



BENEFIT *Advisor*

In This Issue

In this second issue of the McGrawWentworth Benefit Advisor for 2009, we examine the new Mental Health Parity Act. This Act will require health plans to cover mental health and substance abuse services in the same manner they cover other medical and surgical services.

The new rules include two exceptions. First, small group employers will remain exempt. Second, larger employers can apply for a cost exemption which is fairly complicated and requires a period of compliance. For calendar years plans, the effective date will be January 1, 2010. The new Act is vague in some areas and we hope the government will clarify some of the gray areas during 2009.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“New Mental Health Parity Legislation”

On October 3, 2008, President Bush signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act as part of the Emergency Economic Stabilization Act. The Wellstone Act amends the current Mental Health Parity sections of ERISA (Employee Retirement Income Security Act), PHSA (Public Health Service Act) and the IRC (Internal Revenue Code).



The Wellstone Act will require significant changes in most employer group health plans. This Advisor describes the following aspects of this complicated new legislation:

- Historical Overview
- Review of Required Mental Health Coverage
- Discussion of Exceptions to Compliance
- Summary of Action Steps

Organizations have time to comply with the Wellstone Act. It doesn't become effective until the first day of the plan year after October 3, 2009. For calendar year health plans, it becomes effective on January 1, 2010.

The government has also clarified the date these rules apply to plans that are governed by a collective bargaining agreement. For those agreements, the new regulations take effect for plan

years beginning after the later of the following dates:

- The date the last collective bargaining agreement ended (disregarding any extension agreed to after the date this act became law).
- January 1, 2010.

In some cases, these plans may have more time to comply with the act, but your organization will

need to be sure to make the required changes when you negotiate your next contract.

Historical Overview

As a part of the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act prohibited health plans from applying a separate dollar limit for annual or lifetime mental health services. In order to help plans control the resulting costs for mental health services, it did permit the following practices:

- Covering mental health services within the network only, even if the plan paid medical/surgical benefits for out-of-network providers.

- Charging higher co-payments for mental health visits or limiting the number of visits for mental health treatment.
- Imposing limits on the number of covered visits, even if the plan did not impose similar limits on visits for medical and surgical benefits.
- Having different cost-sharing arrangements, such as higher coinsurance payments for mental health benefits, as compared to medical and surgical benefits.



Although the law required equivalent dollar limits for mental health claims, the original Mental Health Parity legislation did not *require* large group health plans and their health insurance issuers to cover mental health in their benefits package; it applied only to large group health plans that covered these benefits.

The initial legislation had two exceptions. First, small group health plans with 50 or fewer employees were not forced to comply with this law. Second, larger plans could claim a cost exemption if they expected the cost for complying with the law to be more than 1% of plan costs. Group health plans were required to complete a form to request this cost exemption.

For the most part, health plans did remove their dollar maximums for mental health claims, but they limited office visits and the number of days they would cover inpatient mental health hospital stays. Most plans also had different copayments or coinsurance levels for mental health benefits. Very few plans applied for the cost exemption because these plan limits helped control overall mental health benefit costs.

The Wellstone Act is significantly broader in scope than the initial Mental Health Parity Act. Organizations are going to need to make significant changes to their benefit plans to comply with the new provisions.

Required Mental Health Coverage

The new legislation requires mental health plan coverage to be truly equivalent to other medical and surgical expenses coverage. Organizations need to consider the following key aspects of the law:

- The Wellstone Act requires equivalent substance abuse benefits; thus most health plans will have to revise their limits on these benefits. The law defines substance abuse benefits as “benefits with

respect to the treatment of substance abuse as defined by the health plan and in accordance with Federal and State law.”

