From: Paul Mayhue [mailto:PaulM@TI-GR.com]
Sent: Friday, May 08, 2009 3:20 PM
To: EBSA, E-OHPSCA - EBSA; Baum, Beth - EBSA
Subject: Kent County Mental Health Parity Discussion Group-Comments on MHParity Act of 2008
Importance: High

This document is presented by the Kent County Mental Health Parity Discussion Group. The information that is attached are the comments that represent a broad base of the, Local Political, Consumers, Behavioral and Mental Health Community Opinion in our Area. We can be contacted at 201 Sheldon St SE, Grand Rapids, Michigan 49503, 616-459-0255 Extention 304 Greg Dziadosz, Extention 184 W. Paul Mayhue, Hank Fuhs 616-4379059, Paul Ippel 616-336-3765, Cyndy Viars 616-949-1100.

Integrated Health Care at its Best
Next Steps after Mental Health Parity

A report of the
Kent County Mental Health Parity Discussion Group

April, 2009

Kent County Mental Health Parity Discussion Group

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Dear Honorable Sir or Mam,

Our country faces a crisis in dealing with the issue of health care costs and coverage. We are pleased to add a significant voice to this discussion. In September, 2008 over a hundred community leaders gathered in Grand Rapids, Michigan to discuss the critical issue of mental health parity. The results of this discussion are summarized in the enclosed document.

As you know the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law by President Bush on October 3, 2008. The medical community has long recognized the intimate connection between mental health and physical health. Mental illness has a biological basis and needs to be treated as other chronic health conditions. Please take a few moments to review this document to understand the implications of this relationship on our health care system and services.

Mental Health Parity is a vision for a better health care approach which is centered on a holistic treatment model for the individual. We want you to join us in this effort to:

- Encourage your employer and insurance company to offer a behavioral health benefit as part of your health insurance coverage.
- Ensure that the coverage of behavioral health benefit is the same as the physical health care benefit.
- Encourage use of a health benefit that leads to a healthy life style, to prevent and to effectively manage chronic health conditions.
- Ensure that the behavioral health interventions have demonstrated effectiveness.
- Encourage universal access to health care.

The Kent County Mental Health Parity Discussion Group believes that a healthy community will address the physical and behavioral health needs of its members. We stand with you to make this happen in our state and country.

Sincerely,

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Governmental Relations Coordinator

Hank Fuhs, Pharmacist
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Introduction

The passage and signing of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 has been celebrated by consumers and supporters of mental health services.

The Act is named for Senator Paul Wellstone, the Minnesota Democrat killed in a plane crash in 2002. Senator Wellstone had a brother with severe mental illness. The main sponsor of the Senate bill, Pete Domenici, Republican of New Mexico, has a daughter with schizophrenia.

The document that was signed into law on October 3, 2008, significantly expands upon the mental health protections of the Mental Health Parity Act of 1996 that had been in effect until this past year when it expired.

Parity is one of many issues that include the consequences of having an employer based insurance system, the separation of behavioral health care from the rest of health care, and the stigma that is still associated with mental illness and substance use disorders.

Local Scene – Kent County Roundtable on Mental Health Parity

In Kent County, anticipating the passage of the federal legislation, a Public Policy Roundtable on Mental Health brought together over 100 representatives of our West Michigan community to learn about and share their perspectives on mental health parity in September 2008. The participants represented business, health care providers, service recipients, government, insurance, advocates, and other stakeholders. The diversity of the participants was reflected in the range of the comments and concerns.

In groups of between seven to ten individuals, participants shared perspectives on four topics:

Physical health, mental health, and the connection between them
Understanding health insurance coverage options
Employers' perspectives on health insurance coverage and parity
What the community should do about mental health parity

National Scene

On March 5, 2008, the House of Representatives passed a bill requiring most group health plans to provide more generous coverage for treatment of mental illnesses, comparable to what is provided for all other covered illnesses. The U.S. Senate had previously passed a similar bill requiring equivalence, or parity, in coverage of mental health and physical ailments. Federal law now allows insurers to discriminate, and most do so, by setting higher co-payments or stricter limits on mental health benefits.

Three factors contributed to broad support for the legislation –

Researchers have found biological causes and effective treatments for numerous mental illnesses.

A number of companies now specialize in managing mental health benefits, making the costs to insurers and employers more affordable.

> Some doctors say that the stigma of mental illness has faded as people see members of the armed forces returning to the States with mental health challenges.

