



Health & Benefits Perspective

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Guidelines for cost-effective implementation of the Mental Health Parity and Addiction Equity Act of 2008

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Introduction

On Oct. 3, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the “Act”) became law. The law requires group health plans that offer mental health (MH) or substance abuse (SA) benefits to provide those benefits on par with medical and surgical benefits. The Act prohibits plans from imposing financial requirements (e.g. co-pays) or treatment limits (e.g. outpatient visit limit) on MH/SA benefits that are more restrictive than the predominant financial requirements or treatment limits that apply to substantially all medical and surgical benefits, and it bars separate cost sharing and treatment limits for MH/SA benefits. The Act also makes permanent the prohibition on lower annual and lifetime dollar limits for covered MH benefits from the 1996 Mental Health Parity Act and expands this prohibition to include covered SA benefits.

Federal regulators are directed to issue coordinated guidance for the Act by Oct. 3, 2009. The guidance may come too late to effectively assist employers with the redesign of their benefit structures, which for many employers must be completed by Jan. 1, 2010. (See timeline for compliance on page 4.) Any coverage reduction or elimination will require employers to: 1) amend plan documents 2) make revisions of summary plan descriptions and other employee communications 3) distribute to participants and beneficiaries a summary of material modifications within 60 days of adopting the reduction or elimination and 4) reprogram claims payment systems. Employers should begin now to determine when they must comply, analyze utilization, assess potential cost impact, evaluate benefit designs and review medical management strategies, applying current interpretations of the Act with the understanding that future guidance may require or permit benefit design modifications. This Perspective outlines the Act’s potential impact on employers and identifies key considerations to guide employers’ efforts to comply with the law.

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Impact on employers

The new law will require many employers to change existing benefit plans to comply with the new parity requirements. Self-insured employers not subject to state parity mandates to cover certain MH/SA conditions may choose not to cover any MH/SA conditions. Employers considering this option should do so with caution, however. Although the direct costs for treatment of MH/SA conditions are expected to increase overall medical costs under the Act, there are significant costs associated with not covering MH/SA conditions.

The indirect costs to employers of not providing adequate MH/SA coverage are more than double the direct costs of treatment. In 2003, it was estimated that depression cost US employers \$83 billion. Less than a third of the \$83 billion was attributed to the direct costs of treating depression.¹ Almost two-thirds of the amount was related to indirect costs of presenteeism and absenteeism. Further, the \$83 billion did not include increased medical costs associated with depression, which have been found to increase the costs of treating some chronic medical conditions by 50 percent. Eliminating MH or SA coverage may negatively impact an employer’s overall costs through increased medical spending, reduced productivity, increased absences, injuries, errors and employee turnover. (See Cost implications of inadequate MH/SA treatment below.)

Cost implications of inadequate MH/SA treatment

In 2007, almost 11 percent of all adults experienced serious psychological distress and 9 percent of individuals older than 12 had a substance abuse disorder.² More than 70 percent of people diagnosed with a mental health or substance abuse condition are employed.³ Prior to the Act, MH and SA typically accounted for only 3 percent to 5 percent of an employer’s overall medical expenditures.

MH/SA conditions can increase medical costs by 25 percent to 50 percent in a variety of ways. First, MH/SA conditions directly affect the immune system, increasing vulnerability to physical health problems. In addition, some untreated MH/SA conditions can cause medical problems such as cirrhosis of the liver. Second, people who are depressed often go to the doctor for complaints about pain or other physical symptoms. The doctor may order tests to determine the cause of the symptoms, but without lab

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¹ Greenburg, et. al., Journal of Clinical Psychiatry, December 2003.

² Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). Results from the 2007 National Survey on Drug Use and Health: National Findings (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

³ Dixon, Kevin PRNewswire, October 13, 2005.

