eActionAlert

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

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Mental health and substance abuse benefits are relatively recent additions to employer-sponsored medical care plans. From the beginning, strict limitations were placed on these benefits because of concerns over the potential for abuse and fraud. The Mental Health Parity and Addiction Equity Act changes that by requiring group health insurance plans to cover mental illness and substance abuse disorders on the same terms and conditions as other illnesses. During the next year health care plan sponsors will be working to make sure their plans are in compliance. We hope the following information is helpful to your compliance efforts.

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Introduction

Since the Mental Health Parity Act of 1996 (MHPA) became law, there have been continuing efforts in Congress to provide true parity between mental health benefits and medical and surgical benefits, both in terms of financial requirements and treatment limitations. Last month, following in the footsteps of the late Senator Paul Wellstone of Minnesota, Senator Peter Domenici of New Mexico allowed H.R. 1424 to be amended to incorporate a parity provision as part of the Emergency Economic Stabilization Act of 2008. In light of the urgent nature of this Act, the House approved the measure without going to conference. The combined parity legislation and financial market rescue bill was signed into law by President Bush on October 3, 2008.

Specifically, the Act amends section 712 of the Employee Retirement Income Security Act of 1974, section 2705 of the Public Health Service Act, and section 9812 of the Internal Revenue Code of 1986 to require equity in the provision of mental health and substance-related disorder benefits under group health plans.

This parity legislation is not a federal mandate for group health plan sponsors to offer treatment for mental health or substance abuse conditions. However, as a practical matter, mental health and substance abuse benefits are offered by most group health plans. These must soon be in total parity with other health benefits.

Effective Date and Response

The new law has no sunset provision. It is effective for employer-sponsored group health plan-years beginning after October 3, 2009. Current MHPA provisions and notification requirements apply for all plan years beginning previously. Group health plans with calendar plan-years must comply beginning January 1, 2010. The earliest affected sponsors are generally those with plan years beginning November 1, 2009.

Collectively bargained group health plans must comply under the above rule but not earlier than the later of the expiration date of the last collective bargaining agreement in effect on October 3, 2008, or January 1, 2009.

Benefits Implications

"Parity" means that the deductibles, copayments, coinsurance and out-of-pocket expenses provided under the plan for mental health and substance abuse must be the same as for other conditions. The most common cost-sharing amounts or benefit limits within the group health plan must apply equally to mental health and substance abuse benefits. For example, if the cost-sharing for other medical conditions consists primarily of 20% coinsurance up to an annual out-of pocket maximum, the same must apply to mental health and substance abuse conditions. MHPA previously imposed a requirement that the annual and lifetime maximum limits for mental health had to be much as other benefits. That requirement will apply as prospectively to substance abuse benefits as well.

Treatment Limitations

Group health plans may impose limits on frequency of treatment, number of visits, or days of coverage in the scope or duration of treatment. A common provision in outpatient mental health benefits was an annual limitation of 30 outpatient visits. Unless a majority of medical benefits have the same or a lesser limitation, such arbitrary cost control limits on mental health and substance abuse benefits must be removed.

Out-of-Network Providers

Similar parity rules will apply with respect to financial requirements and treatment limitations applicable to mental health and substance abuse benefits provided by out-of-network providers.

Cost Exemptions

Group health plan sponsors with less than 50 employees on a controlled group basis are exempt as they were under MHPA. Group health plan sponsors may seek actuarial certifications by currently qualified members of the American Academy of Actuaries once they have been in compliance with the true parity provisions for 6 months. If such certifications confirm an increase in medical benefit costs of at least 2% for the first plan year in which the sponsor is subject to the new parity rules, or of at least 1% for any subsequent plan year, then upon proper notification the plan sponsor is exempt from these rules for the plan year following such an increase. Such notification must be provided to federal and state agencies with jurisdiction, as well as to plan participants and beneficiaries.

Other Considerations

Group health plan sponsors will have a myriad of interrelated issues to resolve, both theoretically and in operation. The Americans with Disabilities Act (ADA) Amendments Act of 2008, which broadens the scope of disabilities, is likely to have an impact on the form in which parity applies to mental health and substance abuse benefits. Recent federal legislation referred to as "Michelle's Law" requires sponsors to maintain coverage for students at institutions of higher learning on medical leaves. The interaction of that, with mental health and substance abuse benefits, will also have an impact on health care cost.

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"Spending on mental health (MH) and substance abuse (SA) treatment is expected to double between 2003 and 2014, to $239 billion, and is anticipated to continue falling as a share of all health spending. By 2014, our projections of SA spending show increasing responsibility for state and local governments (45 percent); deteriorating shares financed by private insurance (7 percent); and 42 percent of SA spending going to specialty SA centers. For MH, Medicaid is forecasted to fund an increasingly larger share of treatment costs (27 percent), and prescription medications are expected to capture 30 percent of MH spending by 2014."

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