Health plans, under the Mental Health Parity Act of 1996, were forbidden to set annual or lifetime dollar limits on mental health care that were lower than the limits for other services. Insurers maneuvered around this law by setting different limits on the number of outpatient visits or hospital days, and by charging different co-payments.

The October 3, 2008 Parity Act will protect over 113 million people across the United States, including 82 million of the individuals who are enrolled in Employee Retirement Income Security Act (ERISA) group insurance plans that are not subject to State parity laws.

The Forward View – Beyond the 1996 Act

Local experts will decode the complicated Wellstone-Domenici Parity Act, enacted on October. 3, 2008, that will provide 113 million more people across the country access to non-discriminatory mental health coverage.

Congress deferred the effective date of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 for plans that otherwise would have been covered in 2009.

For most plans, the new law will take effect January 1, 2010. Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they are terminated.

Expansion of Mental Health Parity – Equivalency

The 2008 Act amends the 1996 Act to include substance use disorders and to require that a group plan of 50 or more employees, or coverage offered in connection with such a plan, that provides both medical and surgical benefits and mental health or substance use disorder benefits will ensure that:

> Financial requirements applied to mental health and substance use disorder benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits that the insurance health plan covers. Such financial requirements include deductibles, copayments, coinsurance, out-of-pocket expenses, as well as annual and lifetime limits.
>
> Treatment limitations applicable to mental health and substance use disorder benefits must be no more restrictive than those applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatments or similar limits on the scope or duration of treatment.

Major provisions of the Parity Act

Out-of-network equivalency - Group health plans that provide out-of-network coverage for medical and or surgical benefits must provide out-of-network coverage, at parity, for mental health and substance use disorder benefits, as under the 1996 Mental Health Parity Act:

In-network mental health or substance use coverage is not mandated – If a plan offers such in-network coverage however, the plan must be provided at parity in accordance with the 2008 Act.

Requirements for disclosures – A group health plan (or coverage) may manage the benefits under the terms and conditions of the plan. A group health plan must make their mental health and substance use disorder medical necessity criteria available to current or potential participants, beneficiaries, or providers upon request. A health care plan must provide reasons for payment denials available to participants or beneficiaries upon request or as otherwise required.

Less than fifty employees – Group health plans of employers with less than 50 employees are exempted from these requirements, although small business owners are still subject to applicable State law. Plans additionally are exempt if the costs of complying with the 2008 Act increase the total cost of coverage by more than 2% during the first plan year or exceed 2% of the actual total plan costs each subsequent year. Determinations about increases in actual cost under a plan must be made and certified by a qualified and licensed actuary. The 2008 bill sets forth procedures for seeking a cost exemption, and authorizes audits of books and records relating to such an exemption.

State prevention of application of the Act – The current HIPAA preemption standard applies and is extremely protective of State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place.

Enforcement of the Act – The federal departments of Labor, Health and Human Services (HHS), and Treasury will continue to coordinate enforcement of the Federal mental health parity requirements and are required to issue regulations to carry out changes made in this Act not later than one year after the enactment date. Treasury may continue to impose an excise tax on any plan for failure to comply with the requirements of the Act.

Auditing to address compliance with the Act – Additional provisions of the 2008 Parity Act include a requirement for the Secretaries of Labor and HHS to designate a group health plan ombudsman within their Departments to serve as an initial point of contact for individuals to obtain information and provide assistance concerning coverage of mental health services under group health plans in accordance with this Act. The Secretaries are required to conduct random audits of group health plans to ensure compliance with this Act.

Congressional reporting – By 2012 and every two years after, the Secretary of Labor must submit to Congress a report on group health plan (or coverage) compliance with this Act. This report must include the results of any compliance audits or surveys, and if necessary, an analysis of reasons for any failures to comply with the law.

The Government Accountability Office (GAO) must evaluate the effect of parity requirements on the cost of health insurance coverage, access to such coverage, the quality of health care, and the impact on benefits and coverage for mental health and substance use disorders including any exclusion of specific mental health and substance use diagnoses by health plans. The GAO must provide a report to Congress within three years (about 2013) and an additional report after five years on the results of the study.

The scope of the Act

The 2008 Parity Act amends the:

Employee Retirement Income Security Act (ERISA)
Internal Revenue Code (IRC).
Public Health Service Act (PHS Act)

By amending all three federal statutes, the 2008 Parity Act standards apply to a broad range of group plans, as well as state licensed health insurance organizations.