“Untreated MH/SA conditions also affect employee productivity and attendance.”

tests for underlying MH/SA issues, the condition may go undiagnosed and untreated. Third, when a patient has a chronic medical condition and a MH/SA condition such as depression, they are less likely to follow medical regimens⁴ or make needed lifestyle changes, costing 1.7⁵ times more to treat the symptoms than those with the chronic medical condition alone. Finally, some primary care physicians address MH/SA conditions under other applicable medical diagnoses with psychotropic medications. When MH/SA conditions are treated in a general medical setting, minimally adequate care is delivered less than 13 percent of the time.⁶

Untreated MH/SA conditions also affect employee productivity and attendance. Studies show that depressed individuals are productive one to two hours less per day than their non-depressed counterparts. Depression, anxiety and sleep disorders are among the top five causes of lost work time.⁷ One-third of sick days associated with chronic conditions have been attributed to MH/SA conditions.⁸ Mercer 2007 surveys⁹ indicated that depression is one of the top five disabling conditions, and its frequency and cost are increasing more rapidly than all conditions except cancer. In another survey, 53 percent of employers reported it was harder to return individuals to work from a MH/SA absence than a purely medical one. Employee turnover rates, grievances, injuries, accidents and errors are all negatively impacted by MH/SA conditions. Clearly, employers must consider the costs of not treating MH/SA conditions before eliminating MH/SA coverage to avoid the increased costs of parity.

⁴Ziegelstein, R.C. Depression in patients recovering from a myocardial infarction. *JAMA*, Vol. 286 (13), pp. 1621-1627, 2001.

⁵Druss, B.G., Rosenhock, R.A., and Sledge, W.H. Health and Disability Costs of Depressive Illness in a Major U.S. Corporation, *American Journal of Psychiatry*, Vol. 157, pp. 1274-1278, 2000.

⁶Wang, P.S., Lane, M., Olfson, M., et al. Twelve-month Use of Mental Health Services in the U.S.: Results from the National Co-morbidity Survey Replication., *Archives of General Psychiatry*, 62(6), pp. 629-640, 2005.

⁷Boress, L., Parry, T. and Loeppke, R. *Measuring Health and Productivity*, Integrated Benefits Institute, 2007. Kessler's HPQ Adjusted to Workforce.

⁸See Wang et al.

⁹The Mercer National Survey of Employer-Sponsored Health Plans and Mercer/Marsh Survey on Health, Productivity and Absence Management Programs 2007 Survey Reports.



“Employers with fewer than 50 employees are exempt, as are retiree plans that cover two or fewer current employees.”

Who needs to comply with the Act?

The Act applies to all self-insured and fully insured health plans covering 50 employees or more. Employers with fewer than 50 employees are exempt, as are retiree plans that cover two or fewer current employees. Self-insured state and local governments can opt out of the Act’s requirements.

Because the new law builds on the 1996 Mental Health Parity Act, the current enforcement structure for non-compliance applies. Potential penalties include an excise tax of \$100 dollars per day for failure to provide required benefits, ERISA fiduciary penalties for failing to properly administer the plan, and criminal penalties for willful ERISA violations. In addition, individuals can sue for benefits that should have been provided by the plan.

What is the timeline for compliance?

The law becomes effective for plan years beginning after Oct. 3, 2009. Table 1 provides examples of plan year effective dates and the date on which compliance with the Act is required.

Table 1

Plan year effective date	Date compliance required
November 1	November 1, 2009
January 1	January 1, 2010
July 1	July 1, 2010
October 1	October 1, 2010

For plans maintained under collective bargaining agreements (CBAs) ratified before Oct. 3, 2008, the expanded parity requirements appear to apply for plan years beginning on the later of Jan. 1, 2010, or the termination date of the last CBA relating to the plan.¹⁰

The cost of compliance

Estimates of cost increases to employers complying with comprehensive state parity mandates range from less than 1 percent to 3 percent or more of overall health care costs. The extent of financial impact of the Act will depend on multiple factors.

First, the scope of an employer’s MH/SA and medical benefits relative to the benefits that will be provided in compliance with the Act will determine cost impact. That is, if an employer had a 50 percent coinsurance for MH/SA conditions and a 10 percent coinsurance for medical conditions, the cost impact of the Act will be greater (assuming that the employer adjusts the MH/SA cost share to match the medical cost share) than if the pre-parity coinsurance rates were more similar.

¹⁰Technical correction bill (s 3712), 12/10/08.

“The MH/SA conditions an employer elects to cover will determine the degree of increased costs.”

Second, the magnitude of the cost increase will depend on the extent to which previous benefit limits impacted utilization. If the removal of cost barriers increases penetration (that is, the number of employees and their dependents that use the MH/SA benefit), direct costs may increase, but this cost may be offset by reduced medical costs and improved productivity. A third factor likely to impact costs is the effectiveness of the managed care strategies in place that address MH/SA utilization. Some studies have shown that introducing managed care in conjunction with parity can result in cost reduction through both better medical management and better network discounts. Enhancing current managed care strategies, as outlined below, can help manage the cost impact of expanded MH/SA benefits.

