VISIONS

Special Issue
November, 2008

Special Issue: Analysis of H.R. 1412

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: **A Guide for Addiction Professionals and Treatment Providers**

A Legislative Summary of H.R. 1424

Parity in One Sentence

•"In the case of a group health plan … that provides both medical and surgical benefits and mental health or substance use disorder benefits, such a plan or coverage shall ensure that— [financial requirements and treatment limitations] applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant [financial requirements and treatment limitations] applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate [cost sharing requirements or treatment limitations] that are applicable only with respect to mental health or substance use disorder benefits" (Sec. 512a and 512b).

•In other words: Plans that choose to offer mental health and substance use disorder benefits (there is no mandate that they do so) must offer them at the same level that they offer medical/surgical benefits. Discrimination against mental health and addiction in the form of sub-standard benefits can no longer be written into health insurance plans. Plans are still allowed to use medical management tools (including medical necessity criteria) to manage benefits.

Terms Defined

•Financial Requirements: "includes deductibles, copayments, coinsurance, and out-of-pocket expenses."

•Treatment Limitations: "includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment."

•Predominant: "A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement."

Plans Covered by Parity

•The Act applies to plans regulated under the Employee Retirement Income Security Act (ERISA), which are self-funded and do not need to comply with most state parity laws, and fully insured plans (those regulated under state laws and the Public Health Act, including Medicaid managed care plans).

Transparency

•The criteria for medical necessity determinations with respect to mental health or substance use disorder benefits must be made available by the plan administrator to current or potential participants,beneficiaries, and contracting providers. The reason for any denial of reimbursement or payment for services shall be made available to the participant or beneficiary on request or as otherwise required.

Scope of Coverage

•"The term 'substance use disorder benefits' means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law." There is an equivalent definition of "mental health benefits."

Out-of-Network Coverage

•If a plan offers out-of-network medical/surgical benefits and provides mental health and substance use disorder benefits, the plan must provide out-of-network benefits for mental health and substance use disorders that are equivalent to its out-of-network medical/surgical benefits.

Small Employer Exemption

•The Act does not apply to employers who employed 50 employees or fewer in the previous year.

Cost Exemption

•If a plan's total costs rise two percent or more in the first year of parity or one percent in any subsequent year, the plan can be exempt from the Act for one year. Cost analyses must be performed by a licensed actuary. A plan must wait six months before applying for an exemption. If a plan qualifies for a one-year exemption, it must notify its participants and provide its cost data to the government, which must keep it confidential and only report it in aggregate. A plan may elect not to seek an exemption regardless of any potential cost increases.

Effective Date

•Regulations for parity must be written by October 3, 2009. Plans must comply with parity starting with the first plan year that begins after October 3, 2009 (in most cases, January 1, 2010).

•If a group health plan is maintained pursuant to a collective bar-

gaining agreement negotiated between a union and employer, the Act does not apply until the first year after the current plan terminates.

Government Reports

1.The Secretary of Labor will issue a report in 2012 and every two years thereafter describing the compliance of insurance plans with parity.
2.The Government Accountability Office (GAO) will release a study in 2012 that analyzes the following:

•Specific coverage rates for all mental health conditions and substance use disorders;

•Which diagnoses are most commonly covered or excluded;

•Whether implementation of this Act has affected trends in coverage or exclusion of such diagnoses; and

•The impact of covering or excluding specific diagnoses on participants' and enrollees' health, their health care coverage, and the cost of delivering health care.

Preemption of State Laws

•The new law will fall under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that only state laws that prevent the application of the federal law are preempted. It was the lawmakers' intention that the Wellstone-Domenici Parity Act not preempt stronger state laws

Frequently Asked Questions

The Law Online

Q: Where can I find the Wellstone-Domenici Parity Act in its entirety?

A: The following link will provide a history of this bill:
http://thomas.loc.gov/cgi-bin/bdquery/z?d110:HR01424:@@@S

The following link is the complete text of H.R. 1424
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h1424enr.txt.pdf

Background and History:

Q: When did the push for parity begin?

A: Advocates have been trying to pass a parity law like the Wellstone-Domenici Parity Act continuously since a more modest parity law (the Mental Health Parity Act) was passed in 1996. Although it was originally intended to be more comprehensive, the 1996 law only applied to lifetime and annual dollar limits and did not include substance use disorders at all. Numerous parity bills had been introduced since then, but none reached the point of an up-or-down vote in either chamber of Congress. However, advocates' support for these bills helped educate members of Congress about parity and set the groundwork for the success in 2008.