The ERISA provisions apply to most group plans sponsored by private-sector plans and unions.

The IRC provisions, which cover ERISA plans plus church-sponsored plans, permit the Internal Revenue Service to assess tax penalties on employers that do not comply with the parity requirements.

The PHS Act provisions apply to insurers and some public-sector group health plans, such as the Federal Employees Health Benefits Program and to some state and local government health plans. Self-insured state and local government health plans may elect exemption from parity. Under provisions included in the 1997 Balanced Budget Act (BBA) (P.L. 105-133), Medicaid managed care plans and State Children's Health Insurance Programs also have to comply with the requirements of the 2008 Parity Act. Medicare is not subject to the provisions of the 2008 Act.

Complications potentially affecting implementation

Health insurance regulation is a patchwork of federal and state laws; and the rules for health plan will differ depending on whether the health insurance is self-purchased, employer-purchased, or part of a self-funded ERISA plan. Congressional leaders and advocates spent considerable time drafting language to ensure that the new parity bill does not undermine states with parity laws stronger and more comprehensive than the 2008 Parity Act, while also being sure to set a solid floor of protections for states with minimal or weak regulation of mental health and substance use benefits. The 2008 Parity Act does not supersede other Federal regulations, such as HIPAA, and generally allows more consumer-protective state-based parity requirements to continue to apply to state-regulated health insurance products.

State parity laws include a wide variety of exemptions and limitations, such as applying only to services for serious mental illness, excluding insurance coverage for addiction treatment, or excluding insurance products sold through individual and small group markets.

The reach of ERSA laws is limited in that they generally do not apply to federally funded programs such as Medicaid and Medicare. Originally created to set national standards for employee pension plans, ERISA limits state efforts to expand health care coverage and regulate insurance markets by essentially preventing states from requiring self-insured employee plans to participate in purchasing pools or even to report data. If a health plan is part of an ERISA plan, then the health plan has to comply with the minimal federal regulations due to a law passed over two decades ago which exempts self-funded ERISA plans from state regulation.

If an employer buys health insurance from an insurance company, or if a consumer purchases their own private plan, then additional state regulations apply. State regulations entitle the consumer (private individual or employer) to certain kinds of coverage, the specifics of which vary from state to state.

Some states require that some type of mental health benefit be included in insurance products, others establish a minimum acceptable mental health benefit, and still others mandate parity if mental health services are covered. At least sixteen states require full parity meaning they require that mental health benefits be included in all group plans and that coverage is on a par with other health services in all respects. Only fourteen states include substance use disorder treatment.

State full parity laws also vary in the types of mental illnesses they cover. In only three states do the laws apply to the treatment of all the conditions listed in the Diagnostic and Statistical Manual of Mental Disorder (DSM-IV). All other full-parity laws restrict coverage to specified "serious" or "biological based" mental illness (e.g., schizophrenia, depression, bipolar disorder). About one-third of the state parity laws exempt small employers, typically those with 50 or fewer employees. In addition to the twenty-two states that have enacted full parity legislation, thirteen states have passed laws mandating a certain minimum level of mental health benefits (but not full parity). Other states have passed so-called mandated offering laws, under which covered plans that choose to offer mental health coverage must provide a specified minimum level of benefits. .

- Parity within ERISA health plans will need to be enforced directly by the Federal government across a wide variety of employment settings, coverage, and funding mechanisms.
- Parity for non-ERISA plans will need to be enforced by each state's insurance authority, and could vary significantly from state to state.
- Determinations will eventually need to be made as to whether the State or Federal laws, in whole or in part, are to be enforced. This will be particularly challenging where parts of State laws are more restrictive than the Federal laws.

Impact and Challenges for Michigan

The Federal parity requirements for mental health and substance use disorder benefits establish a uniform "floor" of coverage for all plans. The passage of the 2008 Parity Act is an opportunity to evaluate the scope of Michigan laws, particularly where there are opportunities to strengthen parity laws that are not comprehensive or weak in their protections.

Advocacy – Stakeholders, provider groups and state officials have opportunities to:

- Publicize the importance of parity, to dispel myths about the costs and administrative burden of parity legislation, and to examine current state regulations regarding parity of mental health benefits with medical and surgical benefits.

- Focus the attention of advocates across the state of Michigan on the development of state regulations that will define the implementation and enforcement of the Parity Act.

