

# HEALTH LAW

## Update

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

## The New Mental Health Parity Act: What It Does and Doesn't Do

January 7, 2009

On October 3, 2008, Congress passed, and President Bush signed into law, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the "Act").<sup>1</sup> The Act requires group health plans providing mental health and substance abuse treatment benefits to ensure that coverage of these benefits is equal to the plans' coverage of medical and surgical benefits.<sup>2</sup>

### Key Changes Implemented by the Act

Effective for plan years beginning after October 3, 2009,<sup>3</sup> plans must ensure that the predominant financial requirements applicable to mental health and substance abuse disorder benefits, such as deductibles, copayments, coinsurance, and out-of-pocket expenses, are no more restrictive than those applicable to substantially all the plans' covered medical and surgical benefits.<sup>4</sup> The Act also prohibits any separate cost-sharing requirements that are applicable only to mental health or substance abuse disorder benefits.

Under the terms of the Act, plans must ensure that the limitations on treatment applicable to mental health or substance abuse disorder benefits, such as limitations on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope and duration of

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<sup>1</sup> The Act is part of the Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (October 3, 2008).

<sup>2</sup> In order to effectuate this requirement, the Act amends the Employee Retirement Income Security Act of 1974 (ERISA), the Public Health Service Act, and the Internal Revenue Code.

<sup>3</sup> Since most plan years coincide with the calendar year, the effective date for most plans will be January 1, 2010. With respect to a plan maintained pursuant to a collective bargaining agreement, the Act would apply to such plan on the later of (1) the date on which the last collective bargaining agreements relating to the plan terminates or (2) January 1, 2010. *Id.* at Sec. 512(e)(2)

<sup>4</sup> The Plan defines a "predominant" type or limit as being the most common or frequent of such type or limit. While the term "substantially all" is undefined, the Act's use of the term requires plans to measure its mental health and substance abuse benefits against a larger offering of its medical and surgical benefits, as opposed to a select portion of such benefits.

treatment are consistent with the predominant treatment limitations on substantially all medical and surgical benefits. Plans may not impose separate treatment limitations applicable only to mental health or substance abuse disorder benefits.

Further, plans offering medical and surgical benefits provided by out-of-network providers must provide out-of-network coverage for mental health or substance abuse disorder benefits that is similar to out-of-network coverage for medical and surgical benefits. Finally, while the Act does not restrict a plan's ability to deny claims for lack of medical necessity, the plan must make available the criteria for its medical necessity determinations and must provide a participant the reason for denial of such coverage in accordance with regulations.

Some plans are excluded from the reach of the Act. Specifically, the Act excludes health plans of employers who employ fewer than 50 employees.<sup>5</sup> The Act also contains a cost increase exemption, permitting plans to opt out of the requirements of the Act if the Act's application would result in an increase in the total actual costs of coverage of medical and surgical benefits and mental health and substance use disorder benefits equal to or greater than a certain percentage of the actual total plan costs. The applicable percentage is 2% the first plan year in which the cost increase exemption is applied, and 1% for each plan year thereafter. Note that a plan wishing to use this cost increase exemption must undertake what is arguably a significant administrative burden.<sup>6</sup>

The Act does not reach government plans, such as Medicare. However, the Medicare Improvements for Patients and Providers Act ("MIPPA"), which was passed July 15, 2008, contains provisions intended to equalize outpatient psychiatric care covered by Medicare with other types of covered care. Currently, Medicare beneficiaries pay a 50% coinsurance payment for most outpatient mental health services. MIPPA reduces, over a six-year period, this coinsurance payment to 20%, which is equal to the coinsurance payment required for most other outpatient services. MIPPA also expands Medicare beneficiaries' access to needed psychiatric medications.<sup>7</sup>

### Why the Act is Significant

The passage of the Act was welcomed by some critics of the Mental Health Parity Act of 1996 ("1996 MHPA").<sup>8</sup> These critics argued that despite its name, the 1996 MHPA did not go far enough to ensure parity of mental health coverage and have long contended that the provisions of the Act are necessary to close "loopholes" created by the 1996 legislation.<sup>9</sup> The 1996 MHPA

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<sup>5</sup> The calculation is based on the number of employees per day during the preceding calendar year, as measured on an average daily basis.

<sup>6</sup> First, the plan must comply with the Act's requirements for a period of six months and then seek a determination by a certified actuary of the cost increases. The plan must then notify applicable federal and state agencies, as well as participants and beneficiaries, of the plan's election to use the exemption. The exemption is granted for only a one-year period, so a plan wishing to use the exemption in more than one year must repeat the process annually.

<sup>7</sup> See Pub. L. No. 110-275, 422 Stat. 2494 (July 15, 2008).

<sup>8</sup> 29 U.S.C.S §1185a and 42 U.S.C.S. §300gg-5.

<sup>9</sup> See Pear, Robert "Bailout Provides More Mental Health Coverage," New York Times, October 6, 2008. See also, e.g., "Protection Eludes Consumers: 1996 Act is Not Enough," American Psychological Association Practice Organization, February 27, 2007 (<http://www.apapractice.org/apo/pracorg/legislative/elude.html#>).

prohibited large group health plans from imposing annual or aggregate lifetime dollar limits on mental health benefits lower than those applicable to medical and surgical benefits. However, it specifically excluded substance abuse treatment from the reaches of the legislation.<sup>10</sup> In addition, it did not prohibit a plan from imposing higher copayments and deductibles on mental health benefits than those applicable to the plan's medical and surgical benefits. Further, provisions in the 1996 legislation stated that the requirements should be construed to affect only disparities in the aggregate lifetime and annual dollar limits on mental health treatment and should not affect other terms and conditions on which group health plans offer coverage for mental health benefits, such as those relating to the duration, amount, and scope of such coverage.<sup>11</sup>

The Act answers many of the key criticisms of the 1996 MHPA, in that it includes in its affected scope of benefits those relating to substance abuse disorders. As mentioned above, the Act also requires equal copayments, deductibles and other financial requirements, and it eliminates a plan's ability to impose different treatment limitations.

#### What the Act Doesn't Do

It is important to note that the Act applies only to plans that provide mental health or substance abuse disorder benefits. The Act does not require health plans that do not offer any mental health or substance abuse benefits to include these benefits, although plans that are not self-funded may be required to do so in any event under applicable state laws and regulations. Additionally, the Act does not define mental health benefits or substance abuse disorder treatment benefits, deferring instead to the definitions of such terms in each individual plan, which may be shaped in part by existing state or federal laws.

If you have any questions on this Health Law Update, please contact one of the attorneys in our Healthcare Industry Practice listed on the following page.

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<sup>10</sup> 29 U.S.C.S §1185a (e)(4) and 42 U.S.C.S. §300gg-5 (e)(4).

<sup>11</sup> 29 U.S.C.S §1185a (b)(2) and 42 U.S.C.S. §300gg-5 (b)(2).

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