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A Diamond in the Rough: Mental Health Parity Balances
Affordability For Patients with Costs to Providers

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A good compromise, a good piece of legislation, is like a good sentence; or a good piece of music. Everybody can recognize it. They say, 'Huh. It works. It makes sense.'
-Barack Obama

I. INTRODUCTION

According to the National Institute of Mental Health, approximately 26.2% of Americans over the age of eighteen will suffer from a diagnosable mental illness in any given year.¹ Mental health disorders are diagnosed in the United States based on the Diagnostic and Statistical Manual of Mental Disorders, ranging from autism to schizophrenia.² For many years, despite the need for intervention and treatment of these serious disorders, health plans offered little, if any, coverage for mental health issues.³ But now, with the regulations accompanying Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), people will finally be able to receive treatment for mental health disorders.⁴

Deep within the Troubled Asset Relief Program (TARP) Act is the MHPAEA. On October 3, 2008, the MHPAEA was signed into law, with many praises and some concerns. The Act sets forth the provisions and amendments to the Employee Retirement

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1. *The Numbers Count: Mental Disorders in America*, NAT'L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml> (last visited Oct. 8, 2010).

2. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994).

3. See, e.g., Nancy Shute, *Paying a High Price for Mental Health*, 143 U.S. NEWS & WORLD REP. (SPECIAL REPORT) 60, 61 (Nov. 5, 2007) (revealing that the family of an eighteen year old diagnosed with Obsessive Compulsive Disorder pay almost \$40,000 out-of-pocket because of limits to mental health coverage).

4. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765, 3881 (2008) (to be codified at 42 U.S.C. § 201).

Income Security Act of 1974 (ERISA).⁵ The MHPAEA changes the Mental Health Parity Act of 2006 (MHPA) by supplementing and expanding the rules of the MHPA.⁶

The MHPAEA stands out as a good piece of legislation because it requires healthcare coverage for the diagnosis and treatment of disorders and diseases that are otherwise left untreated or under-treated. First, this article will briefly explain the background of the passage of the Act and its general requirements. Next, this article will explain who must comply with the new Act. Then, the article will discuss the increased cost exemption provision of the Act and reveal some concerns from Congress. Finally, this article will discuss the affordability of the increased cost exemption provision.

II. HISTORY OF HOW THE ACT CAME TO PASS AND WHAT IT REQUIRES

Paul Wellstone (D-MN) and Pete Domenici (R-MN) worked for many years to pass a bill that would give patients similar healthcare coverage, notwithstanding whether the plan benefit was for a mental health, medical or surgical issue. For decades, they fought to pass the MHPA. In 1996, Wellstone and Domenici introduced the MHPA as an amendment to another healthcare bill.⁷ However, the MHPA did not make it beyond the House, and it was not until 1996 that the MHPA was passed as an amendment to ERISA.⁸ At that time, supporters threatened to filibuster if the amendment was removed for the bill, as it had been before.⁹ According to Domenici, small businesses of fewer than 50 employees are exempt but the act does apply to health plans covering 51 or more employees.¹⁰ Domenici asserts that the law provides parity for 82 million self-insured Americans and 31 million in plans under state regulation.¹¹

MHPAEA requires group health plans and health insurers to provide mental health benefits on par with surgical and medical benefits. Medical benefits typically include

5. *Id.* (amending the ERISA amendments at sec. 512, §712).

6. Lori Patrick, *Mental Health Parity and Addiction Equity Act Regulations Take Effect on April 5, 2010*, PILLSBURY WINTHROP SHAW PITTMAN LLP, 1 (Feb. 24, 2010), <http://www.pillsburylaw.com/siteFiles/Publications/3833916B8A971F11DC720356DE72E82E.pdf>.

7. Sara Nadim, *The 2008 Mental Health Parity and Addiction Equity Act: An Overview of the New Legislation and Why an Amendment Should be Passed to Specifically Define Mental Illness and Substance Use Disorders*, 16 CONN. INS. L.J. 297, 300 (2009).

8. *Id.* at 300-01.

9. *Id.* at 301.

10. *White House Expands Mental Health Benefits in \$700B Bailout Bill*, 16 Andrews Health L. Litig. Rep. 6 (Oct. 23, 2008).