Q: Who in Congress championed the Wellstone-Domenici Act?

A: In the House of Representatives, Reps. Jim Ramstad (R-Minn.) and Patrick Kennedy (D-R.I.) introduced H.R. 1424—the Paul Wellstone Mental Health and Addiction Equity Act—on March 9, 2007. (Paul Wellstone was a senator from Minnesota who was among the first advocates for parity; he died in a plane crash in 2002.) To support their bill, they held over a dozen "field hearings" across the country to hear testimony about the need for parity in mental health and addiction benefits. H.R. 1424 was a very consumer-friendly bill designed to provide strong protections for people in need of treatment. The House passed it on March 5, 2008, by a vote of 268-148.

Senators who supported mental health and addiction parity—led by Sens. Edward Kennedy (D-Mass.), Michael Enzi (R-Wy.), and Pete Domenici (R-N.M.)—had been working for several years with representatives of businesses and the insurance industry to draft a parity bill that could be endorsed by those groups (their opposition had been instrumental in killing earlier attempts at parity). S.558—the Mental Health Parity Act—was introduced on February 7, 2007 and passed on September 18, 2007 by "unanimous consent" (meaning no official vote was taken because no senator objected). Because it had the endorsement of business and insurance groups, S.558 was less consumer-friendly than H.R. 1424.

Q: How were differences between the House and Senate bills resolved?

A: Rather than convene a formal "conference committee" to create a single mutually acceptable bill, House and Senate leaders negotiated informally throughout the spring and summer of 2008. By August, a compromise agreement was in place on all of the policy issues in the bill. The only outstanding issue was how to pay for parity's estimated $3.9 billion price-tag (most of which came from an expected loss of government revenue as employers transferred a small amount of their employees' compensation from taxable salary to non-taxable health benefits). The House of Representatives wanted to "offset" the costs of the bill with tax increases or spending decreases elsewhere in the federal budget, but the Senate did not. As Congress's fall recess rapidly approached, it appeared that parity might become a victim of this broader political standoff.

Q: How was parity finally passed?

A: In late September 2008, many experts thought the U.S. economy was at risk of systematic collapse. Leaders in Congress and the Bush Administration insisted that an influx of federal money was needed to stabilize the financial and credit markets. On September 29, the House of Representatives narrowly failed to pass the $700 billion Emergency Economic Stabilization Act. Yet pressure for government action continued to build, and so the Senate took up the issue. The Constitution prohibits the Senate from initiating new spending bills, so the Senate stripped all the text of the previously-House-passed H.R. 1424 and "amended" it to include the compromise parity legislation, the $700 billion economic rescue package, and a number of popular tax cuts and credits that the House had previously refused to pass because their costs were not offset. The Senate passed the new H.R. 1424 74-25 on October 1, and the House approved it 263-171 on October 3. The final bill was 169 pages, 12 of which concerned parity. Because parity was attached to such a broad bill, the final votes by members of Congress do not necessarily reflect their support for parity itself. Nonetheless, the fact that the parity compromise was ready and supported by members of Congress in both chambers and both parties enabled it to become the vehicle for the Emergency Economic

Stabilization Act.

President Bush signed parity into law on October 3, 2008.

Understanding the New Law:

Q: What, exactly, does the Wellstone-Domenici Parity Act guarantee parity for?

A: The Wellstone-Domenici Parity Act requires insurance plans that cover over 50 people to provide the same level of benefits—both in terms of treatment limitations (frequency of treatment, days of coverage, etc.) and financial requirements (including annual and dollar limits, deductibles, co-payments, coinsurance, etc.)—for addiction and mental health that they provide for medical/surgical diagnoses.

Q: Is parity a coverage mandate?

A: No. Parity does not mandate that any particular diagnosis be covered or receive any particular treatment. Parity says that if mental health and addiction benefits are offered, those benefits cannot be at a lower level than medical/surgical benefits. Insurance plans are free to drop mental health and addiction benefits all together, although evidence from other parity experiments indicate that it is very unlikely that many plans will do so.

Q: How will the new law affect access to treatment?

