CLIENT ALERT

Expansions of Coverage Requirements for Group Health Plans Under Recently Enacted Laws

Dec.10.2008

Mental Health Parity and Addiction Equity Act of 2008

On October 3, 2008, President Bush signed into law the Emergency Economic Stabilization Act of 2008 ("EESA"). Subtitle B of the EESA contains the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), which amends the mental health parity provisions in ERISA, the Public Health Service Act and the Internal Revenue Code to both eliminate the sunset provision under which those existing provisions would have expired on December 31, 2008, as well as to add new requirements regarding mental health and substance use disorder benefits. Apart from the elimination of the sunset provision, the MHPAEA applies for plans years beginning after October 3, 2009 (i.e., for plans with a calendar-year plan year, January 1, 2010). (A special rule for plans maintained pursuant to a collective bargaining agreement may act to extend this effective date for such plans.)

The MHPAEA does not require that group health plans (or health insurance offered in connection with such a plan) provide mental health or substance use disorder benefits. However, the MHPAEA states that, if a group health provides such benefits, the financial requirements (i.e., deductibles, copayments, coinsurance, out-of-pocket expenses, etc.) and treatment limitations (i.e., limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment) for these benefits may not be more restrictive than the most frequent financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered under the plan. This represents a significant expansion from the previous mental health parity provisions, which applied only to annual and lifetime dollar limitations and applied only to mental health benefits, not substance use disorder benefits. Note that the MHPAEA defines "mental health benefits" and "substance use disorder benefits" to mean services for mental health conditions and for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law. Thus, plans remain free to define the benefits covered, subject to applicable law.

In addition to the above, the MHPAEA adds two other requirements on group health plans: (1) If the plan provides coverage for medical or surgical benefits provided by out-of-network providers, the plan must also provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner consistent with the other parity provisions of the MHPAEA (i.e., the financial-requirements and treatment-limitations provisions discussed above); and (2) subject to regulations to be issued, plans will be required to (a) disclose, upon request by any current or potential participant, beneficiary, or contracting provider, the criteria for medical necessity determinations made under the plan for mental health or substance use disorder benefits, and (b) make available to the participant or beneficiary the reason for any denial of reimbursement or payment for services for mental health or substance use disorder benefits.

The parity requirements of the MHPAEA contain an exemption for certain small employers (those that employed an average of at least 2 employees but no more than 50 employees during the preceding calendar year). In addition, the MHPAEA allows a plan to seek an exemption from the requirements of the MHPAEA if, as a result of providing this coverage, the cost of coverage

with respect to medical and surgical benefits and mental health and substance abuse disorder benefits rise more than a specified percentage (2 percent in the first year and 1 percent annually thereafter). In order to take advantage of this exemption, the plan must (a) have implemented the requirements of the MHPAEA for at least six months before seeking an exemption; (b) have an actuary certify that the actual total costs for the current plan year increased by the specified percentage; and (c) file an exemption request with the Secretary of Labor. Such an exemption would apply for one plan year. In other words, a plan seeking a long-term exemption would have to reapply on an annual basis.

Michelle's Law

On October 9, 2008, President Bush signed into law Michelle's Law, which is intended to ensure that seriously ill college students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law, which is effective for plan years beginning on or after October 9, 2009 (i.e., January 1, 2010 for plans with calendar-year plan year), amends ERISA, the Public Health Service Act and the Internal Revenue Code to provide that a group health plan (or a health insurance issuer that provides coverage in connection with a group health plan) must continue the coverage of a dependent child (as defined in the plan) who is on a medically necessary leave of absence from a postsecondary educational institution until the earlier of (a) one year from the start of the medically necessary leave of absence, or (b) the date on which such coverage would otherwise terminate under the terms of the plan.

A "medically necessary leave of absence" is defined under Michelle's Law to mean a leave of absence by a dependent child from a postsecondary educational institution (including colleges and universities), or any other change in enrollment of such child at such an institution, on account of a serious illness or injury which would otherwise cause the child to lose student status for purposes of coverage under the terms of the plan. The continuation coverage required by Michelle's Law only applies where the plan has received a written certification by a treating physician of the dependent child certifying that the child is suffering from a serious illness or injury that would require a medically necessary leave of absence. Once a dependent child receives this continuation coverage, they must receive the same level of benefits that they would have received if they had not experienced any change in their enrollment status.

Michelle's Law also requires a plan to provide, with any notice it sends regarding a requirement for certification of student status for coverage under the plan, a description (in language which is understandable to the typical plan participant) of the terms of the continued coverage available under this law.

Conclusion

Plans should expect further guidance on these issues. While the MHPAEA explicitly directs the Secretary of Labor to issue further guidance (in conjunction with the Secretaries of Health and Human Services and Treasury), both laws raise questions that would need to be addressed even absent such explicit direction. For example, it is unclear at this time how the continuation coverage under Michelle's Law interacts (if it does interact) with the continuation coverage provisions under COBRA. Fortunately, there is sufficient lead time before either law becomes effective, so these issues will hopefully be addressed before that time. In the interim, however, plans should be reviewed to ensure that they do not contain more restrictive coverage for mental health care or substance use disorder than for the most frequent treatment of physical conditions. If plans do set more restrictions on mental health care or substance use disorder benefits, they will need to be amended to provide parity in coverage. Furthermore, plans will need to prepare proper notices under Michelle's Law and may need to be amended to account for this new type of continuation coverage.

If you have any further questions about the MHPAEA or Michelle's Law and how plans should approach implementing the requirements of these laws, please contact those listed below.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.