



# Federal Legislative Brief

## New Federal Mental Health Parity Law: What it Means for Plan Sponsors 2008-21

On October 3, 2008, Congress passed and President Bush signed into law the Emergency Economic Stabilization act of 2008 (EESA), also known as the “700 Billion Dollar Bailout Bill” (HR 1424), to encourage certain members of Congress to vote for its passage, EESA contains a number of unrelated but pet legislative proposals which became law with the Bailout Bill. The most well known of these proposals was “The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008”, Section 511 et seq. of the Bailout Bill (MHPAEA). The MHPAEA amends the Employee Retirement and Income Security Act (ERISA), the Internal Revenue Code (IRC), and the Public Health Service Act. The following is an overview of the MHPAEA.

### **Effective Date and Applicability**

The MHPAEA will take effect for plan years beginning on or after October 3, 2009, with most health plans affected as of January 1, 2010. It will apply to employers with more than 50 employees who maintain a health plan which contains mental health benefits. The law requires federal HIPAA agencies (CMS, DOL, IRS) to produce implementation rules/regulations no later than October 3, 2009. Plans must comply regardless of the timely availability of this upcoming guidance.

### **In Brief**

This new law makes permanent the original provisions of the 1996 Mental Health Parity Act which would have expired on December 31, 2008. In addition, it calls for health plans to provide the same benefits (subject to same co-pays, deductibles, and limitations) as are available for any other illness. It also requires the new benefit levels to be made available for substance abuse claims, previously excluded from the original Mental Health Parity law. If a group health plan offers no mental health benefits, then it is exempt from the requirements of the new law.

### **One Year Cost Exemption**

The MHPAEA will permit a group health plan to elect not to be subject to the new law’s provisions if the plan can prove that the new benefits would result in an increase of 2% or more in the total cost of the health plan in the first year of the law’s applicability (original MHPA had a similar provision) and more than a 1% increase in total plan cost for subsequent plan years. See our [Discussion](#) below for details.

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## Discussion

- 1. Equal Benefits.** The new law requires that the financial requirements, which it defines as co-pays, deductibles, number of visits, benefit maximums, etc., must be the plan's predominant financial requirements. For example, if the plan routine office visit co-pay is \$20 per visit, then the mental health visit would have a \$20 co-pay, even though the co-pay for an optometrist's office visit is only \$15 per visit. In other words, the law's "predominant" definition means the most common co-pay. Plans must provide for the same number of visits and hospital inpatient days as is predominant for any other illness.

To apply the Equal Benefits rule, Plan Sponsors can treat each component group health policy/contract separately even though they are part of a consolidated plan.

- 2. Out-of-network Benefits.** The new law will permit the plan to pay out-of-network benefits at the same level as for out-of-network medical benefits (e.g. 70% instead of 80%) if the mental health services are out of network. Similarly, if the plan has an exclusive provider (EPO) network, it can exclude coverage for services not obtained through the EPO network.
- 3. Disclosure Requirements.** The new law also requires that the plan (insurer or self-funded plan administrator) must make available upon request by a potential or current plan participant or medical provider, criteria used for making claims determinations with respect to mental health or substance disorder benefits, in accordance with upcoming regulations. We expect that the regulations, when published, will require similar information to be included in a summary plan description. It may also require an initial notice to plan participants.
- 4. The Cost Exemption.** To obtain this exemption the plan must obtain a certification from a qualified and licensed actuary, who is a member in good standing of the American Academy of Actuaries, that the cost exceeds 2% (1% after first year). The certification must be based on not less than the first six months claims experience of the plan year involved while the new benefits are in effect. The certification must contain the claims experience for the current period as well as the preceding twelve month period.

If the plan qualifies for the exemption, it must notify all plan participants and covered dependents that the plan is exempt as well as notify state and federal agencies. The agency notification must contain the supporting detail. The new law will permit the agencies to conduct their own audits of plan and plan sponsor records, but the data must remain confidential.

- 5. The Meaning of "Mental Health Benefits."** By definition, the term means the benefits provided for the mental health services provided under the terms of the plan and in accordance with the law. Similarly, the new law will require the plan to provide equal benefits for those disorders which the plan defines as covered substance disorders. In both instances the benefits available must be equal to those paid for other medical conditions or services.
- 6. State Laws.** A number of states mandate mental health benefits. Plans subject to both state law (insured plans) and the new law must provide the more generous benefit to plan participants. In California, for example, insured plans must cover bi-polar and similar serious mental disorders, but not for neuroses. In most instances, the MHPAEA will provide for the more generous benefit, as will happen in California.

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- 7. Applicability of the MHPAEA.** As we stated above, the new law will apply to health plans that offer mental health and/or substance disorder benefits and the employer has over 50 employees. It applies to private employers as well as public agencies, whether the plans are insured or self-funded and whether the mental health benefit is inside the group plan or offered on a carve out basis. It does not apply to Small Employers.
- 8. Small Employer.** To be exempt from the provisions of the new law, an employer will be considered a Small Employer as long as he/she employs at least two employees on the first day of the prior plan year but not more than 50 employees (any) business day during that year. (ERISA Section 712(c)(1)(B).  
  
If the employer was not in existence in the preceding year, then the determination will be made based on the average number of employees reasonably expected to work on business days during the current calendar year. (ERISA Section 712(c)(1)(C)(ii).
- 9. Collectively Bargained Plans.** The new law will not apply to bargained plans existing as of October 3, 2008, until the expiration of the applicable collective bargaining agreement.
- 10. MHPA Remains in Effect.** The original Mental Health Parity Law was set to expire on December 31, 2008. The new legislation extends its applicability until the implementation of the new expanded rules.

## **Action Plan**

Absent future guidance, Plan Sponsors may want to review their existing health plans to determine how the new law, once implemented, will affect their current plan designs. It is also our understanding that very few, if any, health plans will qualify for the one year or multi-year exemptions. A number of benefit professionals have expressed a similar opinion upon the publications of the new law.

If you wish to review the terms of the new law, please visit my website at [www.abferisa.com](http://www.abferisa.com).

I will provide you with additional information on this important new legislation once it becomes available.

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