



# Managing Behavioral Health Costs: A Guide to Mental Health Parity Compliance

*Brought to you by American Health Holding  
and CuraLinc Healthcare*

**August 27, 2009  
2:00 p.m. ET**



# Agenda

- Welcome and Introduction of the Panelists
- Overview of the Mental Health Parity Act (MHPA)
  - ❖ Legal Implications
  - ❖ Clinical Implications
  - ❖ Best Practices
- Roundtable Discussion
- Closing



## Our Featured Panelists



**Tim Quinlivan**  
Vice President and  
Associate General Counsel  
American Health Holding  
*Legal Perspective*



**John Kamilis, MA, LCPC**  
Director of Clinical Services  
CuraLinc Healthcare  
*Clinical Perspective*



**Richard Hodsdon Jr.**  
Vice President of Sales  
American Health Holding  
*Health Plan Perspective*



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  - ❖ Clinical Perspective
  - ❖ Health Plan Perspective
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# Legal Perspective



**Tim Quinlivan**  
Vice President and  
Associate General Counsel  
American Health Holding

## General Provisions

- On October 3, 2008 the Emergency Economic Stabilization Act (the “Bail-Out Bill”) was signed into law
- The Paul B. Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPA) was attached to the “Bail-Out Bill”
- The MHPA builds on the 1996 federal Mental Health Parity Act, which already requires mental health parity for annual and lifetime dollar limits

## Overview of MHPA Requirements

- Does not mandate coverage of mental health and/or substance abuse benefits
- New requirements apply only if mental health and/or substance abuse benefits are offered
- Mental health benefits are defined as benefits for mental health services “as defined under the terms of the plan and in accordance with applicable federal and state law”
- Substance Abuse benefits are defined as benefits for substance abuse disorders “as defined under the terms of the plan and in accordance with applicable federal and state law”

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## Overview of MHPA Requirements

- A plan that provides coverage of mental health and/or substance abuse benefits may not apply “financial requirements” and “treatment limitations” that are more restrictive than the predominant financial requirements and treatment limitations applied to “substantially all medical and surgical benefits”
  - ❖ Financial Requirements = **includes** deductibles, copays, coinsurance, out-of-pocket expenses, but excludes aggregate lifetime/annual caps
  - ❖ Treatment Limitations = **includes** limits on frequency of treatment, number of visits, days of coverage or similar limits that would impact the scope or duration of treatment
  - ❖ Predominant = the most common or frequent type of limit or requirement

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## Overview of MHPA Requirements

- Requires out-of-network coverage for mental health and/or substance abuse benefits if the health plan otherwise provides out-of-network coverage for medical/surgical benefits
- If requested (or otherwise required) plans must disclose:
  1. **Criteria for determining medically necessity** to current or *potential* plan participants and contracting providers; and
  2. **Reason for denial** of any mental health or substance abuse benefits to any plan participant
- Includes a cost exemption for certain employers

## Impact on State Law

- MHPA applies to ERISA and non-ERISA plans
- State law is preempted by ERISA for self-funded ERISA plans
- For non-ERISA plans:
  - ❖ Compliance will still be required for state laws that provides greater benefits than required by the federal law, and that do not otherwise prevent compliance with the federal law.
    - 48 states currently have some type of enacted law but these laws vary considerably

## What is NOT required by the law?

- Does not require a plan to offer mental health and/or substance abuse benefits
- Does not require that all mental health/substance abuse benefits are covered
  - ❖ Definition of “mental health” and “substance abuse” benefits is broad and is defined under the terms of the plan
  - ❖ Allows plans to only cover certain conditions/diagnoses

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## What is NOT required by the law?

- Does not require a health plan to cover out-of-network benefits the same as in-network benefits
- Does not prohibit a group health plan from utilizing medical management practices
- Does not apply to small employers (1-50 employees) or the individual market

## Cost Exemption

- Limited exemption may be sought if a plan's actual total cost of coverage with respect to medical, surgical, mental health, and substance abuse combined, increase by:
  - ❖ 2% or more in the case of the first plan year; or
  - ❖ 1% in the case of each subsequent plan year
- Exemption applies only to the following plan year and is granted only for one year

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## Cost Exemption

- The following steps must be taken in order to seek this exemption:
  - ❖ *Determination by a Qualified and Licensed Actuary* in good standing with the American Academy of Actuaries.
  - ❖ *Six-Month Rule*. Plans must comply for at least six months before an actuarial determination may be made. The exemption will not be applied until the following plan year.
  - ❖ *Notice*. The plan must promptly notify the Secretary of Labor, any appropriate state agencies, and plan participants and beneficiaries. The notification to the Department of Labor (DOL) must contain certain required information.
  - ❖ *Audit*. The plan must be willing to undergo an audit by the DOL and/or applicable state agency.

