

## Special points of interest:

- **NEW LAW EXPANDS MENTAL HEALTH PARITY REQUIREMENTS FOR GROUP HEALTH PLANS**
- **LEGISLATION EXTENDS EXISTING HEALTH COVERAGE FOR DEPENDENT COLLEGE STUDENTS IN CASES OF MEDICALLY NECESSARY LEAVES OF ABSENCE**
- **MEDICARE PART D NOTIFICATION TO PLAN PARTICIPANTS**
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**New Law Expands Mental Health Parity Requirements For Group Health Plans**

Source: EBIA Weekly 10-9-08 [ww.ebia.com](http://www.ebia.com)

[Emergency Economic Stabilization Legislation, Pub. L. No. 110-343, Div. C (Oct. 3, 2008)] For a copy:

[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110\\_cong\\_bills&docid=f:h1424enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h1424enr.txt.pdf)

The mental health parity requirements for group health plans have been expanded as part of the emergency economic stabilization legislation that was signed by President Bush on October 3, 2008. The legislation amends the mental health parity provisions in ERISA, the PHS Act, and the Code, eliminating the sunset provision under which existing requirements would have expired on December 31, 2008, and adding new requirements regarding mental health and substance use disorder benefits *that apply for plan years beginning after October 3, 2009* (with a special rule for plans maintained pursuant to a collective bargaining agreement). Here are some highlights of the new requirements:

==> Substance Use Disorder Benefits. The existing mental health parity provisions--which require parity between medical/surgical benefits and mental health benefits in the application of annual and aggregate lifetime limits--have been expanded to apply to substance use disorder benefits. As discussed below, the other changes made by the new law also apply to substance use disorder benefits.

==> Parity in Financial Requirements. Plans that offer both medical/surgical benefits and mental health or substance use disorder benefits must ensure that the financial

requirements that apply to mental health or substance use disorder benefits are no more restrictive than the most common or frequent financial requirements that apply to substantially all medical and surgical benefits covered under the plan. For this purpose, the term "financial requirements" includes deductibles, co-payments, co-insurance, and out-of-pocket expenses. Furthermore, plans may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

==> Parity in Treatment Limitations. Likewise, the treatment limitations that apply to mental health or substance use disorder benefits may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits covered under the plan, and plans may not have separate treatment limitations that apply only to mental health or substance use disorder benefits. For this purpose, the term "treatment limitation" includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

==> Plan Information. The criteria for medical necessity determinations for mental health or substance use disorder benefits must be made available to current or potential participants, beneficiaries, or contracting providers upon request in accordance with regulations. The reasons for any denial of mental health or substance use disorder benefits must also be made available to the participant or beneficiary on request or as otherwise required in accordance with regulations.

==> Out-of-Network Providers. If a plan provides both medical/surgical benefits and mental health or substance use disorder benefits and offers coverage for out-of-network medical or surgical benefits, then coverage must also be

provided for out-of-network mental health or substance use disorder benefits "in a manner that is consistent with" the parity requirements.

==> Small Employer Exemption. The parity requirements continue to include an exemption for certain small employers. The definition of "small employer" has been modified slightly and now includes employers that employed an average of at least 2 employees (or 1 employee in the case of an employer residing in a state that permits small groups to include a single individual) but no more than 50 employees during the preceding calendar year (determined on a controlled group basis).

==> Cost Exemption. The existing increased cost exemption has been replaced with a more detailed cost exemption that is available only if the plan has complied with the parity requirements for the first six months of the plan year involved. A plan will qualify for the exemption if the increased cost of applying the parity requirements to mental health and substance use disorder benefits exceeds: (1) 2% of the actual total plan costs in the first plan year in which the parity requirements are applied; and (2) 1% in each of the subsequent plan years. Cost-increase determinations must be made and certified by qualified and licensed actuaries. Plans that qualify for and elect to apply the cost exemption must provide notice to the appropriate governmental agencies, participants, and beneficiaries in accordance with the law's requirements.

EBIA Comment: The new parity requirements go far beyond the existing requirements of parity in the application of annual and aggregate lifetime limits to mental health benefits. Employers, insurers, and administrators will be busy analyzing the impact of these changes and making sure that their plans and coverage will meet the new requirements before they take effect. And it looks like there will be more guidance to come--the legislation directs DOL, HHS, and the Treasury Department to issue regulations within a year of the law's enactment to carry out its provisions, although the effective date of the new requirements is not contingent upon such regulations being issued.