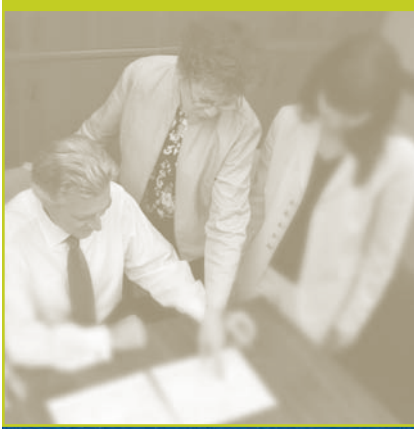
Additionally, the MH/SA conditions an employer elects to cover will determine the degree of increased costs. If an employer significantly limits the MH/SA conditions covered, direct costs may decrease but indirect costs may increase. For this reason, Mercer recommends caution in limiting coverage to “biologically based” MH/SA conditions. Covering only these conditions may leave untreated some conditions that contribute to an employer’s medical and other workplace costs.

How does an employer design MH/SA benefits to comply with the Act?

We don’t yet have guidance from regulators on how they will define and apply key parity terms and rules. Generally, employers will need to identify a plan’s predominant medical and surgical financial requirements and treatment limits, review cost-sharing requirements, annual or lifetime dollar limits and other benefit design features. To identify the “predominant” medical and surgical benefit plan limit, an employer should identify the most common or frequent benefit limit for “substantially all” of the medical and surgical benefits.¹¹ Then, the employer should compare the predominant medical and surgical benefit structure to the MH/SA benefit structure. If the predominant medical and surgical benefit plan treatment and financial limits are the same as (or more restrictive than) those for the MH/SA benefits, the treatment and financial limits are compliant with the Act. If any of the MH/SA limits are more restrictive than the predominant limits that apply to medical/surgical benefits, the employer must change either the medical/surgical or MH/SA limits, or both.

For example, in a plan with a \$20 co-pay for substantially all medical and surgical benefits and no co-pay for the MH/SA benefit, the medical/surgical financial requirement is more restrictive and should not require any action on the employer’s part. If, however, the plan has a \$30 co-pay for MH/SA services, the employer may need to change the predominant medical/surgical co-pay to \$30, adjust the MH/SA co-pay to \$20, or adjust both of the benefits to a third co-pay amount. Similarly, if the employer has a 60 day inpatient limit on MH/SA benefits but no inpatient limit for medical/surgical, the employer may adjust the MH/SA benefit so that it is the same as the medical surgical inpatient benefit.

¹¹ “Substantially all” is not defined in the legislation.



Cost-sharing requirements. An employer should review cost-sharing requirements such as deductibles and out-of-pocket limits for medical/surgical and MH/SA benefits. If medical, surgical and MH/SA benefit costs accrue to a single deductible and single out-of-pocket limit, the cost-sharing limits are likely consistent with the Act. The legislation leaves some ambiguity as to whether separate but equal deductibles or out-of-pocket maximums will be permissible.

Annual or lifetime dollar limits. An employer must compare the predominant annual or lifetime dollar limits for substantially all medical/surgical benefit with the MH/SA annual or lifetime dollar limits. Because the 1996 Mental Health Parity Act banned more restrictive annual and lifetime dollar limits for MH than for medical/surgical benefits, employers' current compliance issues will likely be with SA benefits. If the annual and lifetime dollar limits for MH/SA benefits are equal to or greater than the annual and lifetime dollar limits for the medical and surgical benefits, the coverage complies with the law. If not, employers may consider a single annual or lifetime dollar limit for medical/surgical and MH/SA benefits.

Table 2 summarizes common coverage scenarios and compliance issues that employers need to consider. The last column in the table offers examples of benefit design changes that would likely be compliant with the Act (based on Mercer's current understanding of the law), although all of the options presented are not equally desirable. For example, while imposing a 50 visit limit on medical outpatient visits to match the MH/SA visit limit may be compliant with the Act, it is not recommended from an overall benefit plan perspective.

