AMERICAN PSYCHOLOGICAL ASSOCIATION
PRACTICE ORGANIZATION

Mental Health Parity Law

Psychologically Healthy Workplace Program

An Employer's Guide to the Mental Health Parity and Addiction Equity Act

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In 2008, Congress passed legislation that requires private health insurance plans to provide equal coverage for mental and physical health. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Wellstone-Domenici Parity Act) was passed with the intent to improve access to appropriate treatment for people suffering from mental health disorders and extend equal coverage to all aspects of health insurance plans. The act preserves existing state parity and consumer protection laws while extending protection of mental health services to those not protected by state laws. The Wellstone-Domenici Parity Act was designed to include mental health coverage for both in-network and out-of-network services. The law applies to groups with more than 50 employees and goes into effect January 1, 2010.

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Mental Health Problems are Common and Often Untreated

More than 57 million Americans suffer from a mental health disorder, according to the National Institutes of Mental Health. A 2008 nationwide survey by Harris Interactive in conjunction with the American Psychological Association found that 25 percent of Americans do not have adequate access to mental health services and 44 percent either do not have mental health coverage or are not sure if they do. Additionally, a 2006 survey by the Substance Abuse and Mental Health Agency reports that 49 percent of U.S. adults with both serious psychological distress and a substance use disorder go without treatment.

The Wellstone-Domenici Parity Act will provide coverage for treatment of many psychological ailments and mental health disorders including depression, anxiety and panic disorders. It can also include treatment for trauma victims suffering from post traumatic stress disorder, teenage girls fighting to survive anorexia or bulimia, new mothers struggling with post-partum depression, children suffering from attention-deficit hyperactivity disorder and many people struggling with alcohol and substance use problems.

What Mental Health Parity Means for Employers

Mental health parity has been misunderstood for as long as it has been debated. For many years, opponents have expressed concerns about the cost of implementing parity laws. Those concerns have been called into question by years of experience showing the organizational benefits and improved health that result from recognizing the mind-body health connection and implementing parity in coverage for physical and mental health services.

Research shows that physical health is directly connected to emotional health and millions of Americans know that suffering from a mental health disorder can be as debilitating as any major physical health disorder. Passage of the Wellstone-Domenici Parity Act will lead the health care system in the United States to start treating the whole person, both mind and body.

Employers are well aware that employee health and well-being are critical to running a productive, profitable, successful business and addressing employees' mental

health needs is a key ingredient in achieving those business results. This guide outlines steps employers can take to optimize outcomes for employees and the organization, while implementing the changes required by the law.

Best Practices in Mental Health Parity Implementation

Mental health disorders cause more days of work loss and on-the-job impairment than many other chronic conditions such as diabetes, asthma and arthritis.[1] Approximately 217 million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing U.S. employers $17 billion each year.[2] In total, estimates of the indirect costs associated with mental illness and substance abuse disorders range from a low of $79 billion per year to a high of $105 billion per year (both figures based on 1990 dollars).[3]

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To optimize the organizational value when implementing the Wellstone-Domenici Parity Act, health plans should review their benefits design and the various ways mental health services are accessed, delivered and paid for. Federal implementation guidelines for the Wellstone-Domenici Parity Act will not likely be available until the fall of 2009 and follow-up questions and answers will likely stretch into 2010.

The following material is offered as immediate help and support for employers wanting to implement best practice suggestions that are likely to meet any minimum federal standards for the Wellstone-Domenici Parity Act and provide the greatest contribution to creating a healthy workplace.

1. **Equalize benefit structures per Wellstone-Domenici Parity Act requirements –** Equalize all financial requirements and treatment limitations for mental health with medical and surgical benefit designs.

2. **Assure adequate access to a full range of settings for patient care –** For mental health benefits this includes hospitalization, partial hospitalization, residential care and outpatient services.

3. **Eliminate office visit limits and/or hospital day limits on mental health services –** The Wellstone-Domenici Parity Act does not allow restrictions on mental health treatments to be more limited than those restrictions applied to substantially all other medical/surgical benefits. Most health plans do not have annual or other limits on the number of office visits for medical care. This would mean that mental health office visits must be the same.

4. **Use common deductibles and maximum out-of-pocket cost-sharing –** Use a common deductible and common maximum out-of-pocket cost sharing features in health plan designs. That is, use a single deductible where all cost-sharing is applied whether or not the covered claim is for mental health or a medical/surgical claim.

5. **Equalize coinsurance –** For plans using a coinsurance benefit design, the predominant coinsurance percentage covered by the plan should apply to mental health claims. In the past, some plans paid 80% coinsurance on medical/surgical claims and 50% for mental health. Under this example, to comply with the Wellstone-Domenici Parity Act, the 80% coinsurance would also apply to mental health claims.

6. **Equalize office copayments –** For plans with copayments, the psychotherapy office visit copayment should be the same as the predominant office visit copayment under the plan. In general, this is likely to be the same as that applied to primary care physicians.

7. **Improve coordination between disease management programs, general medical care and mental health services –** Employers should require their disease management vendors, as part of their regular practice, to periodically screen all patients enrolled in their respective programs for common behavioral health conditions, and coordinate care with other providers as indicated.

