. Doing so would enable plan sponsors to determine if the delivery of mental health and substance abuse services is shifting between primary and specialty care settings, especially in the area of psychotropic drug use. Plan sponsors may also wish to evaluate the adequacy of their mental health and substance abuse provider network in light of these increased benefit levels.

For more information about the new laws affecting employer-sponsored health plans, please contact your Milliman consultant.