- Speak with The State Attorney General, The Insurance Commissioner and other state representatives about the significance of the 2008 Parity Act, and to discuss where Michigan state regulations could support or augment the federal bill.

- Monitor compliance with the Federal laws and report concerns to the ombudsman of the Secretary of Labor or the Secretary of Health and Human Services.

- Examine fee structures to be sure that insurers are reimbursing at rates comparable to medical and surgical benefits.

Enforcement – The Parity Act may prompt insurers to make diverse, surgical cuts to the fabric of their insurance coverings. The dollar coverage may remain the same for the overall package, but the details in the plan may change significantly. If costs are going to be audited through external quality reviews, insurers and purchasers will be necessarily positioned to make changes to their traditional offerings that may include increases in co-pays, limits on the number of visits, elimination of particular coverage for one service in order to appropriately fund another service.

It will be important for state regulators and actuaries to carefully attend to equivalencies when making determinations about compliance and claims of increased costs.

Back to the Local Scene – Grand Rapids Roundtable on Mental Health Parity

The first Grand Rapids Roundtable identified issues critical to the implementation of parity and to the future development of health care delivery and funding.

The Connection of Physical Health and Mental Health

The body is composed of many parts. There are sensory organs for hearing and seeing, the heart for pumping the blood of our lives, and a central nervous system whose command center is within the brain. Health care has historically carved out behavioral health care. Yet the brain is part of the body, and disorders of brain function are medical disorders. There is increasing evidence that mental and other health conditions interact with one another.

There are several reasons for why both health and health care have been separated into physical and behavioral categories.

> There are lingering and pervasive beliefs rooted in the philosophy of mind/body dualism that the mind is not the realm of medicine.
>
> The psychotherapeutic tradition, although created by a physician, took treatment of mental and emotional disorders outside of the mainstream of medicine.
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> Behavioral health carve outs within managed care have perpetuated delivery and payment systems that are separate from the rest of health care.

Parity would not be an issue if what we call behavioral health care were perceived to be part of health care. Full integration of behavioral health with the rest of health care would produce better care.

Insurance and the Connection of Physical Health and Mental Health

Mental health parity is not widely understood to be an insurance coverage issue. The phrase is not meaningful to many outside of advocates, providers, and some politicians.

Insurance coverage in general is confusing to both those covered and to their employers.

Many people and their employers do not know what is covered and what is not. Coverage varies significantly from one policy to the next, and even within policies from one time to the next.

Coverage for behavioral health treatment is rarely, if ever, equal to that for other health conditions.

Mental health parity needs to be addressed in the broader context of availability of affordable and effective health care coverage. Coverage and care for chronic health conditions, which includes many mental health conditions, is inadequate and ineffective. A growing number of people have no coverage for any health care condition, or the policies have very limited benefits.

From an insurance company perspective, parity advocates appear to be just one more interest group trying to get a bigger cut of the premium. There has not been effective differentiation of the case made by the mental health advocates from those made by others. Behavioral health interventions are poorly understood and to insurance companies might look like a bottomless demand.

Employer perspective on health insurance coverage and parity

For many employers health care has become, or is quickly becoming, an unbearable cost. Anything that might add to the cost, no matter how small, is perceived as a negative, even the possibility that mental health parity might increase costs, no matter how little, is viewed as problematic. The over-riding issue of cost leads some employer groups to oppose any form of mandated health insurance coverage. Increases in costs may lead employers to cut coverage and increase employees costs or to drop group health coverage altogether.

Many employers believe that a healthy workforce is important for the success of their business. Behavioral health issues, like any other health condition, if not quickly and effectively treated will lead to more absenteeism and lower productivity. However, behavioral health issues are not as well understood or accepted by employers or co-workers. The reaction to calling in with a migraine will receive a kinder reception than calling in for depression.

That parity is presented almost exclusively as a mandate on employers, rather than as a health care access issue, likely increases opposition from business.

Action Plan for Our Community

An action plan to influence our community in the implementation of parity will need to involve a variety of essential initiatives and necessitate a cross section of vested stakeholders. The

following areas require the specific action of education and information dissemination and expanded community dialogue. These action areas were identified in the September 2008 Kent County Round Table. This process has prompted questions related not just to parity for behavioral health but, has widened the need to educate about the relationship of behavioral health care in any deliberation regarding health care reform.