8. **Encourage preventive mental health care and early intervention –** Remove stigma and encourage plan members to seek mental health support for high stress and depression. Prevention and early intervention can help avoid more costly services that result from untreated conditions.

9. **Address the high-risk of comorbidities –** Primary care physicians and other health providers under the plan should be alert to and screen for depression and other common mental health conditions among individuals with chronic medical illnesses. Patients left untreated for depression are often less able to maintain adherence with medications and other recommended treatments.

10. **Refer to mental health providers –** Primary care physicians are often the first to identify depression and other mental health conditions in their patients. Referrals from primary care to mental health providers should be encouraged to effectively diagnose a patient's condition and improve patient care.

11. **Encourage collaborative care –** Use a collaborative care model to address the needs of patients with mental illnesses who are also receiving primary care services. Collaboration on care and treatments by all providers should follow accepted professional standards.

12. **Assure equal in-network and out-of-network access –** Patients in need of mental health services should have access to quality providers when seeking either in-network or out-of-network services.

13. **Equalize benefits for out-of-network mental health services –** Out-of-network mental health benefits cannot have more restrictive financial requirements than medical/surgical benefits. If out-of-network medical/surgical benefits are provided, out-of-network mental health benefits must be provided on an equal cost-sharing basis.

14. **Review mental health services annually –** Review mental health services each year and make plan changes to reflect new treatments and procedures that should be added to the plan's benefit design.

15. **Don't look for loopholes –** The value of providing mental health coverage is well established and the Wellstone-Domenici Parity Act states clearly that there are to be "no separate cost-sharing requirements that are applicable only with respect to mental health or substance use disorder benefits."

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During the past few years employers have focused on general health quality and benefit design improvements to better engage plan members. Many organizations now understand that employee health and organizational performance are inextricably linked and recognize the importance of mental health in the overall well-being of their workforce. Now is the time to engage and treat the whole person – mind and body – in a comprehensive approach to creating healthy, high-performing organizations.

[1] Kessler RC. Greenberg PE. Mickelson KD. Meneades LM. Wang PS. The effects of chronic medical conditions on work loss and work cutback. *Journal of Occupational and Environmental Medicine*. 2001; 43(3): 218-225.

[2] Hertz RP, Baker CL. The impact of mental disorders on work. *Pfizer Outcomes Research*. Publication No P0002981. Pfizer; 2002.

[3] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999.

Frequently Asked Questions About the Mental Health Parity and Addiction Equity Act

What is the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Wellstone-Domenici Parity Act) is a federal law that requires private health insurance plans to provide equal coverage for mental and physical health. It was signed into law on October 3, 2008 by President Bush. The law is intended to improve access to appropriate treatment for people suffering from mental health disorders and extend equal coverage to all aspects of health insurance plans.

Does this law apply to all employers and organizations?

The law applies to organizations and companies with group health plans for more than 50 employees. It preserves existing state parity and consumer protection laws while extending protection of mental health services to those not protected by state laws.

What does "parity" mean?

Parity means equal coverage for mental health and substance use and physical health conditions covered under health plans. The Wellstone-Domenici Parity Act provides the following:

Equal benefits: Benefits coverage for mental health and substance use benefits must be at least equal to the coverage provided for physical health benefits.

Equal limits: Financial requirements and treatment limitations applied to mental health and substance use benefits may be no more restrictive than those applied to physical health benefits.

Equal cost-sharing: Patient cost-sharing (i.e., deductibles, copayments, maximum-out-of-pocket costs) may be no higher for mental health and substance use benefits than it is for physical health benefits.

Equity applied to all financial requirements, including:

a. lifetime and annual dollar limits;
b. deductibles, copayments, coinsurance;
c. out-of-pocket expenses; and
d. all treatment limitations, including frequency of treatment, number of visits, days of coverage and other similar limits.

How is the Wellstone-Domenici Parity Act different from the 1996 federal mental health parity law?

The 2008 Wellstone-Domenici Parity Act amended and increased the parity requirements of the federal Mental Health Parity Act of 1996, which only required parity coverage for lifetime and annual dollar limits. The 2008 Wellstone-Domenici Parity Act requires that all financial requirements and treatment limitations applicable to mental health/substance abuse disorder benefits are no more restrictive than those requirements and limitations placed on physical benefits.

When does the Wellstone-Domenici Parity Act take effect?

The Wellstone-Domenici Parity Act will apply to health plans beginning **January 1, 2010**. (The effective date is slightly different for labor union plans pursuant to collective bargaining agreements.) This will give health plans the time necessary to redesign their coverage to come into compliance with the new law. The current 1996 parity law will remain in effect through December 31, 2009.

Which health plans will have to comply with the Wellstone-Domenici Parity Act?

The Wellstone-Domenici Parity Act applies to all group health plans with more than 50 employees, whether the plans are self-funded (regulated under ERISA) or fully-insured (regulated under state law) that provide mental health or substance abuse benefits. Those health plans with 50 or fewer employees that must meet state mental health parity requirements will continue to do so. The new law does not apply to the individual insurance market.

