

Balancing Equality and Cost

Understanding Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, included in HR 1424 known as the “Emergency Economic Stabilization Act” makes major changes to the existing Mental Health Parity law. The new legislation requires mental health and substance abuse to have “true parity” with other benefits. This paper provides a brief summary of these changes to employers who are impacted by this law, and summarizes guidance with regard to the law and balancing equality with cost.

This law applies to fully insured and self-insured plans covered by ERISA, non-ERISA plans – both insured and self-funded, and collectively bargained plans. Employers with 50 or fewer total employees are exempt.

This change in legislation is an opportunity to improve the health of your employees. Mental health and substance abuse coverage is a cornerstone to drive holistic health and well being for your employees. Many employees see this as integral to their success. A person who is mentally healthy is more likely to have a better clinical outcome. Better clinical outcomes mean lower costs.

Effects of the Law

The passing of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 means that most group health plans renewing after October 3, 2009 must evaluate their benefits for compliance and make any necessary changes. For many plans, this evaluation will take place on January 1, 2010.¹

Changes in Plan Design

The changes required seem fairly simple at first glance. However, due to various creative plan designs, bringing

plans into parity will require benefit managers to make some very important and potentially difficult decisions. Below is a summary of the most common changes plans will need to make in order to comply with the law:

1. Coverage levels must be the same. Mental Health and Substance Abuse (MH/SA) benefits must be covered on at least the same basis as, or better than, the predominant coverage levels applicable to substantially all medical and surgical benefits. This includes:

- co-payments
- coinsurance
- day and visit limits
- deductibles
- out of pocket maximums
- lifetime maximums

The most common change groups will likely make is to remove day and visit limits for MH/SA benefits. The next most common change will be aligning copays and coinsurance levels for inpatient and outpatient services.

Coverage level example:

Employer A's benefit plan requires a \$250 inpatient per admission copay for medical and a \$350 inpatient per admission copay for MH/SA. To comply with regulations, the MH/SA copay could be reduced to \$250 or less or the medical copay could be increased to \$350.



CIGNA

828966 06/09

it's time to feel better

- 2. Network features must be the same.** Plans that include an out-of-network feature for medical and surgical benefits must also provide out-of-network MH/SA benefits in parity with the out-of-network medical benefit; and the cost sharing must be the same.

Network feature example:

Employer B's benefit plan offers 70% coinsurance coverage for medical services by an out of network provider and 50% coinsurance coverage for MH/SA services by an out of network provider. To comply with regulations, the MH/SA out of network coinsurance must be increased to 70% or more to be in parity with the medical out of network coinsurance.

- 3. No separate cost sharing requirements.** The law states that there can be "no separate cost sharing requirements" that require any unique or different financial requirements that only apply to MH/SA benefits. There is more than one interpretation of this requirement in the health insurance community. Group health plans will decide for themselves how to structure benefits to comply with this law; the government has not provided any guidance on this point as of this writing.

Sharing deductibles, out of pocket maximums, and lifetime maximums between medical and MH/SA is the optimal choice in response to the new parity legislation when both medical and MH/SA are with one company. However, in situations where all benefits are not with one carrier, we feel that separate but equal administration is perfectly acceptable as long as the same cost sharing methods are applied.

Cost sharing Example:

Employer C's benefit plan includes *copays* on medical benefits and *coinsurance* on MH/SA benefits. Even if the coinsurance on MH/SA costs less to the individual, the coinsurance is unique to the mental health benefits and must change to a copay benefit to comply with the "no separate cost sharing" provision.

Defining Mental Health

The Mental Health Parity and Addiction Equity Act of 2008 allows health plans to define "mental health benefits" and "substance use disorder benefits." CIGNA defines and identifies mental health conditions and substance use disorders as per criteria in the most recent version of the Diagnostic and Statistical Manual issued by the American Psychiatric Association (currently DSM-IV TR).

The act *does not* preempt state laws for mental health and substance abuse if the state laws do not prevent compliance with the federal law. Therefore, insured plans must continue to comply with any state laws that provide for coverage of specific diagnoses or treatments, or for richer benefits.

Controlling Cost

The financial impact of providing behavioral benefits in parity with medical benefits will vary by employer, depending on their current level of mental health/substance abuse benefits. Co-payment, coinsurance, differences in the current plan and any applicable state laws will be a factor in determining the cost impact. Claims analysis indicates the average increase in total claim cost (medical + behavioral) is only 0.4%,² and this is in line with government expectations.

The law permits health plans to apply standard medical necessity determinations, utilization review provisions and pre-certification requirements to mental health or substance abuse benefits. The criteria for medical necessity determinations and the reason for denial of payment for these benefits must be made available to any current or potential members and contracted providers.

Exemptions

Self insured non-federal government plans may file for an exemption with the Centers for Medicare and Medicaid Services (CMS).

Some groups may be eligible for exemption if this law results in an increase of actual total costs for medical/surgical and MH/SA for the plan year that exceeds: (a) 2% for the first plan year; and (b) 1% for subsequent plan years. The cost determination must be made by a certified actuary, and the plan must notify the Secretary of the Dept. of Labor, appropriate state agencies, and all members of the plan if they elect to exempt themselves from this mandate based on the cost increase. If they do so, the exemption is realized for only the following (one) plan year.

Having a healthy and productive employee population effectively reduces medical claims costs on a sustainable basis and helps companies improve human performance in the workplace. Therefore, it is strongly recommended that employers maintain their MH/SA offerings. Filing for exemption should not be used as a cost saving measure.

Conclusion

CIGNA is committed to helping the people we serve improve their health, well-being, and security. Engaging individuals in behavior change is the foundation of successful health and productivity optimization. Changing behavior in the interest of health optimization and disease prevention is what sets us apart from our competitors. CIGNA is committed to helping employers understand and comply with this legislation providing a legal and compliance team dedicated to interpreting the law to ensure benefit plan designs are in compliance. Our competitive advantages are our 30 plus years of behavioral change management experience and our superior ability to engage individuals in sustainable health improvement that supports their optimum health and productivity. A person with sound mental health is more likely to have a positive clinical outcome – the net result is lower healthcare costs.

¹ Collectively Bargained plans must comply with the later of: (a) the date on which the last collectively bargained agreement (notified prior to October 3, 2009) expires; or (b) January 1, 2010.

² In the event clarifying regulations or interpretations become available some of the assumptions used in our analysis may change. It is also possible that publicity regarding passage of the parity law will raise awareness of this benefit and drive utilization in a way that is not captured by our analysis. As a result, the actual financial impact due to benefit changes to comply may be more or less than our estimates and will not be known until parity changes go into effect.

"CIGNA," "CIGNA HealthCare" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