- Parity provisions apply to all health plan costs the employee must pay, such as copayments, coinsurance, deductibles and out-of-pocket expenses. The plan must treat mental health and substance abuse benefits in the same way it treats medical and surgical benefits. Your organization needs to review key aspects of your plan document. Answering the following questions will help you identify the parts of your plans you may need to amend:

- Are your office visit copays for mental health or substance abuse visits the same as your copays for medically necessary office visits?
- Does your plan require the same deductible for mental health and substance abuse visits as it does for medically necessary office visits?
- Does your plan require the same coinsurance for mental health and substance abuse services as it does for medically necessary services?
- Are your limits for mental health or substance abuse services the same as the limits for medically necessary services?

NOTABLE THOUGHTS

**WHEN YOU REALIZE THE VALUE OF ALL LIFE, YOU DWELL
LESS ON WHAT IS PAST AND CONCENTRATE MORE ON THE
PRESERVATION OF THE FUTURE.**

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- Do your plan's out-of-pocket copayment maximums apply to mental health or substance abuse services? If your plan does not apply out-of-pocket copayment maximums for mental health or substance abuse treatments but does apply them for medically necessary services, your plan will violate these rules.
- Some health plans cover mental health and substance abuse services only if the patient uses an in-network provider. If you cover other medically necessary services in- and out-of-network, you will also need to cover mental health and substance abuse services in- and out-of-network in order to comply with the Wellstone Act.
- Organizations will also need to review how the plan defines what mental health and substance abuse services will be covered under the plan. Early versions of the Wellstone Act actually stipulated that health plans had to cover treatments for all conditions described in the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSMR IV), the bible for accepted mental and nervous conditions. Using the DSMR IV as the criteria for determining covered services would be tough on employer health plans. The DSMR IV contains a wide range of conditions that many health plans do not currently cover. The final version of the Wellstone Act **does not** include this stipulation.

Employers will need to establish the criteria for determining which services and treatments will be covered by the plan. The criteria for what services will be considered medically necessary must be released to providers and participants upon request.

Once again, the act does not *require* the plan to cover mental health or substance abuse services. However, if the plan does cover these services, it must cover them in substantially the same way it covers all other medically necessary services.

It makes sense to review your plan document carefully to determine what charges will need to be made to comply with the Wellstone Act. Some aspects of providing parity will be easy; others will be more difficult. For example, if your plan requires employees to pre-certify a mental health or substance abuse inpatient hospital stay but does not require them to pre-certify other types of inpatient hospital stays, you'll need to change that provision. If your plan covers mental health office visits to a maximum of \$50 a visit but does not have the same limit for medical office visits, you'll need to amend that provision as well.

Exceptions to Compliance

The Wellstone Act has also tightened the exceptions for compliance. Employers may be exempt from complying with this act in two situations:

1. **Small Employer Exception:** A company with an average of at least two employees (or at

least one in states that permit small groups to include only one person) but not more than 50 employees during the preceding year is exempt.

2. **Cost Exemption:** Employers can apply for a one-year cost exemption if their total annual cost to comply with the Wellstone Act significantly increases plan cost. An increase of more than 2% during the first year is considered significant. The cost increase to be considered is the combined cost of medical, surgical, mental health and substance abuse coverage. The 2% cost increase must be due solely to the Wellstone Act

requirements and apply only to the first year. In subsequent years, employers can apply for the cost exemption if they can

show at least a 1% increase. The Wellstone Act cost exemption is much more specific than the initial Mental Health Parity Act cost exemption.

The new regulations explain how to apply for the cost exemption. Employers need to comply with the Wellstone provisions for at least six months before they can apply for the exemption. If a plan applies for the exemption at six months, the application will apply to the next plan year.



Following are more details on the cost exemption:

- A qualified and licensed actuary must verify the employer qualifies for the cost exemption. The actuary must be a member in good standing of the American Academy of Actuaries.
- The employer must keep the materials relating to the cost exemption application and all the underlying claims data used to calculate the cost increases for at least six years.
- It appears the plan's actual experience must be used to calculate the exact cost increase. However, some health plans may find it difficult to get this information from their carriers. For that reason, the DOL will probably issue additional information to help actuaries calculate the cost accurately.
- When they apply for a cost exemption, employers must agree to allow the DOL or an applicable state agency to audit their cost exemption application records.
- If the employer finds the cost increases have exceeded the increase threshold, the employer must notify the Secretary of Labor, any appropriate state agencies and all plan participants and beneficiaries in order to claim the exemption for the following plan year.