11. *Id.*

things like physician examinations, whereas surgical benefits include things like approved surgical procedures that take place in a hospital or clinic. Health plans and insurance company benefits usually break down into two categories: financial requirements and treatment limitations.¹² Financial requirements include such things as co-pays and deductibles.¹³ Treatment limitations include such things as office visit limits.¹⁴ In addition to financial and treatment requirements, if such plans provide for out-of-network surgical and/or medical benefits, then they must also provide for out-of-network mental health and substance abuse disorder benefits.¹⁵

Health plans need to employ standards and terms that are recognized in the industry when defining mental health or substance use disorder benefits.¹⁶ Standard terms are important so that no provider misclassifies a disorder to escape the parity requirements.¹⁷ The regulations provide that plan terms defining whether benefits are mental health or substance use disorder benefits must be “consistent with generally recognized independent standards of current medical practice.”¹⁸ Such standards can be based on a state guideline, for example, and need not be based on a national standard.¹⁹ These provisions are a victory for Americans who need better and more affordable mental health treatment.²⁰

III. WHO IS REQUIRED TO COMPLY WITH THE ACT

The MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured and fully insured arrangements. This act also applies to health insurers who sell coverage to employers with more than 50

12. U.S. DEP'T OF LABOR, THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA) (Jan. 29, 2010), *available at* <http://www.dol.gov/ebsa/newsroom/fsmhpaea.html>.

13. *Id.*

14. *Id.*

15. *Id.* at 2. The Department of Labor uses the term ‘substance use’ in place of ‘substance abuse.’

16. *Interim Final Regulations Issued Implementing the Mental Health Parity and Addiction Equity Act of 2008*, DAVIS & HARMAN LLP 2 (Feb. 1, 2010), http://www.appwp.org/documents/mhp_regsummary-dh020110.pdf.

17. Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 45 C.F.R. § 146.136(a) (2010).

18. *Id.*

19. *Id.*

20. Michelle Andrews, *New Laws Expand Mental Health Coverage*, KAISER HEALTH NEWS (Oct. 5, 2010), <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/mental-health-coverage.aspx>.

employees.²¹ The Department of Treasury expects the MHPAEA to benefit the approximately 111 million participants in 446,400 ERISA-based employer group health plans, and an estimated 29 million participants in the approximately 20,300 public, non-federal employer group health plans sponsored by state and local governments.²² The MHPAEA will affect approximately 460 health insurers, and at least 120 Managed Behavioral Health Organizations providing mental health or substance use disorder benefits in the group health insurance market.²³

IV. AN IMPORTANT EXEMPTION TO COMPLIANCE: THE INCREASED COST EXEMPTION

The Increased Cost Exemption in the MHPAEA is a provision that providers can use to offset the costs associated with mental health benefits if the parity requirements are too burdensome.²⁴ Under the MHPAEA, plans that comply with the parity requirements for one full year, are exempt from the parity requirements for the following plan year, if there is a two percent increase in actual total costs. This allowance lasts for only for one year.²⁵ In the year following, the provider must again comply with the parity requirements.²⁶ Thus, the increased cost exemption may only be claimed for alternating

21. U.S. DEP'T OF LABOR, *supra* note 12, at 1.

22. *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, INTERNAL REVENUE BULLETIN, n.9, (May 3, 2010), http://www.irs.gov/irb/2010-18_IRB/ar09.html (last visited Oct. 8, 2010). ("The Department of Treasury estimates of the numbers of affected participants are based on DOL estimates using the 2008 CPS. ERISA plan counts are based on Department Of Labor estimates using the 2008 MEP-IC and Census Bureau statistics. The number of state and local government employer-sponsored plans was estimated using 2007 Census data and DOL estimates. Please note that the estimates are based on survey data that is not broken down by the employer size covered by MHPAEA making it difficult to exclude from estimates those participants employed by employers who employed an average of at least 2 but no more than 50 employees on the first day of the plan year").

23. *Id.* at n.10. ("The Department of Treasury estimate of the number of insurers is based on industry trade association membership. Please note that these estimates could undercount small state regulated insurers.").

24. 29 U.S.C.A. § 1185a(c)(2)(A). The cost exemption provision states:
With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

25. *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*, 29 C.F.R. § 2590.712(g) (2010).

26. But if in this year the provider experiences and one percent increase in total costs, then the provider

plan years.²⁷ The MHPAEA changed the former MHPA 1996 Increased Cost Exemption in several ways.²⁸ The changes include: 1) raising the threshold for qualification from one percent to two percent for the first year for which the plan is subject to MHPAEA; (2) requiring certification by qualified and licensed actuaries who are members in good standing of the American Academy of Actuaries; and (3) revising the notice requirements.²⁹ The MHPAEA added these changes to make compliance (and non-compliance) easier to identify.

One Congressman supported the inclusion because “individuals suffering from mental health illnesses deserve access to adequate and appropriate health care.”³⁰ Likewise, another Congressman recognized that “. . . legislation could have proceeded on its own, without being attached to the emergency bailout bill.”³¹ The Increased Cost Exemption is an effective mechanism in the parity requirements because it provides a way out for providers whose businesses might not be able to survive compliance.