Education and Stigma Reduction
Education and information is necessary because mental health parity is not a widely understood issue. Community education needs to focus on the realities that a mental health condition is another health condition, and that there is a different and deficient coverage for mental health conditions. Public education is critical because there is still significant stigma associated with mental health conditions. Stigma reinforces the separation of mental health care from the rest of health care and keeps people from seeking care when they need it.

Ultimately, whether parity occurs depends on successfully combating the stigma associated with mental health conditions and legislative action to assure that all health care coverage (employer sponsored, universal, or individual market) treats mental health equally.

Accurate Information on the Cost
Accurate information about cost is important, although it may become lost in general concerns about the cost of health care coverage. Still, parity needs to be included in any consideration of health cost coverage reform. There are significant concerns about the cost of health insurance. In a market in which providing or buying health insurance is increasingly expensive, any possibility of increased cost is of serious concern. Discussion has suggested that the real debate is not so much about whether mental health conditions should have equal coverage but about health care affordability. Access to early intervention for chronic conditions prevents their more costly progression and, in the long term, has been shown to contribute to effective cost controls.

Understanding Michigan's Insurance Laws and Federal Parity Law
Because insurance laws vary among the states, the Parity Act will be played out differently between states. Insurance commissions will have a role in defining how the Parity Act is implemented within a particular state. Stakeholders, advocates, and consumers will have a definitive impact on how the Parity Act is defined locally. Over 113 million people will be directly impacted by the passage of the law, but a vast number of individuals may also see changes or be positioned and influenced to ask, "what about us?" Since insurance laws vary among States it makes it even more important that Michigan adopt its own parity law.

Understanding of the Needs of the Currently Uninsured
The rapidly growing number of uninsured will not be affected or covered by the federal; parity law. This must become a part and focus of this community action plan and the community discussion. In fact, this uninsured population contributes to significant cost shifting within health care systems and to other systems of adult and child welfare, and to the education system. The prevalence of multiple chronic conditions in the uninsured will demonstrably encourage a wider discussion of the need for comprehensive health care reform.

Integration of Behavioral Health Care into Health Care
We are living with the consequences of centuries of belief that conditions that affect thinking and emotion, illnesses of the mind, are distinct from illnesses of the rest of the human body. In many ways, not just insurance coverage, but behavioral health care itself is different and separate from the rest of health care. For a number of reasons, this separation has often been encouraged by the behavioral health community. All sides of this issue need to carefully consider the likely consequences of continued separation or of integration. This strongly prompts several questions which need to be answered as to how parity will be addressed in any national health care reform plan that may emerge over the next several years.

Build Upon People's Seeking Greater Understanding
In today's world, most everyone knows of someone who has been impacted by behavioral health issues. Whether in the workplace, within the nuclear family, or within one's neighborhood, folks are aware of how the journey of life can change with mental illness and substance use disorders. The movie industry and backyard conversations frequently discuss the challenges of addressing behavioral health. There seems to be more openness that the experiences of mental illness and substance use disorders are safe topics about which people can have frank and honest conversations. Many people want to know and understand chronic illnesses, including mental illness and substance use disorders. They are seeking to become informed partners in their own health care for themselves and for their family member. They are searching for a medical home where access to care and coordination of care can be managed. As with other current topics like the environment, world relations, and the economy, people want discussions. We live in a more educated world, where opinions are many and the thirst for information is real and appropriate.

People celebrated the election of an African American president smacking the face of centuries of racial prejudice. That our same American citizens can handle going after the behavioral stigma is a real issue. Stigma interferes with effective treatment at the personal, business, and service provision levels as well as at that of insurance coverage. We can tackle the issue of why not parity. Folks love a valid discussion on issues that improve the human condition. Addressing the stigma means asking the hidden questions and acknowledging the real roadblocks:

- If a person doesn't believe that mental illness is a real illness, that person is unlikely to support insurance coverage for its treatment.

- If a person has a negative attitude toward those who have a mental illness or a substance use disorder, that person is unlikely to be an advocate for mental health parity.

Recommendations

Encourage your employer and insurance company to offer a behavioral health benefit as part of your health insurance coverage.

Encourage that the coverage of the behavioral health benefit is the same as the physical health care benefit.

Encourage use of a health benefit that leads to a healthy life style, to prevent, and to effectively manage chronic health conditions.

Ensure that the behavioral health interventions have demonstrated effectiveness.

Encourage universal access to health care.