## Compliance Date

- Compliance is required beginning on the 1<sup>st</sup> day of the 1<sup>st</sup> plan year after October 3, 2009, which for most plans will mean they need to comply by January 1, 2010
- Special exception for groups covered as a part of a collective bargaining agreements (CBA). Compliance is not required for plans maintained pursuant to a CBA that was *ratified* prior to October 3, 2009 until the later of:
  - ❖ The date the existing CBA terminates (does not include any extensions that were granted after enactment) or
  - ❖ January 1, 2010

## Regulations, Enforcement & Penalties

- Required regulations to be issued jointly by the IRS, HHS & DOL by October 3, 2009
  - ❖ As of today, regulations have not been issued
- Enforcement by DOL for self-funded plans
- Penalty:
  - ❖ \$100 per member per occurrence under the Internal Revenue Code and Public Health Service Act
  - ❖ Penalties that can otherwise be assessed by law



# Clinical Perspective



**John Kamilis, MA, LCPC**  
Director of Clinical Services  
CuraLinc Healthcare

## The Importance of MH/SA Benefits

- Providing mental health and substance abuse (MH/SA) services can save employers money by reducing medical costs and increasing workplace efficiency.
  - ❖ Mitigate the workplace and personal impact of employees with MH/SA conditions
  - ❖ Reduce unnecessary medical claims for MH/SA issues
  - ❖ Boost employee productivity by decreasing absenteeism, “presenteeism” and frequency of disability claims
  - ❖ Lower the frequency of MH/SA issues leading to physical illnesses

## Statistics

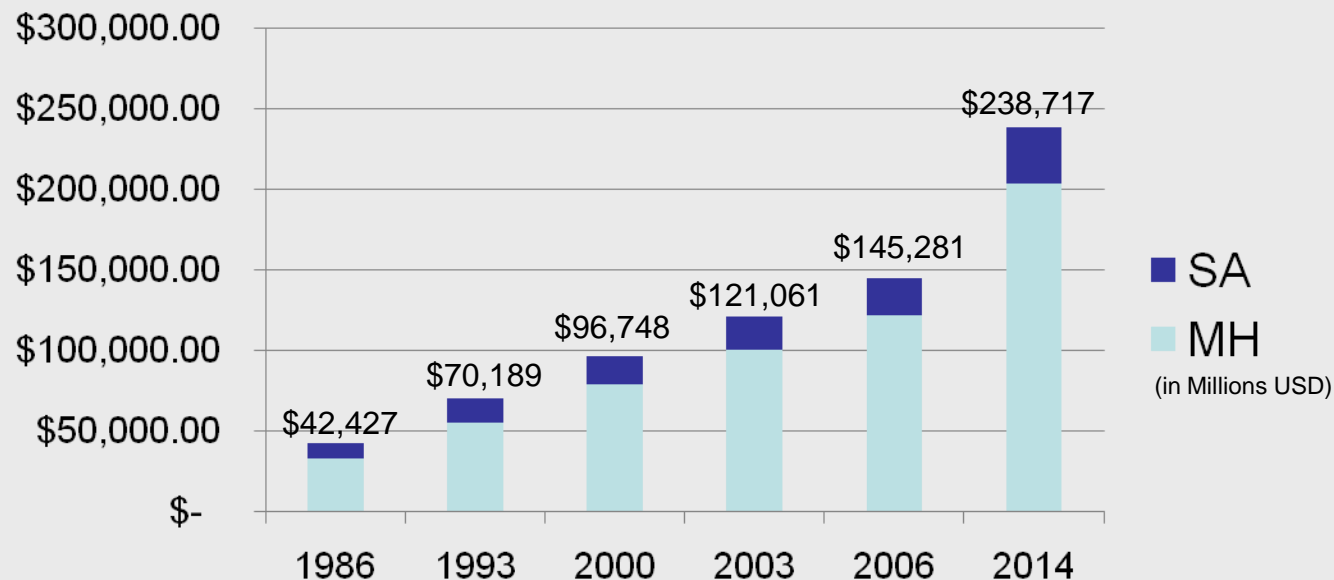
- People with MH/SA disorders:
  - ❖ 1 in 4 have a diagnosable MH condition.
  - ❖ 75% of Illicit drug users (12.9 million) are employed.
  - ❖ 70% of people diagnosed with a MH condition are employed.
  - ❖ 42% of “highly educated” workers abuse prescription meds.

