



Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

FREQUENTLY ASKED QUESTIONS

This Act requires that group health plans and group health insurers apply the same treatment and financial limits to mental health and substance abuse benefits as they do to medical and surgical benefits. These FAQs are intended to provide an overview of the Mental Health Parity Act specifically as it applies to health insurance plans.

1. What is the basic structure of the new law?

The Mental Health Parity Act amends the existing federal mental health parity requirements found in the Employee Retirement Income Security Act (ERISA), Public Health Service Act (PHSA) and Internal Revenue Code (IRC).

2. What types of health coverage are subject to the Mental Health Parity Act?

The Act applies to ERISA group health plans and to health insurers that provide coverage to group health plans. Medicaid health plans and the State Children's Health Insurance Program (SCHIP) are also subject to the Mental Health Parity Act. Within Wellpoint, this includes all of our group health plans (insured and self-funded; branded and unbranded; and National Accounts), FEP, State-Sponsored, and Medicare Advantage (if offered through a large group ERISA health plan).

Insurers that provide "excepted benefits" to group health plans (such as disability income insurance and long-term care and Medicare supplemental insurance coverage that is offered separately) *are not* subject to the new law.

3. Are all employers subject to the new law?

Only those employers with 51 or more employees are subject to this law. Employers with 50 or fewer employees, including companies in states that apply group insurance laws to "groups of one," are exempted from the law.

4. Are self-insured (ASO) groups included?

Yes. Self-insured groups (ASO), which are typically exempt from state regulations, are subject to the federal mental health parity legislation. These plans were previously subject to the 1996 federal parity law and are now included in this new legislation.

5. Does the Mental Health Parity Act *require* plans to cover mental health or substance abuse benefits?

No. The Mental Health Parity Act *does not* mandate coverage of mental health or substance abuse benefits. Health insurance carriers may, however, be subject to state laws that mandate coverage for some or all of these benefits.

6. What takes priority, state or federal parity legislation?

Stronger state mental health parity laws are not preempted by the federal law. If, for example, a state law requires parity for all diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders ("DSM"), this state requirement remains in place, as do state laws that require parity for specific diagnoses (usually, a list of severe mental illnesses). In addition, the bill does not override an obligation created in state law to either cover or offer mental health benefits.

If a state parity law does not include substance use disorder, but a plan covers substance use disorder, the coverage must be at the federal parity level.

7. How does the Mental Health Parity Act govern the provision of mental health or substance abuse benefits?

Health insurance plans that provide coverage for mental health or substance abuse benefits must do the following:

Annual and Lifetime Limits

In general, the existing parity requirements applicable to annual and lifetime financial and treatment limits were unchanged. As a result, if the health insurance plan includes an aggregate annual or lifetime financial or treatment limit on substantially all medical and surgical benefits, it must either:

- apply the same applicable limits to mental health and substance abuse benefits or
- not include an aggregate annual or lifetime financial or treatment limit for mental health or substance abuse benefits that is less than the limits applied to medical and surgical benefits

Financial Requirements

“Financial requirements” are defined in the Mental Health Parity Act as including deductibles, copayments, coinsurance and out-of-pocket expenses. The financial requirements applied to mental health or substance abuse benefits must not be more restrictive than the predominant¹ financial requirements applied to substantially all medical and surgical benefits. In addition, the health insurance plan *may not* apply a separate financial requirement to mental health or substance abuse benefits that is not applicable to medical and surgical benefits.

Treatment Limitations

“Treatment limitations” are defined as including limits on the frequency of treatment, number of visits or days of coverage or other similar limits on the scope or duration of treatment. The treatment limitations applied to mental health or substance abuse benefits must not be more restrictive than the predominant¹ treatment limitations applied to substantially all medical and surgical benefits. In addition, the health insurance plan may not apply a separate treatment limit to mental health or substance abuse benefits that is not applicable to medical and surgical benefits.

Here is an example of how existing benefit designs would need to change in order to be compliant with the law. These are for illustration only – benefit design changes are currently under review:

Current Benefit	Predominant Medical/Surgical	Current MH/SA	Required Change under Parity
Inpatient coinsurance	20%	25%	Decrease MH/SA to 20%
Outpatient visit limit	None	30 visits	Eliminate 30 day limit on MH/SA
Inpatient visit limit	None	60 days	Eliminate 60 day limit on MH/SA
Out of network benefits	Yes	No	Allow out of network benefits for MH/SA

8. Can utilization reviews be applied?

Health insurance plans are not restricted from applying utilization review, medical necessity determinations or other tools to encourage appropriate and effective care. However, the bill requires disclosure of the criteria for medical necessity determinations (and reasons for denials of coverage) regarding mental health or substance abuse benefits to any current or potential participant, beneficiary or contracting provider upon request.

9. What diagnoses are included?

The bill imposes no requirements as to what mental health and substance use disorder conditions must be covered and did not select the DSM as the source for included codes. (Subject to state mandates when applicable as noted above)

10. How does the new law affect out-of-network coverage?

Health insurance plans that cover mental health or substance abuse benefits must provide out-of-network coverage for such benefits if the plan provides out-of-network coverage for medical and surgical

benefits. The parity requirements apply to the out-of-network coverage for medical and surgical benefits as well as mental health and substance abuse benefits.

11. When do the provisions of the Mental Health Parity Act go into effect?

The requirements of the new law are effective for plan years beginning on or after one year from the date the legislation was signed into law (October 3, 2008). As a result, the provisions apply to new contracts and renewals on or after October 3, 2009.

- For groups with plan year² benefits, the parity benefit changes will take effect 11/1/2009
- For groups with calendar year benefits, the parity benefits will take effect on a 1/1/2010 purchase or renewal
- For collective bargaining agreement plans, the effective date is the later of 1/1/10 or the date that the collective bargaining agreement expires.

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

12. What are the cost implications of this Act for an ASO group?

Actuarial analyses have been conducted both internally (WP Actuarial team) and externally and both estimate the cost impact for employers that currently comply with state parity mandates to be in the 0.2 - 2% range³.

The primary external source for this information is a Milliman Actuarial Study⁴, which projects cost increases of 0.1% to 0.6% depending on the level of management in place. The Congressional Budget Office has projected an average increase of 0.4% for plans. Please note that the figures in the Milliman study do reflect a scenario in which the copay for a BH provider changes from \$25 to \$10.

The magnitude of the cost impact will depend on several factors, including the group's current cost-sharing, whether or not OON benefits are currently excluded, and whether or not OP services are currently managed.

End Notes

1. A financial requirement or treatment limit is "predominant" if it is the most common or frequent of such type or limit.
2. "Plan year" is the time period that the employer discloses to the Department of Labor in its annual 5500 filing. It is not necessarily the same as our renewal date. Since we do not have any information regarding a group's plan year, unless we are told otherwise by the group, we will assume that plan year and renewal are the same.
3. Mercer Health and Benefits Perspective. "Guidelines for cost-effective implementation of the Mental Health Parity and Addiction Equity Act of 2008." January 2009.
4. Milliman - An Actuarial Analysis of the Impact of HR 1424, "The Paul Wellstone Mental Health and Addiction Equity Act of 2007" Stephen P Melek, Bruce S Pyenson, Kathryn V Fitch. Milliman Inc. July 5, 2007.