A: The Wellstone-Domenici Parity Act does not guarantee access to any particular treatment—instead, it guarantees that the benefits offered for mental health and addiction treatment must be equivalent to medical/surgical benefits under the plan. Insurance plans are still free to use medical management tools (including their own medical necessity criteria) to control costs and determine the need for and level of treatment. The parity law creates a new requirement that medical necessity criteria must be made available to plan participants. State laws that mandate certain levels of access to care will remain in effect.

Q: Does the new law require all diagnoses in the DSM-IV be covered?

A: No. That was the requirement in the original House-passed bill, but it was dropped during negotiations with the Senate. The DSM-IV is not mentioned in the final bill. Scope of coverage for mental health and addiction is ultimately determined by the terms of the insurance plan and relevant state and federal laws.

Q: When does parity go into effect?

A: For most plans, parity goes into effect January 1, 2010. Health plans negotiated by collective bargaining agreements between unions and employers may be implemented later, depending on the plan.

Q: What health plans are covered by the new parity law?

A: All group health plans that are self-funded (regulated under ERISA) or fully-insured (regulated by state insurance laws) are covered. It is estimated that over 80 million individuals are enrolled in ERISA plans, which are not subject to state parity laws.

Q: Which health plans are exempt from parity?

A: Parity does not apply to plans with less than 50 participants. Insurance plans can also seek a one-year exemption if their costs rise more than two percent in the first year of parity and one percent in any year thereafter. However, the reporting requirements involved with qualifying for this exemption are so expensive and onerous that it is not expected that many insurance plans will seek it.

Q: What is the effect on Medicare and Medicaid coverage?

A: The parity law does not affect Medicare coverage (a separate Medicare parity law was passed in 2008, but it only affects mental health coverage).

Medicaid plans are sold in state insurance markets, and thus will be subject to the Wellstone-Domenici Parity Act.

Q: Will there be parity for out-of-network benefits?

A: Yes. If a plan offers out-of-network medical/surgical coverage, it must provide equivalent out-of-network mental health and addiction treatment coverage.

Q: Will parity affect provider reimbursement?

A: No. Parity addresses the cost-sharing between consumers and their plan, not the reimbursement rates between the providers and the plan.

Q: How does parity affect state parity or mandate laws?

A: Parity is not intended to preempt state parity laws that are stronger than the new federal "floor." This is consistent with the 1996 HIPAA preemption standard in insurance law. The law says that "substance use disorder benefits" must be defined in accordance with state and federal law.

Q: What monitoring will be provided by the federal government?

A: The law requires the Government Accountability Office to study the "specific rates, patterns, and trends" in coverage of mental health and substance use disorders. The first study must be published three years after parity goes into effect. This study will give us data about the ways that insurance plans are actually managing the substance use disorder benefits and their effects on utilization.

Q: Who will write the regulations, and when will they be promulgated?

A: The Departments of Treasury, Health and Human Services, and Labor share responsibility for drafting regulations for parity (in essence, translating the legislative language into practical guidelines). These regulations will be drafted in 2009 by the Obama Administration. The regulations must be in place by October 3, 2009. The three agencies also bear responsibility for disseminating information about the new law to consumers.

Q: Will state insurance commissioners have new oversight powers?

A: State insurance commissioners will have responsibility for ensuring that their state's insurance policies are compliant with the parity law, but it is not expected that they will have new oversight responsibilities as a result of parity.

Parity in the States

Over 40 states have some kind of mental health or addiction parity law. However, most of these laws are significantly less comprehensive than the Wellstone-Domenici Parity Act. The new parity law will create a federal "floor" of coverage which sets a national minimum for insurance plans. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets the current preemption standard for insurance plans. HIPAA says that state laws are only preempted if they "prevent the application" of the federal law (for example, a state law that is weaker than the new parity law would prevent its application and thus be preempted). If a state law is stronger than the new parity law, it will not be preempted.

Two previous experiments with parity can help us anticipate some of the effects of the Wellstone-Domenici Parity Act. Although these examples are different from the new law in many significant ways, they also provide important information for addiction professionals and treatment providers as we prepare ourselves for parity to go into effect.