Table 2

	Predominant medical/surgical	Current MH/SA	Example compliance options (Recommended strategies are indicated with a *)
Financial requirements			
Inpatient co-insurance	20% ¹²	25%	*Decrease MH/SA to 20% Change both to 15% Increase medical to 25%
Outpatient co-payment	\$20	\$25	*Decrease MH/SA to \$20 Change both to \$15 Increase medical to \$25
Dollar cap	Reasonable and customary (R&C)	\$50 per visit	*Remove \$50 per visit cap and pay R&C for MH/SA Impose a \$50 per visit cap for medical visits Impose a third dollar amount as a cap on payments for visits for medical/surgical and MH/SA limits

¹²The Predominant Medical benefit features represent median amounts for large employers based on Mercer's 2008 National Survey of Employer-Sponsored Health Plans.

Table 2 (continued)

	Predominant medical/surgical	Current MH/SA	Example compliance options (Recommended strategies are indicated with a *)
Treatment limits			
Outpatient visit limit	None	30 visits	*Eliminate 30 visit limit for MH/SA Impose 30 visit limit on both medical/surgical and MH/SA Impose a different number of visits as an outpatient visit limit for both MH/SA and medical
Inpatient day limit	None	60 days	*Eliminate 60 day limit for MH/SA Impose a different inpatient day limit for both MH/SA and medical
Separate cost sharing¹³			
Deductible	\$300 individual \$800 family	\$200/admission	*Eliminate per admission MH/SA deductible *Accrue MH/SA expenses toward individual and family deductibles for medical/surgical ¹⁴ *Increase current medical/surgical deductible and apply to both medical/surgical and MH/SA services
Out-of-pocket maximum (OOPs)	\$2,000 per year	Additional \$1,250 per year	*MH/SA accrues toward \$2,000 OOPs ¹⁵ *Set a different OOP maximum for which medical/surgical and MH/SA expenses accrue.

Examples are for illustration only, and are not intended to represent all coverage scenarios or compliance options.

¹³The Act does not define the term “cost sharing”; one interpretation is that the restriction on separate cost sharing will apply to deductibles and out-of-pocket maximum limits.

¹⁴There is ambiguity in the Act regarding whether separate but equal deductibles are permissible.

¹⁵There is ambiguity in the Act regarding whether separate but equal OOP maximums are permissible.

Other design features. The parity requirements described above apply to an employer's in-network **and** out-of-network (OON) MH/SA benefits. Plans offering OON coverage for medical/surgical benefits must also provide OON coverage for MH/SA benefits in a manner consistent with the parity requirements.

If an employer has multiple health plans, the steps delineated above will need to be applied to each health plan. For example, if an employer offers one HMO plan, two PPO plans and a POS plan, each of the four plan's respective benefits must be adjusted to be consistent with the Act. This is true even if the employer carves out MH/SA benefit administration to a single vendor for all health plans. If the medical/surgical benefit designs are dissimilar, the MH/SA carve-out vendor may have to manage multiple MH/SA benefit designs. Alternatively, to reduce administrative costs, an employer could offer one MH/SA benefit that reflects the richest medical/surgical benefit financial requirements and treatment limits across the various health plans. If the richest inpatient coinsurance is 10 percent in the PPO plan, but the richest outpatient co-pay is \$15 in the EPO plan, then if an employer opts for a single MH/SA benefit design, it would need to match the 10 percent PPO inpatient coinsurance and the \$15 EPO outpatient co-pay. The law provides little guidance on how parity applies to levels of care or services applicable only to MH/SA conditions such as residential treatment or intensive outpatient programs. To assure compliance, an employer could remove all financial or treatment limits for these services, but future guidance may indicate that such limits are permissible.

How does an employer determine which MH/SA conditions to cover?

The Act generally permits employers to determine which MH/SA conditions, if any, to cover.¹⁶ For example, a self-insured employer may choose to cover treatment for all addictions except caffeine.¹⁷ The exclusion of this condition from coverage is permissible under the law, but the predominant inpatient and outpatient benefit limits for treatment of the covered addictions must be on par with substantially all of the plan's medical and surgical benefits.

¹⁶State law may limit this flexibility for employers with insured plans and certain governmental plans by requiring coverage of certain conditions.

¹⁷Employers may wish to consider applicable employment discrimination laws prior to excluding coverage for a specific condition.

