

Mental Health Parity and Addiction Equity Act 2008

On October 3, 2008, the United State Congress passed the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*. The law requires that medical insurance plans that provide mental health or substance use disorder benefits offer full parity between medical and mental health and substance use disorder benefits. Specifically, the financial requirements that apply to mental health benefits can be no more restrictive than the predominant financial requirements that apply to all medical benefits, while the treatment limitations that apply to mental health benefits can be no more restrictive than the predominant financial requirements that apply to all medical benefits. Moreover, there can be no separate cost sharing or treatment limitations that apply only with respect to mental health or substance use disorder benefits. This language also applies to out-of-network providers: if the medical insurance plan provides coverage for medical and surgical benefits out-of-network, it must also provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with full parity. The regulatory process will provide additional details in time.

The law provides definitions for several key terms in the legislation. The term 'financial requirements' includes deductibles, copayments, coinsurance and out-of-pocket expenses, but excludes an aggregate lifetime limit and annual limit. The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment. Finally, the Act expands coverage under the old mental health parity law to include substance use disorder benefits.

As is the case in many mandated benefits, the law provides two ways in which employers can avoid the mandate represented in this law. The first is for small employers (defined elsewhere in the legislation as those with 1 – 50 employees) and the second is for those plans which can demonstrate that the addition of this benefit caused their actual total cost of coverage to exceed 2 percent of actual total plan costs in the first plan year in which the benefit was offered and 1 percent in the case of each subsequent year. Thus, for those medical insurance plans that are offered by employers with ≥ 51 employees, the benefit will have to be provided for plan years beginning on or after October 4, 2009. For those plans that are collectively bargained, the provisions of the Act will not apply to plan years beginning before the later of 1) the date on which the last of the collective bargaining agreements relating to the plan terminates or 2) January 1, 2009. In addition, it would also appear that self-funded non-federal government medical insurance plans would still have the opportunity to opt out of the provisions of the Act pursuant to 42 U.S.C. § 300gg-21.

Thus, institutions which maintain a collective bargaining agreement with public school employees that maintain a fully-insured medical insurance plan that offers mental health or substance use disorder benefits will have to demonstrate full parity between medical and mental health and substance use disorder benefits by the later of the date on which the last of the collective bargaining agreements relating to the plan terminates or January 1, 2009. Those

institutions in the same situation but with a self-insured medical insurance plan may not have to do so if they opt out of that provision of law pursuant to their right to do so under law.

Here it should be noted that mandates represent a way in which government requires employers to adopt and pay for benefits which may or may not be valued by employees. If employees value the benefit and are willing to pay for it, the mandate may make sense for the group and society as a whole. If the benefit is not valued, the mandate contributes to a reduction in employee wages by driving up the price of health insurance. One problem with the Act is that it allows for exemptions on the basis of cost alone. While this approach is typical with many mandated benefit laws (see, for instance, Laugesen et al., 2006), others utilize measures of medical efficacy or public health impact (Bellows, Halpin & McMnamin, 2006) to estimate the health effects of such mandates (McMenamin, Halpin & Ganiats, 2006).

Thus, while those institutions which utilize a self-insured approach to medical insurance benefits may tend to favor opt-outs as a cost management strategy, a more prudent approach might be to implement the mandated benefit and measure its impact on plan costs, health status, and perceived value among health plan participants retrospectively. Moreover, it would behoove all labor-management health insurance committees to consider the plan costs holistically, understanding that mental health and substance abuse costs might reside outside the institution's health insurance program in the guise of worker's compensation costs for injuries and accidents on the job, absenteeism and disability claims.

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