The Federal Employee Health Benefits Program (FEHBP)

The federal government is the nation's largest employer and operates the country's largest employee benefits program. Over 350 health insurance products are available for the 8.5 million FEHBP beneficiaries, including current and retired federal employees and their dependents. In June 1999, President Bill Clinton issued an executive order to implement parity of mental health and substance use disorder benefits in the FEHBP. Parity went into effect in January 2001 (unlike the Wellstone-Domenici Parity Act, out-of-network benefits were not included). Since then, many advocates for parity have argued that the American public deserves the same mental health and substance use disorder benefits available to federal employees and members of Congress.

In 2006, the New England Journal of Medicine published an analysis of the FEHBP parity program entitled "Behavioral Health Insurance Parity for Federal Employees" by Dr. Howard Goldman, et.al. The study compared seven FEHBP plans with comparable non-FEHBP plans. The key findings are as follows:

•"The primary concern [of parity critics] has been that the existence of parity would result in large increases in the use of mental health and substance-abuse services and spending on these services. With respect to the seven FEHB plans we studied, these fears were unfounded. In addition, the goal of expanding financial protection by decreasing out-of-pocket spending was the Vermont Case Study realized in all but two of the plans. These findings suggest that parity of coverage of mental health and substance-abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs" (1386).

•Treatment limitations and financial requirements decreased significantly for MH/SUD treatment after the implementation of parity; for example, one sample FEHBP PPO eliminated its annual day limit for inpatient coverage from 100 to unlimited, cost sharing from 40% to 0, limit of outpatient visits from 25 to unlimited, and cost-sharing for outpatient from $25 to $15. Over the same period, the comparable non-FEHBP plan in the study did not change its MH/SUD benefits at all.

•Prior to parity, three of the seven FEHBP plans used a carve-out vendor to manage MH/SUD benefits. After parity, six of seven plans used a carve-out.

•"[W]e believe the evidence points to a finding of little or no effect of the implementation of parity of coverage for mental health and substance-abuse services on use and total spending …" (1385). Although utilization and spending rates of MH/SUD services increased in all the plans, only one of the plans saw these rates increase more than in comparable plans without parity (in other words, during the period of the study, all plans experienced increased utilization and spending on MH/SUD services, but most parity plans did not experience greater increases than non-parity plans). This plan that recorded a significant increase in utilization relative to non-parity plans was the same one that did not use a carve-out vendor.

•In five of the seven plans, parity was associated with significant reductions in out-of-pocket spending for beneficiaries. The sixth plan saw an insignificant decrease, and the seventh saw a small but significant increase.

The Vermont Case Study

Vermont implemented the nations most comprehensive parity law in 1998. Parity was required for health insurance coverage of both mental health and substance abuse benefits. In 2003, the Substance Abuse and Mental Health Services Administration (SAMSHA) published a special report entitled "Effects of the Vermont Mental Health and Substance Abuse Parity Law." There was no small business exemption but out-of-network benefits were not included in parity.

The study analyzed data from the two largest insurance plans in Vermont in 1998 were the Kaiser/Community Health Plan (Kaiser/CHP) and Blue Cross/Blue Shield of Vermont (BCBSVT), which together covered nearly 80 percent of the privately insured population.

• Both health plans changed the way they managed MH/SUD services; BCBSVT switched from indemnity contracts to a managed care carve-out (an arrangement that transfers the handling of mental health and addiction services from the primary insurance company to a separate specialty organization, usually in an effort to contain costs) and Kaiser/CHP switched from a managed care system to a hospital diversion and step-down programs that increased the use of partial hospitalization treatment and group theory while reducing the use of inpatient treatment. In other words, the decision-making point shifted from the demand side (where consumer cost-sharing and coverage limits were the primary determinants of utilization rates) to the supply side (where provider networks and stricter medical necessity criteria were the primary determinants of utilization rates). For example, both health plans approved only a limited number of outpatient visits at one time

and required prior approval and concurrent review for inpatient and partial treatment.

•Employers did not drop health coverage as a result of the law. Only 0.3 percent of employers dropped health coverage for their employees, and only 0.1 percent said that parity played a role in their decision to self-insure.

•More people received outpatient MH services after parity (by about 20%); fewer people received SUD treatment (the likelihood of receiving SUD treatment fell 51% in Kaiser/CHP and 34% in BCBSVT).

•Spending for MH/SUD fell by about 12% overall after parity was implemented.

•Consumers paid a smaller share of total spending for MH/SUD treatment after parity; in BCBSVT, consumer cost-sharing fell about 20% (although the consumer share for SUD services held steady at about 13% pre- and post-parity).