V. DISSENTERS OF INCREASED COST EXEMPTION

Some Congressmen do not think favorably of the MHPAEA, and in particular are critical of the Increased Cost Exemption provision. Health providers and insurers are concerned about parity laws because of the potential for increased costs.³² Long before the MHPA or MHPAEA became law, employers and insurance companies were against full mental health parity requirements because of an estimated five to ten percent increase in costs.³³ Policymakers, too, often argued that mental health care should not be covered because it is “too costly.”³⁴ Opponents of the amendment point to problematic effects of

can again apply for the exemption from the parity requirements.

27. 29 C.F.R. § 2590.712(g), *supra* note 25.

28. *Id.*

29. *Id.* (For example, an actuary who is in good standing will be more likely to come up with an accurate account of whether or not the total costs of compliance with the parity laws has resulted in a one percent increase to the total costs. The notice and threshold requirements simply allow for open and clear understanding of what Congress expects from providers.)

30. 154 CONG. REC. S10220-02, S10259, (daily ed. Oct. 1, 2008) (statement of Rep. Levin).

31. 154 CONG. REC. S10220-02, S10260, (daily ed. Oct. 1, 2008) (statement of Rep. Feingold).

32. Colleen L. Barry et al., *The Costs of Mental Health Parity: Still an Impediment?*, 25 HEALTH AFFAIRS 623, 623-624, (2006), <http://content.healthaffairs.org/cgi/reprint/25/3/623.pdf>.

33. Shute, *supra* note 361.

34. Barry, et al., *supra* note 32, at 624.

the “Increased Cost Exemption” provision.³⁵ The dissenters address a risk of a “yo-yo” policy, arguing that because the exemption only lasts for one year, the benefits must be reinstated the following year.³⁶

The dissenters’ main issue with the provision is that it is not easing the burden of providing for mental health benefits because the barriers to obtain the Increased Cost Exemption are burdensome in their own right.³⁷ This provision allows employers to claim a waiver from the parity requirement, but provides that the waiver would only be available for one year.³⁸ After the waiver, the employer or insurer must comply with the parity rule and potentially suffer the cost increase for another period until cost exemption can be claimed again.³⁹ It is “one year in, one year out, followed by another year in.”⁴⁰ Accordingly, dissenters argue that businesses would suffer an extreme burden from the provision. They argue it would ultimately hurt both the beneficiaries of mental health and the businesses that provide the benefits.⁴¹ The dissenters’ viewpoints are important because the Increased Cost Exemption is meant to ease the burden of the MHPAEA requirements.

VI. OVERSIGHT OF THE INCREASED COST EXEMPTION PROVISION

It is not yet clear how the increased cost exemption will be implemented. Many departments have asked for ideas and comments on how to implement the provision.⁴² Regular processes for implementing medical benefit standards such as preauthorization, concurrent review, retrospective review, case management, and utilization review provide oversight for health benefits.⁴³ However, with the Increased Cost Exemption, it is

35. H.R. REP. NO. 110-374(III) (2008) (Dissenters were Joe Barton, Nathan Deal, Cliff Stearns, Joseph R. Pitts, Michael Burgess, and Mike Rogers).

36. *Id.*

37. *See supra* text accompanying Part IV, fn. 29.

38. H.R. REP. NO. 110-374(III), at 26 (2008).

39. *Id.*

40. *Id.*

41. *Id.*

42. For example, how does a plan provider count the one year rule for exemption? Does it use a calendar year, the medical plan year, or the date when the patient started using a given health benefit? How are plans regulated to make sure they do not exceed the exemption past one year?

43. These processes are meant to provide only medically necessary treatments to patients and return the covered person to work only when medically advisable. Preauthorization is the process by which a health care service is approved by the insurer before it is allowed. Utilization review is a process used during preauthorization to ensure that the patient gets treatment that is necessary, covered by the patients plan, and

difficult to discern how many companies will qualify.⁴⁴ Some states have experimented with the parity rules, and did not find a significant increase in costs, thus they were unable to reach the percentage increase required for the Increased Cost Exemption provision of the MHPAEA.⁴⁵ These experiments show that the parity requirements do not necessarily hurt providers financially. One study conducted with federal employees shows that new parity requirements are affordable for the provider.⁴⁶