***BAS will provide you with additional information regarding the parity requirements and will assist you in bringing your Plan into compliance with the new law.***

**Legislation Extends Existing Health Coverage For Dependent College Students In Cases Of Medically Necessary Leaves Of Absence**

Source: EBIA Weekly 10-9-08 [www.ebia.com](http://www.ebia.com)

[Michelle's Law, Pub. L. No. 110-381 (Oct. 9, 2008)] For a copy:

[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110\\_cong\\_bills&docid=f:h2851enr.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h2851enr.txt.pdf)

On October 9, 2008, President Bush signed Michelle's Law, which is intended to allow seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The measure was inspired by, and named after, a college student in New Hampshire who was diagnosed with cancer but continued her studies on a full-time basis in order to avoid losing health coverage under her parents' plan. *This law is effective for plan years beginning on or after October 9, 2009 (calendar-year plans must comply beginning January 1, 2010) and to medically necessary leaves of absence beginning during such plan years.*

The legislation applies to health plans governed by ERISA, the Code, and the PHSA--some of the notable features are discussed below:

==> Medically Necessary Leave of Absence. The extension of coverage applies to a dependent child's leave of absence from, or any other change in enrollment at, a postsecondary educational institution (including colleges and universities) on account of a serious illness or injury from which the child is suffering while covered under a health plan that would otherwise cause the child to lose dependent status for purposes of coverage.

==> Length of Continued Coverage. Coverage continues until the earlier of: (1) one year from the start of the medically necessary leave of absence, or (2) the date on which such coverage would otherwise terminate under the terms of the health plan.

==> Definition of Dependent Child. The child must be enrolled as a dependent under a health plan and qualify for coverage on the basis of being a student at a postsecondary educational institution, immediately before the medically necessary leave of absence involved.

==> Certification by Physician. Written certification must be provided by a treating physician of the dependent child certifying that such individual is suffering from a serious illness or injury that would require a medically necessary leave of absence.

==> Notice. The health plan (and a health insurance issuer providing coverage in connection with a health plan) is required to provide notification, in plain language, describing the terms of the continued coverage available

under this law. This description should be included with any notice regarding a requirement for certification of student status for coverage under the plan.

No Change in Benefits During Leave; Continued Application in Case of Changed Coverage. A dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Moreover, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to dependent children under the plan.

***BAS will assist you in bringing your Plan into compliance with this new law.***

### **Medicare Part D – Prescription Drug Coverage**

As you know, the Medicare Prescription Drug, Improvement & Modernization Act (MMA) implemented a voluntary prescription drug benefit (Part D) for Medicare eligible individuals beginning on January 1, 2006.

Two key components of this Medicare program, established by CMS, (Centers for Medicare and Medicaid) that impacts group health plans are:

- Part D Medicare eligible individuals must be *notified* by the group health plan whether or not the prescription drug coverage provided by the group health is or is not "creditable coverage". "Creditable Coverage" as defined by Medicare is coverage that is equal to or greater than the coverage being offered under the Medicare Part D program, and
- Annually, the group health plan must notify CMS of the Plan's Creditable/Non-Creditable Status.

### **Notification to Plan Participants**

If BAS administers your primary medical plan and your prescription drug program (or if we have been provided with an analysis of your prescription drug plan) you had the option to have BAS distribute the applicable Creditable or Non-Creditable Coverage Notice to all of your Plan Participants by first class mail. If you elected to have BAS distribute the Notice, they were mailed before November 15, 2008.

### **Annual Creditable Coverage Disclosure to CMS Website**

#### **PLEASE NOTE:**

In addition to the Creditable Coverage Notification requirement for Medicare eligibles, employers must disclose their

Creditable Coverage status to CMS on an annual basis. The disclosure form **must be** completed online - **electronic filing is required**. The form and instructions for completion can be found at: [www.cms.hhs.gov/apps/ccdisclosure/default.asp](http://www.cms.hhs.gov/apps/ccdisclosure/default.asp)

The Disclosure Notice and policy guidance were posted on the Medicare website and require that the Disclosure Notice must be made to CMS on an annual basis and upon any change that affects whether the drug coverage is creditable. The initial Disclosure Notice had to be provided by March 31, 2006 for plan years that end in 2006. **For plan years that end in 2007 and beyond, disclosure of creditable coverage status must be provided within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS. (Example: plan year begins on April 1, 2008 – disclosure to CMS must be made by May 31, 2008.) Disclosure must also be made within 40 days after the termination of the prescription drug plan; and within 30 days after any change in the creditable coverage status of the prescription drug plan.**

**CMS has released a Disclosure Notice form that requires information such as name of entity; Federal tax identification number; street address; type of coverage; number of options offered by the entity, creditable coverage status of option; period covered by the disclosure notice; number of Part D eligible individuals expected to be covered under the plan as well as the name, title and email of the Entity's authorized Individual.**

A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed in the regulation at 42 CFR Section 423.56(d) and are referenced on the creditable coverage homepage at <http://www.cms.hhs.gov/creditablecoverage/>. Those entities include group health plans, including those offered by employers; union/Taft-Hartley plans; church, Federal, State and local government, and other group-sponsored plans. (Entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement.)

**How to find this information:** CMS has issued guidance on the form, manner and timing of providing the Disclosure Notice to CMS. This Disclosure to CMS guidance is posted on the Creditable Coverage web page at <http://www.cms.hhs.gov/creditablecoverage/>.

We encourage you to complete the Disclosure Notice at the CMS website as soon as possible and we recommend that you keep a copy for your records. If you have any questions or need assistance, please contact BAS' Pharmacy Department at [www.benadmsys.com](http://www.benadmsys.com) or 708-799-7400.