•Consumer awareness about parity was extremely low and may have affected utilization and spending rates.

• Stakeholders in Vermont recommended (1) a proactive education campaign about parity to raise awareness and avoid confusion for both consumers and providers and (2) a proactive strategy to ensure smooth transitions in patient care when health plans shift to more tightly managed provider networks.

Discussion

Although it is important to note that neither the FEHBP nor Vermont case studies are perfectly analogous to the current national parity landscape for many reasons, they do help us aniticipate some of the effects of the Wellstone-Domenici Parity Act. The following conclusions are important to consider:

• Parity affects benefits far more than it affects access to care. Parity forbids insurance plans from having explicitly discriminatory and sub-standard benefits for mental health and substance use disorders. However, the elimination of those discriminatory benefits does not necessarily translate into increased utilization of those benefits.

• Parity does not cause significant increases in health care costs for insurance companies nor does it cause employers to drop their health care coverage.

•Insurance plans generally respond to parity laws by tightening their medical management tools, such as medical necessity criteria. The Wellstone-Domenici Parity Act requires insurance plans to be transparent about their medical necessity criteria, which may help provide greater accountability and clinically appropriate care in the long term. Providers and consumers need to be prepared to navigate these new systems.

• Public education and outreach is essential to ensure that consumers understand their new benefits and their new rights to information about their medical necessity criteria.

•There are important symbolic benefits to the new parity law regardless of its effects on utilization—it is now the universal "law of the land" that mental health and substance abuse disorders are "real" health conditions and deserve the same benefits as other diagnoses. Consumers can be confident that mental health and substance use disorders are included in their health plans and covered at the same level as their other benefits. This has the long-term potential to reduce stigma and help bring addiction treatment into the mainstream of the U.S. health care system.

• Data is critical to analyze the effects of parity legislation and modify it as needed; the Department of Labor and Government Accountability Office (GAO) studies commissioned in the Wellstone-Domenici Parity Act will provide invaluable information about the effects of the new parity law.

Prepared by the NAATP-NAADAC Government Relations Department, November 2008
1001 N. Fairfax Street, Suite 201, Alexandria, VA 22314
800.548.0497 x129 · www.naadac.org · www.naatp.org

Upcoming Events

The American Academy of Addiction Psychiatry (AAAP), will hold its 19th Annual Meeting and Symposium on December 4-7 in Boca Raton, Florida. A pre-conference Buprenorphine training will take place December 3. For more information, visit www.aaap.org.

The Southeast Conference on Addictive Disorders (SECAD) will be held February 8-11, 2009 in Atlanta, GA. Visit www.secad09.com for more information and to register. SECAD 2009 is brought to you by NAATP, NAADAC and the Vendome Group.

The Community Anti-Drug Coalitions of America (CADCA) will hold its 19th Annual National Leadership Forum on February 9-12, 2009 in National Harbor, Md. Just outside Washington, D.D. Visit www.cadca.org for more information.

The NAATP and NAADAC Advocacy in Action Conference will be held in Washington, DC on March 8 – March 11, 2009. Watch for more details on registration.

The American Association for the Treatment of Opioid Dependence (AATOD) will hold its national conference April 25-29, 2009 in New York City. Visit www.aatod.org or call 856-423-3091 for more information.

The American Society of Addiction Medicine (ASAM) will hold its 40th Annual Medical-Scientific Conference on April 30-May3, 2009 in New Orleans, LA. For more information visit www.asam.org.

The National Association of Addiction Treatment Providers (NAATP) will hold its 2009 Annual Addiction Treatment Leadership Conference on May 17 – 20, 2009 in West Palm Garden, FL.

NAATP VISIONS

NAATP VISIONS is published ten times a year by NAATP. Information printed in NAATP Visions does not represent official NAATP policy or positions.

The editorial office is located at:
313 West Liberty Street, Suite 129
Lancaster, PA 17603-2748

Editor
Ronald J. Hunsicker
President/CEO
Phone: 717-392-8480
Fax: 717-392-8481
E-Mail: RHunsicker@naatp.org
Web Site: www.naatp.org

NAATP Board Chair
Ed Diehl, President
Seabrook House
Phone: 856-455-7575
Fax: 856-455-7015
ediehl@seabrookhouse.org

Newsletter Submissions may be sent to Angela Abshire at *aabshire@naatp.org*