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Economic Stimulus Package Contains New Parity Rules for Mental Health Benefits

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This column discusses the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act," which was part of the Economic Stimulus package enacted by Congress in October 2008. The Act increases and expands the protections for mental health benefits that were established under the 1996 Mental Health Parity Act.

Overview and Background

Buried in the massive economic stimulus package signed by former President Bush on October 3, 2008, is the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act" (the Act or the 2008 Act). The Act expands and makes permanent provisions enacted in 1996 that required equal treatment of mental health benefits under group health care plans. The Act was named for Senator Paul Wellstone, a Minnesota Democrat killed in a plane crash in 2002, who had a brother with severe mental illness, and for Senator Pete Domenici, a Republican of New Mexico and the main sponsor of the Senate bill, who has a daughter with schizophrenia.

The Act's sponsors argued that the legislation was necessary and would not be cost prohibitive. They maintained that researchers have found biological causes and treatments for numerous maladies formerly considered

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"mental illness," thus blurring the line between physical and mental illness. They pointed to the federal health benefit plan (FEHBP), which does provide mental health benefits for members of Congress and over eight million federal employees. They argued that research has shown that there has been no significant cost increases attributable to this parity requirement in the FEHBP. According to House Speaker Nancy Pelosi's office, the Congressional Budge Office estimated a "miniscule" impact on premiums as the result of the Act—two tenths of one percent.[1]

Specific Provisions of the Act

The Act increases the protections for mental health benefits that were established under the 1996 Mental Health Parity Act (1996 Act). The 1996 Act amended Section 713 of ERISA, Section 2705 of the Public Health Service Act, and Section 9812 of the Internal Revenue Code to prohibit group health plans that provide mental health benefits from establishing annual or lifetime dollar limits on mental health care benefits that are lower than the limits set forth for medical or surgical benefits. The 1996 Act did not apply to benefits for substance abuse or chemical dependency. The 1996 Act allowed group health plans to set terms and conditions (such as cost-sharing and limits on the number of visits or days of coverage) for the amount, duration, and scope of mental health benefits that differed from the terms for treatment of physical ailments. The 1996 Act did not require that group health plans offer mental health benefits; the restrictions in the 1996 Act described above go into effect only if mental health benefits are offered.

Similarly, the 2008 Act does not require that group health plans offer mental health benefits. But if such benefits are offered, the 2008 Act imposes more significant requirements that mandate parity between benefits for mental and physical ailments than under the 1996 Act. First, the 2008 Act modifies the original definition of mental health benefits protected under the 1996 Act. "Mental health benefits," initially defined as "benefits with respect to services for mental health conditions, defined under the terms of the plan" are now defined as "benefits provided under the terms of the Plan, and in accordance with applicable federal and state law." The exclusion for benefits related to substance abuse or chemical dependency has been removed. "Substance use disorder benefits," defined as "benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law," are now subject to the parity requirements.

The 2008 Act retains the 1996 Act's mandate for parity in the application of aggregate lifetime and dollar limits for physical and mental health benefits, and now includes substance abuse benefits as covered by this requirement. But in addition to parity for aggregate limits, the 2008 Act requires parity between plans covering physical and mental benefits with respect to most financial requirements for, and restrictions

on, benefits. Thus, group plans that provide mental health or substance use disorder benefits must ensure that any financial deductibles, copayments, coinsurance, and out-of-pocket expense requirements are not more restrictive or costly than the "predominant financial requirements" applied to substantially all medical and surgical benefits under the plan. There can be no separate cost sharing requirements that apply only to mental health or substance use disorder benefits. The frequency of treatment, number of visits, and days of coverage that are applied to mental health or substance use disorder benefits, cannot be more restrictive than the predominant treatment limits applied to substantially all medical and surgical benefits covered by the plan. For example, annual limits of 24 visits to a doctor or 24 days of medical care per year for mental health treatment would be prohibited if similar limits are not imposed on treatments for physical ailments such as cancer, heart disease, or other conditions. For these purposes, a financial limit is considered to be "predominant" if it is the most common or requested type of limit or requirement.

Finally, if the plan or issuer allows for payment for medical or surgical benefits by out-of-network providers, out-of-network providers must be allowed for mental health or substance use disorders.

