



Mental Health Parity

The Mental Health Parity Act (“MHPA”) was originally passed in late 1996. It amended ERISA and the Public Health Service Act (“PHSA”) to prohibit a group health plan from offering benefits that contain annual and/or lifetime dollar maximums for mental health benefits that are more restrictive than limitations imposed on benefits for physical illness. The Mental Health Parity and Addiction Equity Act of 2008 (the “Act”) was enacted on October 3, 2008 and extends the MHPA parity requirements in ERISA and the PHSA to substance use disorder benefits and requires any such offered benefits to be similar to those for physical illness.

When are mental health parity laws effective?

The MHPA was first effective for plan years beginning on or after January 1, 1998. It contained a sunset date which was extended a number of times. The Act, which amends ERISA and the PHSA to remove the sunset date, is applicable to plan years beginning after October 3, 2009 and to group health plans under a collective bargaining agreement at the later of the expiration of such agreement or by January 1, 2009. Thus, most calendar year plans must comply with the new requirements by January 1, 2010.

Who must comply?

The following group health plans must comply with the MHPA and the Act:

- Fully insured group health plans,
- Self-funded group health plans,
- Church plans, and
- Non-federal governmental plans.

Employers with fewer than 50 employees during the preceding calendar year are not required to comply with the MHPA and the Act. For purposes of determining group size, both part-time and full-time employees are included. Plans offering only HIPAA exempted benefits are not required to comply (e.g., dental, vision only).

Non-federal governmental plans that are self-funded may choose not to comply. In order to opt out, the plan must file an election with the Center for Medicare and Medicaid Services prior to the beginning of each plan year and notify the plan participants of its choice to opt out.

Does the law require that mental health or substance use disorder benefits be provided?

No. Neither the MHPA nor the Act requires that group health plans provide mental health or substance use disorder benefits. However, fully-insured group health plans located in a state where mental health and substance use disorder benefits are mandated must comply with both state law, the MHPA and the Act.

What coverage is required?

The MHPA and the Act require that any annual and/or lifetime dollar maximums imposed on mental health or substance use disorder benefits be no less than those applicable to coverage for physical illness and that offered benefits be comparable.

Does the Act govern benefits for treatment of alcohol and drug abuse?

Yes. The Act now specifically includes substance use disorder benefits.

May a plan apply cost sharing to mental health or substance use disorder benefits under the Act?

The Act does not prohibit the application of cost sharing tools such as copayments/coinsurance and deductibles to mental health or substance use disorder benefits, so long as the cost sharing tools apply equally to physical health benefits.

May a plan apply day or visit limits to mental health or substance use disorder benefits under the Act?

The Act does not prohibit application of day or visit limits to mental health or substance use disorder benefits, so long as the limits apply equally to physical health benefits.

Does the law have an exemption when compliance is overly burdensome?

Yes. Until the Act becomes effective, the MHPA exemption provisions must be followed. The MHPA provisions provide that the MHPA does not apply to plans where compliance would result in a 1% increase in cost to the plan. In order for a group health plan to be exempt from the MHPA, it must:

- Comply with the MHPA for a period of at least six months,*
- Determine that the cost of compliance is at least 1% by comparing retroactive claim data,
- Notify plan participants that the plan will be amended and that they may request at no charge a summary of information on which the exemption was based, and
- Notify the appropriate federal agency.

**In no event can the six-month period begin prior to the date the Act applied to the group health plan.*

The exemption is effective 30 days from the date notice is provided to plan participants and the appropriate federal agency.

Once the Act becomes effective, its provisions must be followed and are similar to the MHPA in the treatment of exemption criteria. However, the Act amends the applicable increased cost percentage to 2% in the case of the first plan year that the new requirement applies and 1% in the case of each subsequent plan year.

Please contact your ALCOS / Brown & Brown representative at **586.977.6300** if you have any questions or would like to discuss modifying coverage for mental health or substance use disorder benefits.

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