## Cost and Productivity

- Cost of untreated (or uncovered) MH/SA issues
  - ❖ People with MH conditions have lower productivity, higher absenteeism rate
  - ❖ Medical costs as much as 50% higher due to misdiagnosis, mistreatment, and unnecessary MH and SA services
  - ❖ More difficult to return to work after an MH/SA absence than a medical absence
  - ❖ One-third of sick days for chronic illness are attributed to MH/SA conditions

## Cost and Productivity

- Cost of Mental Health (MH) and Substance Abuse (SA) Expenditures
  - ❖ MH spend expected to rise at a higher rate than SA
  - ❖ MH/SA costs projected to increase by 462% from 1986 to 2014



## Why Keep MH/SA Benefits?

- Direct Costs
  - ❖ Eliminate unnecessary visits to ER or PCP for MH/SA conditions
  - ❖ State-Specific (MA) Study -- Cost of implementing parity is \$1.46 PMPM
  - ❖ Reduce medical costs for members with depression by one-third
  - ❖ Reduce duration of disability leave for member with both MH issues and medical issues
  - ❖ Decrease likelihood of STD claim becoming LTD claim

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## Why Keep MH/SA Benefits?

- Indirect Costs
  - ❖ Indirect costs of not providing MH/SA are double the cost of treatment
  - ❖ Members with access to MH services are more productive: Two hours per day per employee
  - ❖ Reduce employee turnover by 70%
  - ❖ For employees with depression, absenteeism rate reduced by 50%



# Health Plan Perspective



**Richard Hodsdon Jr.**  
Vice President of Sales  
American Health Holding

## Anticipated Financial Implications

- Milliman, which provided the actuarial analysis of the MHPA to the Congressional Budget Office, estimated that:
  - ❖ On average, the expected overall cost increase for plans without MH utilization management (UM) would be 0.6% and the Congressional Budget Office determined that the MHPA will increase total plan costs by only 0.4%.
  - ❖ Average cost with UM would be 0.1%
  - ❖ Plans without UM may notice **increases of up to 30%** for outpatient MH claims and **10%** for inpatient MH claims.
  - ❖ Plans with UM may notice an **increase of 3%** for outpatient **and 0%** for inpatient MH claims.

## Choices Related to Parity

- Options
  - ❖ Drop the MH/SA benefit
  - ❖ Drop the MH/SA benefit and supplement with alternative carve out model (i.e. onsite clinic, high session model EAP)
  - ❖ Convert Plan to Parity requirements
  - ❖ Convert Plan to Parity requirements and develop “Best Practice Model”

## “Best Practice Model”

- Mitigate risks by aggressively managing MH/SA care in the same way that medical benefits are managed today
  
- Key Components
  - ❖ Health Plan
    - Progressive, MH/SA-friendly plan design
    - Access to geographic and specialty diverse PPO panel
    - Ability to track claim spend and share info in “virtual integration model”

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## “Best Practice Model” *cont’d*

- Key Components (*cont’d*)

- ❖ EAP

- Member focused
- Robust, year-round promotion
- Clearly defined access point for entry
- Ability to receive and refer in “virtual integration model”

- ❖ Medical Management

- URAC Accreditation
- Mental health pedigree
- Clinical diversity and expertise
- Ability to coordinate patient activity in “virtual integration model”
- Technology-savvy with predictive modeling capabilities



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# Roundtable Discussion



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## Question 1:

**Are any plans using separate but equal deductibles or out-of-pocket maximums for Medical and Behavioral Health?**

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**Question 2:**  
**Is there any difference between  
managing medical benefits and  
managing mental health benefits?**

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**Question 3:**  
**Does the law apply to alcoholism  
and/or substance abuse as well,  
or just mental illness?**

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**Question 4:**  
**Are you seeing clients move their  
mental Health benefits from the health  
plan to an EAP-only coverage?**

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**Question 5:**  
**How is mental illness defined? For example, does it include attempted suicide, behavioral disorders, etc.?**

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## Question 6:

**What is the ideal way to educate plan participants on how to access and use MH/SA benefits in the most cost-effective manner?**

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**Question 7:**  
**What are the biggest unknowns yet  
with the mental health parity issue,  
and when will they be defined?**



Contact Us

**For more information about the Mental Health Parity Act or to learn ways to effectively manage plan costs, contact us:**

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**American Health Holding, Inc.**

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