What diagnoses are included under parity?

The Wellstone-Domenici Parity Act covers all diagnoses for mental disorders. It goes beyond the 1996 act and some state parity and mandated benefit laws by also requiring parity for substance use disorders. There are no explicit exclusions. In effect, whatever a plan covers must be covered at parity with physical health benefits. As in the current system, a health plan may deny coverage based on medical necessity or under the terms of its coverage contract with an employer.

Can benefits for a diagnosis be excluded from coverage under the new parity law?

Yes, employers are not prohibited from dropping coverage for a diagnosis. The Wellstone-Domenici Parity Act broadly defines mental health and substance use disorder benefits to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.

Does the Wellstone-Domenici Parity Act have any impact on benefits management and medical necessity criteria?

Benefits management: A health plan may manage the benefits under the terms and conditions of the plan. Benefit management of mental health services that is more restrictive than benefit management of medical/surgical services could be a violation of the Wellstone-Domenici Parity Act.

Medical necessity: There is no language in the Wellstone-Domenici Parity Act defining medical necessity. Medical necessity standards for mental health services that are more restrictive than medical necessity standards for medical/surgical could be a violation of the Wellstone-Domenici Parity Act. The Wellstone-Domenici Parity Act requires a plan to make mental health/substance use disorder medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. A plan must also make reasons for payment denials available to participants or beneficiaries on request or as otherwise required.

Does the Wellstone-Domenici Parity Act apply to out-of-network services?

Yes. Under the new law, if a health plan provides both out-of-network physical and mental health/substance use disorder benefits, these services must be provided at parity. If a plan currently provides only out-of-network physical health benefits, this new law will require it to add out-of-network mental health and substance use disorder benefits, at parity.

A few health plans, typically referred to as "closed panel" or "staff model" HMOs, do not provide for any out-of-network coverage. Since these plans do not provide out-of-network physical health coverage, they are not required to provide out-of-network mental health and substance use coverage.

Does the Wellstone-Domenici Parity Act impact network reimbursement?

No. The new law does not address reimbursement rates. Reimbursement rates for services paid to network providers are negotiated between the providers and the health plan. However, an employer may be in violation of the Wellstone-Domenici Parity Act if covered mental health or substance use services are reimbursed at rates that limit provider participation or restrict access to care more than medical/surgical services.

What is the cost of the Wellstone-Domenici Parity Act?

The Congressional Budget Office (CBO) has determined that Wellstone-Domenici Parity Act will raise overall national health plan premiums by an average of about 0.4% (four-tenths of one percent), to be split between employers and their employees. Due to this very low cost, it is expected that health plans will continue to provide substantial mental health and substance use coverage. Of course, depending upon the current level of benefits provided before parity, the costs for a given employer's plan may be higher or lower than the CBO average.

Can health plans drop mental health and substance use benefits completely?

Yes. The Wellstone-Domenici Parity Act does not require health plans to provide mental health and substance use benefits, but if the plan does provide such coverage, it must be at parity with physical health coverage.

Elimination of these benefits would likely be very expensive to health plans. A Kaiser Family Foundation Annual Survey of Benefits showed that 97% of plans already provide mental health and substance use benefits. It is now well accepted that these benefits are an integral part of treating most health conditions. Effective treatment of illnesses like diabetes, asthma and congestive heart failure requires a full recognition and treatment of co-morbid mental health and substance use disorders.

My state already has a parity law. How will this new federal law affect state law?

State laws only apply to fully insured groups. They do not apply to self-insured ERISA groups. Forty-three states have enacted parity laws. While some of these laws provide for strong parity protections, many are not as comprehensive as the new federal law. For those states with strong existing parity laws, the Wellstone-Domenici Parity Act is protective of state law. Under HIPAA, only a state law that "prevents the application" of the federal law is preempted. This means that if a provision in a state parity law provides for less protection than the federal law, it is preempted. If the state law provides for more protection than the federal law, it is not preempted. In essence, if a group plan is fully insured under state law, the Wellstone-Domenici Parity Act is a "floor" from which states may provide for greater protection.

Does the Wellstone-Domenici Parity Act apply to Medicare and Medicaid patients?

The Wellstone-Domenici Parity Act does not apply to Medicare patients. In July 2008, Congress provided for Medicare coinsurance parity for Medicare patients by 2014 when it enacted "phase-in parity" under the Medicare Improvements for Patients and Providers Act (MIPPA). The Wellstone-Domenici Parity Act, however, does apply to Medicaid managed care health plans.

How will the Wellstone-Domenici Parity Act be enforced?

For fully insured plans, states can pass parallel legislation to maintain enforcement responsibility with the Wellstone-Domenici Parity Act. If states fail to act, federal agencies will enforce the law. As with the 1996 mental health parity law, the U.S. Departments of Labor (for ERISA-regulated health plans), Health and Human Services (for all other health plans including self-insured plans) and Treasury (for tax penalties for noncompliance) will jointly enforce the law. Prior to the January 1, 2010 enforcement date, these departments will be creating regulations to enforce the law.