“Employers offering fully insured plans may be subject to state parity laws that require coverage of certain MH/SA conditions or specific types of treatment or providers.”

To determine which MH/SA conditions to cover, Mercer recommends that an employer analyze its workforce’s current utilization of existing MH/SA benefits, including psychotropic medication use, and identify any unmet MH/SA needs that should be addressed. Other guidelines to consider:

- Cover those MH/SA conditions such as depression, anxiety and substance abuse disorders that are known to raise medical costs, and reduce productivity and increase accidents.
- Exclude MH/SA conditions such as mental retardation or learning disorders that are best addressed in an educational rather than a medical setting.
- Cover those MH/SA conditions that are amenable to treatment and exclude those that are not.
- Address “V-Codes” (that is, problems that are not yet defined as MH/SA conditions but may be effectively addressed with counseling, such as relationship concerns) only in the EAP.

Impact of state parity insurance requirements. Employers offering fully insured plans may be subject to state parity laws that require coverage of certain MH/SA conditions or specific types of treatment or providers. According to the National Alliance on Mental Illness, only two states (Alaska and Wyoming) have not passed a law requiring either some form of mental health parity or mandated a minimum mental health benefit.¹⁸ Eighteen states and the District of Columbia (DC) require fully insured plans to cover a broad range of mental health conditions. Twenty-seven states require plans to cover serious mental illnesses (SMI). Twenty-one states and DC require coverage of substance use disorders. Arkansas requires coverage for mental illness and Florida mandates coverage for mental illness plus substance use disorders. To address the administrative burden of complying with multiple state parity mandates, employers may wish to identify the most comprehensive mandate(s) and apply that benefit structure in all states in which it operates, if the cost benefit of reducing administrative costs outweighs the costs of broader coverage.

¹⁸State Mental Health Parity Laws 2007, National Alliance on Mental Illness.



How can an employer manage the cost impact?

In addition to following the steps described above, an employer can manage the costs of complying with the Act assuring the effectiveness of the employer's current health care or MH/SA vendors in managing MH/SA benefits. The Act permits the application of medical necessity criteria, utilization review and other medical/case management techniques to MH/SA services. Best-in-class care management strategies should include:

- Implement performance standards and performance guarantees specific to MH/SA managed care strategies and treatment outcomes, not only with MH/SA carve-out vendors but also with plans where MH/SA is administered within the medical plan.
- Require the medical management program to use data-driven algorithms using claims and/or outcomes data to identify individuals with a MH/SA condition who are not improving at the expected rate or who are not receiving care consistent with established clinical practice guidelines.
- Monitor health plan or MH/SA specialty vendor performance regarding:
 - Consistent application of medical necessity criteria and level of care guidelines to ensure authorization of levels of care most likely to result in a positive treatment outcome in the most cost-effective setting;
 - Network management strategies that address quality of care, provider incentives and market-competitive rates.
- Encourage members to access prepaid EAP benefits to address problems before they become MH/SA conditions.
- Implement an integrated behavioral health-medical approach that addresses high-cost medical populations who are most at risk for reduced adherence to necessary medical regimens and poorer medical outcomes as a result of their MH/SA condition.
- Review MH/SA provider reimbursement rates to determine whether discounts are market competitive.

If an employer determines that the vendor(s) managing its MH/SA benefits





For additional information, please contact your Mercer consultant.

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does not have the necessary expertise or capabilities, the employer should consider procuring another vendor.

Finally, if complying with the law is cost prohibitive, the Act provides a cost exemption for employers whose costs increase by more than 2 percent. To obtain the cost exemption, an employer must comply with the parity requirements for at least the first six months of the plan year. An employer must obtain a written report from a qualified and licensed actuary showing that total actual costs of the employer's health plan have increased by the specified amount. If an employer's plan qualifies for and elects a cost exemption, it will be exempt from the parity requirements for the next plan year. To qualify for another exemption, an employer apparently may reapply if plan costs increase by more than 1 percent.

With the right benefit design, implementation and management, the Mental Health Parity and Addiction Equity Act of 2008 can improve the overall health and well-being of our nation's workforce and their dependents without adding significant costs to our already over-burdened employer-based health care system. Effectively integrating MH/SA benefits with other health and wellness programs in the workplace can result in improved productivity, reduced health care costs and a safer work environment.

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