The federal study began in January of 2001 when the Office of Personnel Management directed health plans that provide benefits to federal employees to comply with a policy that required equality between medical care and mental health expenses.⁴⁷ The study involved approximately 250 health plans, which gives credence to the reliability of the results.⁴⁸ The federal employees were to receive mental health and substance abuse services similar to general medical care with respect to deductibles, co-payments, and limits on physician visits and in-patient days.⁴⁹ The study had several key findings. One result was that costs associated with mental health services increased only at a similar rate to plans provided by large employers who did not offer parity for mental health covered expenses.⁵⁰ There is almost a dichotomy of needs - regulators want to know how

backed by evidence based medicine. Concurrent review is the part of utilization review that takes place during the in-patient setting or an ongoing outpatient setting. Retrospective review is a peer review (other physician in similar practice) process that looks at the facts of the case after the patient receives a health care benefit. Case management is the process by which a treatment plan is developed to coordinate the necessary and covered treatments with firm goals to maximize recovery and return to work. *See* J. Scott Andersen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 432-435 (1998) (for explanation of utilization management and utilization classifications).

44. Nadim, *supra* note 7, at 308.

45. *See* Kate Mulligan, *More Data Confirm Affordability of Parity*, 37 PSYCHIATRIC NEWS 18 (June 21, 2002), [http://](http://pn.psychiatryonline.org/cgi/content/full/37/12/18)

pn.psychiatryonline.org/cgi/content/full/37/12/18; *see also* Nadim, *supra* note 7, at 308 (“For example, when Texas implemented parity for severe mental illnesses and substance use disorders, a study found that there was a decrease of fifty percent in per-member, per person cost. Managed care was also introduced at the same time. Similar results were found in North Carolina, and a study on the impact of mental health parity in California revealed that costs did not increase after one year.”).

46. Kate Mulligan, *Major Study of Parity Costs Proves Its Affordability*, 40 PSYCHIATRIC NEWS 1 (Sept. 16, 2005). <http://pn.psychiatryonline.org/content/40/18/1.1.full?sid=c308356e-2057-4761-ab15-fa9b3b292628>; *see also* Goldman, et al., *Behavioral Health Insurance Parity for Federal Employees*, 354 NEW ENG. J. MED. 1378, 1384 (2006) (concluding that when coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs).

47. Mulligan, *supra* note 46.

48. *Id.*

49. *Id.*

50. *Cost to Beneficiaries Declined*, 40 PSYCHIATRIC NEWS 36 (Sept. 16, 2005), <http://pn.psychiatryonline.org/content/40/18/36> (including other key findings: access to mental health

to provide oversight for a legislative provision, yet providers might never reach the threshold of financial change to trigger compliance with the requirement.

VII. CONCLUSION

The MHPAEA is not intended to be a penalty to health providers and insurers. Rather, it is a chance for people who suffer from mental health and addiction issues to get help. U.S. Representative Brian Baird, an original co-sponsor of the bill, said that the legislation is needed because almost all health care plans impose financial limitations and treatment restrictions on mental health and substance abuse benefits.⁵¹ Baird also remarked that despite state requirements to facilitate mental health inclusion in insurance plans, there was no federal standard for mental health care coverage before the passage of the bill.⁵² “Making the decision to get help is often the most difficult step, yet without this legislation, many who suffer from mental illness and addiction are being turned away by their insurance companies or being forced to pay for treatment entirely out of their own pocket.”⁵³ Sometimes the hardest thing for someone suffering from mental health problems to do is merely reach out. Now they have an affordable way of doing so.

The parity laws create equality of coverage for mental health and medical/surgical health issues. The makers of the bill, in an effort to fairly measure the cost burden to insurers and providers, included the increased cost exemption provision as a way to share the implementation changes for mental health issues. Making incremental changes such as this and sharing the burden make for realistic and reasonable legislation. The alternating years requirement allows the industry to gauge the real costs of mental health treatment. It gives some providers a chance to exempt themselves from the parity requirements if compliance would put the business entity at too much financial risk.

In conclusion, some providers may be weary of the alternating years requirement and may therefore not even apply for the exemption. Yet, exposure to market forces for mental health coverage may actually be good for patients and providers, since it could

services also increased at a similar rate to large employers compared in the study, out-of-pocket costs declined for federal employees in comparison with employees of large employers in study, and two-thirds of plans incurred no additional administrative costs).

51. *White House Expands Mental Health Benefits in \$700B Bailout Bill*, *supra*, note 10.

52. *Id.*

53. *Id.*

naturally keep prices low. Further regulatory guidance is still needed in many areas, and the interaction of the individual pieces of legislation remains unclear. What is clear, though, is that the MHPAEA is a good piece of legislation because it gives equal coverage to disorders and diseases that otherwise may be left untreated, while keeping costs aligned with other medical and surgical benefit costs.