The DOL notification must include:

- The current number of people the plan covers, and if applicable, the number of people the plan covered when previous cost exemptions were requested.
- A description of the actual total cost for covering medical and surgical, mental health and substance abuse benefits under the plan for both the plan year in which the cost exemption is sought and the previous year.
- A description of the actual total cost for covering only mental health and substance abuse benefits under the plan for both the plan year in which the cost exemption is sought and for the previous year.

Clearly, the DOL will need to explain how actuaries should calculate the cost increases. It would be particularly helpful if the DOL could provide options for employers who cannot obtain detailed cost information from their insurance carriers. Employers also need more DOL guidance on applying for the exemption and notifying plan participants that the plan qualifies for the cost-exemption.

With the expanded health plan benefits the Wellstone Act will require, it is likely more than a few plans will apply for the cost exemption. It appears the cost exemption is good for a year and then plans will need to cover mental health benefits again for at least another six months in order to apply for the exemption again in the next following year.

Action Steps

All employers with more than 50 employees must take the following steps to comply with the new Mental Health Parity law. Employers hope the DOL will clarify many issues within the coming year; however, it does make sense to develop a compliance action plan.

Step One: Review your SPD and highlight all mental health and substance abuse benefits or plan provisions that apply to these benefits. These are the areas your organization will need to examine.

Step Two: Ask your vendor for input. If your plan is fully insured, the insurance carrier will be the one responsible for amending the plan to comply with this act. Your carrier may have various options to consider. If you are self-funded, your third party administrator (TPA) can recommend the changes you need to make. In particular, your TPA can tell you how to specify the medically necessary services the plan covers.

Step Three: Decide whether your plan will apply for the cost exemption. On the surface, it appears complying with this legislation could conceivably increase costs by more than 2%. However, this cost increase will depend on the services covered and limits placed on the benefits today and what changes you will need to make. If your plan currently covers mental health services and substance abuse treatment generously, the changes for parity may not increase your cost significantly. If you intend to apply for the cost exemption, begin to look for actuaries who will analyze the increase for a reasonable fee.

Step Four: Be patient. The regulations are not detailed enough for employers to really understand how to comply with these regulations responsibly. It is likely the DOL will clarify these regulations within the next six months.

Step Five: Take action when planning for 2010. The government should issue qualifying guidance early in 2009; however, even if it doesn't, your health plan will still need to comply with these regulations. Include a request for pricing the needed changes as part of your planning for 2010.

Employers may not have all the details they need to comply with the Wellstone Act, but they certainly have enough information to review their plans and highlight areas of concern until the DOL clarifies this new law.

Concluding Thoughts

The concept of true mental health parity has been debated in Congress for years. Good mental health is as important as good physical health. Mental health advocates lobbied strongly for mental health benefits to be equivalent to medical and surgical benefits. Employers and insurance carriers argued against parity simply because of the concern over the added plan costs.

The concern is very real. A review of the DSMR IV includes a number of conditions that could be very costly for plans providing equal benefits. The costs for treating conditions such as autism, eating disorders, attention deficit disorder, and addiction disorders can be very high. For that reason the new regulations allow employers some latitude in defining covered services.

Employers also need more guidance on specific issues such as how a plan with various copays for various services can offer "equal" coverage. For example, if a plan has a specialist copay and the plan considers mental health providers as specialists, can the plan charge the specialist copay? At this point, these simple questions do not have clear answers.

McGraw Wentworth will keep you updated as any new guidance on the Wellstone Act is issued.

Please contact your McGraw Wentworth Account Director with any questions. [MW](#)



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