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Compliance with the new Mental Health Parity and Addiction Equity Act

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The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (the Parity Law) was included in the Emergency Economic Stabilization Act of 2008 [Pub. L. 110-343], commonly known as the "Bailout Bill." The Parity Law permanently extends and significantly expands upon existing mental health parity provisions in the Employee Retirement Income Security Act (ERISA), the Public Health Services Act, and the Internal Revenue Code, which were set to expire December 31, 2008.

Effective date

The Parity Law takes effect January 1, 2010, for group health plans (GHPs) operated on a calendar year basis, and the first plan year starting after October 3, 2009 for other GHPs. The effective date for collectively bargained plans is based on the date of the expiration of the current collective bargaining agreement. The effective date for collectively bargained plans is the later of: (a) the first plan year beginning after October 3, 2009, or (b) the first plan year beginning after expiration of the longest-running collective bargaining agreement ratified by October 3, 2008. This special effective date will give many collectively bargained plans additional time to comply with the Parity Law.

Implementing regulations

The Parity Law directs the Department of Labor, the Department of Health and Human Services and the Department of the Treasury to promulgate implementing regulations by October 3, 2009. These regulations, if actually promulgated within that time frame, should assist GHPs in carrying out their compliance efforts. However, there is certainly no guarantee that the regulations will be promulgated within the directed time frame. Moreover, because calendar year GHPs will have to comply with the Parity Law as of January 1, 2010, prudence dictates that these GHPs consider the issue of compliance prior to issuance of the regulations.

Application

The Parity Law applies to GHPs that include coverage for medical conditions and coverage for mental health conditions and/or substance abuse disorders. Federal law currently requires parity between medical benefits and mental health benefits relative to annual and aggregate lifetime dollar limits only. The Parity Law significantly expands existing mandates to provide that:

- Parity is required for substance abuse benefits, as well as mental health benefits;
- Limits on inpatient days and outpatient visits for the treatment of covered mental health conditions and substance abuse disorders cannot be more restrictive than those applied to treatment of medical conditions;
- The co-pays, deductibles, coinsurance, annual limits, and lifetime limits applied to the treatment of covered mental health conditions and substance abuse disorders cannot be greater than those applied to the treatment of medical conditions; and
- If a GHP provides out-of-network coverage for the treatment of medical conditions, it will have to provide a similar level of out-of-network coverage for the treatment of mental health conditions and substance abuse disorders.

Importantly, the Parity Law does not require GHPs to provide any mental health or substance abuse benefits whatsoever and does not apply to GHPs that do not provide such benefits.

Exemptions

The Parity Law retains and revises existing exemptions for small employers (generally defined as those having 2-50 employees during the preceding calendar year, based on controlled group rules) and other employers who experience a 2% increase in actual, total GHP costs due to compliance with the parity requirements in the first plan year in which they apply (1% in subsequent years). Many GHPs will not qualify for the small employer exception due to size. Further, even if a GHP could qualify for the cost exemption, that exemption requires six months of actual compliance in order to even apply, and the exemption is only available every other plan year, both of which significantly decrease this exemption's overall usefulness to GHPs.

Compliance options

GHPs have two general paths to compliance with the Parity Law:

- Create parity between medical benefits

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and mental health and substance abuse benefits, or

- Eliminate limited mental health and substance abuse benefits altogether, in which case, the Parity Law would not apply.

Each GHP will have to decide whether the elimination of mental health and substance abuse benefits is an attractive or viable compliance option. Nevertheless, if a GHP wants to ensure that the Parity Law would not apply to it, the GHP could eliminate all benefits for mental health conditions and substance abuse disorders. It is possible that such a GHP could retain prescription drug coverage for mental health conditions and substance abuse disorders without having to otherwise comply with the Parity Law (i.e., without also having to provide comprehensive inpatient and outpatient benefits as is done for medical conditions), but this issue is not specifically addressed in the Parity Law.

To the extent a GHP decides to bring its current mental health and substance abuse benefits into parity, it must review each financial requirement and treatment limitation applied to mental health and substance abuse benefits which is not also applied to substantially all medical benefits covered by the GHP. This exercise will be relatively simple for GHPs with consistent medical benefit levels, but it will certainly be more difficult to determine the predominant financial requirements and treatment limitations for medical benefits when the GHP provides multiple benefit levels. Furthermore, because of the outstanding compliance issues discussed below, it is impossible at this time to definitively determine the exact design changes that would be required for any GHP to achieve parity.

Outstanding compliance issues

The Parity Law fails to meaningfully explain how GHPs are actually supposed to achieve compliance with its mandates. Although the impending regulations should provide guidance on compliance issues, the lack of guidance at this time leaves many open questions for GHPs that are prudently considering compliance and cost issues now. For example, in the absence of additional guidance, we do not know whether "parity" means that:

- Alternative A: GHPs have the choice of providing mental health and substance abuse benefits by provider type and diagnosis/condition (i.e., parity exists when a GHP provides inpatient hospital benefits for depression on the same terms as for medical conditions, but does not provide any outpatient benefits for depression when outpatient benefits are provided for medical conditions); or
- Alternative B: GHPs can only limit mental health and substance abuse benefits by diagnosis/condition, but not provider type (i.e., parity does not exist when a GHP provides inpatient hospital benefits for depression on the same terms as for medical conditions, but the GHP does not provide any outpatient benefits for depression when outpatient benefits are provided for medical conditions, because the lack of outpatient benefits is an impermissible treatment limitation).

Arguably, there is support for both interpretations under the Parity Law. Thus, one cannot definitively state how the government will eventually interpret the parity requirements. Nevertheless, it seems more likely that the government will choose the broader interpretation of "parity," as expressed in Alternative B above, because the other interpretation (Alternative A) could significantly detract from the underlying purpose of the Parity Law.

The issue of compliance is further complicated by the fact that the Parity Law injects state law into its definitions of "mental health benefits" and "substance use disorder benefits," which state:

> MENTAL HEALTH BENEFITS - The term 'mental health benefits' means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

> SUBSTANCE USE DISORDER BENEFITS- The term 'substance use disorder benefits' means 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*.[1] (emphasis added)

These references to state law raise the question of whether self-insured GHPs covered by ERISA (which are typically exempt from state insurance laws) will now be subject to state mental health and substance abuse parity laws. Based on the language "applicable … State law" in these definitions, there is an argument that ERISA preemption would still apply because these state laws are not otherwise applicable to ERISA GHPs now. Again, however, we cannot state whether this will be the government's interpretation of this language.

Compliance considerations

In the near future, all GHPs should determine the date by which they need to comply with the Parity Law, if that task has not already been completed. To the extent an available exemption does not apply, each GHP will then have to consider which path it will choose for compliance. Although a host of considerations will come into play in making this decision, it will surely be driven to some extent by the anticipated cost of achieving parity and the current economic climate. GHPs should discuss potential compliance

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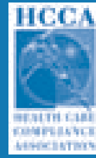
options with legal counsel, insurers, and third-party administrators (TPAs), as applicable. We anticipate that much of the early compliance analysis will be undertaken at the insurer/TPA level because these entities will have to bring their existing products into legal compliance. As with most other GHP design changes, the design changes necessitated by the Parity Law will likely require updating of the GHP's summary plan description and other participant materials and communications. ■

Note: This article is for general information purposes and should not be regarded as legal advice.

1 See Parity Law, H.R. 6983, amending ERISA §712(e).



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