It is likely that guidance under the 1996 Act allowing use of medical management tools that are based on medical evidence and pertinent to the patient's medical condition will be continued, as long as such practices are consistent with the 2008 Act.

Note that the 2008 Act does not change the section of the law that provides that the Act is applied separately to every option under the plan. Thus, there need not be parity between benefits offered under different plan options such as an HMO option or an indemnity plan option (although there must be parity within each option offered).

Exemptions

The law exempts businesses that employ 50 or fewer employees. It also exempts a health plan if it can demonstrate that the mental health parity rules would increase total plan costs by more than 2 percent in the first year after application of the parity law (it was one percent under the 1996 Act) and one percent for subsequent years. However, the plans must implement parity for at least six months to take advantage of this exemption. Determinations as to increases in cost under a plan must be made and certified by qualified actuary who is a member of the American Academy of Actuaries, and these must be noted in a written report prepared by the actuary and maintained at least six years.

The 2008 Act does not preempt state statutes that have stronger and more stringent parity and consumer laws. Only state laws that "prevent the application" of the 2008 Act are preempted. This means that employers and insurers essentially must comply with the stronger of the two.

Disclosure and Enforcement

The criteria for medical necessity determination made under the plan with respect to mental health or substance use disorder benefits must be made available by the plan administrator or health insurance issuer in accordance with regulations to participants, beneficiaries, or contracting providers upon request. Plans will also be required to comply with other applicable disclosure rules (*e.g.*, ERISA).

Like the 1996 Act, the law will be enforced by the Department of the Treasury and Department of Labor, and (with respect to the plans subject to the Public Health Service Act), the Department of Health and Human Services. The Comptroller General must report to Congress about coverage and exclusion rules for mental health under group health plans, as well as trends with respect to mental health and substance abuse benefits.

Effective Date

The 1996 Act had a sunset provision that was amended several times and extended most recently to December 31, 2008. The new Act eliminates the sunset provision for the 1996 Act, and makes the aggregate limit provisions of the 1996 Act permanent effective January 1, 2009. The provisions of the 2008 Act apply for plan years beginning after October 3, 2009, so for calendar year plans that means plan years beginning January 1, 2010. There is a special effective date for plans maintained by collective bargaining agreements. As clarified under a Technical Corrections Act, that date is the later of January 1, 2010 or the first plan year beginning after expiration of the longest-running collective bargaining agreement ratified by October 3, 2008.[2]

Request for Comments

In 2009, the Labor Department, Treasury Department and Department of Health and Human Services Department issued a joint request for comments on the Act.[3] The agencies requested assessment of costs and benefits of legislation and regulations under Executive Order 12866, the Regulatory Flexibility Act and the Paperwork Reduction Act. The Departments are also requesting comments as to the types of plans and procedures that would be affected by the Act, and the costs, benefits, and parties affected. Specific comments as to the effect on small businesses and paperwork burdens are requested.

The agencies also requested comments as to the current types of financial limits and plan practices that could be affected by the Act. Specific information sought includes the criteria for medical necessity determinations and the reasons mental health or substance use disorder benefits are currently being denied, as well as the scope of

out-of-network coverage rules for mental health and substance use disorder benefits.

Conclusion

The new mental health parity rules will require employers who offer such benefits to reexamine the limits placed on coverage and use. Employers should watch for further guidance as 2010 approaches. It will also be interesting to see the extent to which these and other mandates are contained in any health care reform legislation.

Notes

1. *See http://www.speaker.gov/legislation*. This appears to be based on a Congressional Budget Office (CBO) analysis of the legislation passed by the House of Representatives, which may have been slightly more costly. The CBO estimated that the House bill would increase premiums for group health plans by four tenths of one percent, but that this increase would be reduced to about two tenths of one percent by the changes employers might be expected to make to health plans to reduce enrolled employees or the overall level of benefits as a result of the legislation. *See* Congressional Budget Office Cost Estimate, H.R. 1424, Paul Wellstone Mental Health on Addiction Equity Act of 2007 (November 21, 2007).

2. Pub. L. No. 110-460, the Technical Corrections Bill signed December 23, 2008.

3. 74 *Fed. Reg.* § 19155 (April 28, 2009).

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