Ballard: My guest today is Ron Bachman, president and CEO of Healthcare Visions, a thought leadership firm dedicated to advancing ideas and policy initiatives that are transforming the U.S. health-care market. He’s a senior fellow at the Center for Health Transformation and the Wye River Group on Health. Mr. Bachman is an actuary with extensive experience in health-care strategy for payers, providers and employers. He’s a retired partner from PricewaterhouseCoopers, and served as a designated expert on actuarial issues to the Centers for Medicare and Medicaid Services; the Congressional Budget Office; the Department of Labor; the National Institute of Mental Health, and was an expert resource on mental health policy to several members of congress including Senators Ted Kennedy and Pete Domenici. Thanks for joining us today, Ron.

Bachman: Glad to be here.

Ballard: Today we’re going to be talking about the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. That’s a mouthful, so I’m just going to refer to it as the Mental Health Parity Act throughout this interview. Let’s start out with a thumbnail sketch - what is the Mental Health Parity Act and what does it mean for employers?

Bachman: Well parity means equal coverage for mental health and physical health conditions covered by health insurance plans that are offered up by employers. And what equal coverage means is that you can no longer differentiate by reimbursing claims that are for a mental health diagnosis as opposed to any other diagnosis. So an individual who has a mental health condition will have the same level of coverage in all aspects of the insurance program, and I’m sure we’ll get into more details about what those different factors are.

Ballard: Could you talk a little bit about what specifically has to be equalized between mental health and medical-surgical benefits?

Bachman: Yes, there are three main areas. Equal benefits means that the benefits coverage for mental health must be equal to those for physical health. In more specific detail, what that means is that you have to have equal limits. The financial requirements and treatment limits applied to mental health and substance abuse benefits can be no more restrictive than for physical benefits, so you can’t have, as we used to have in many places previous to the legislation, where you would have a limit on outpatient visits, for example, or a limit on the number of inpatient stays. So the limits that used to be applied to cut off the benefits of care for a particular member who needed mental health or substance abuse care, those are no longer going to be allowed. You have to
equalize those. The third area is you have to equalize the cost sharing. The deductibles, the co-pays, the coinsurance; those things that require an individual to pay out of their own pocket for things that the insurance company, the insurance plan is not paying for. There’s always some kind of cost sharing involved in most medical and surgical treatments and coverages. You have to equalize that in the same way for mental health benefits.

Ballard: Now we had a mental health parity act back in 1996 and it kept getting renewed year after year. How does the new act differ from the 1996 one?

Bachman: It’s a substantial, dramatic expansion that. The 1996 act was actually fairly limited. It only required an equalizing of annual and lifetime limits. So one of those three areas we just went through in equalizing limits was the key to the '96 act. But the limitations did not apply to those things that are probably most important to somebody who’s seeking mental health or substance abuse benefits -- the day or visit limits. It didn’t apply to those. It only applied to annual and lifetime limits, which generally in insurance policies these days, for example, could be a million to five million dollars to unlimited. Well of course, equalizing those levels are kind of meaningless in some ways, because if you have ten-visit or twenty-visit limits, you’d never reach the million dollar equalizing requirement under the '96 act. Now the '96 act was very important, don’t mistake the value of that, because what happened in 1996, while the federal bill was very limited and we’re now coming around to expanding that to cover all aspects of equalizing benefits, the '96 act spurred the advocates and the advocates in each of the communities out there were able to act on the '96 bill at the state level and expand the state laws much more dramatically, which had a boomerang effect of allowing us most recently to come back and implement the new federal law. Because so much had been done at the state level, it made any of the cost estimates that much more favorable when we got to this new federal legislation.

Ballard: So to whom does the new mental health parity act apply? What types of organizations are subject to it?

Bachman: For the most part it applies to insured and self-insured groups, but the law applies to any group that is more than 50 employees. So it doesn’t apply to everybody under this new law. Many states apply mental health parity in their state laws to some of the smaller groups. Now, about 97 percent of these plans provide some mental health or substance abuse already. And that’s the good news, that in equalizing and sort of going that final step, it brings all those different state laws that apply to groups above 50 lives into uniformity so that we now know across the country, everybody’s going to have the same kind of coverage for mental health as they have for medical and surgical benefits.

Ballard: Are there exemptions to this new law?
Bachman: There are some exemptions. The new law of course, as we just said, really doesn’t apply to groups of 50 or fewer. The new law does not apply to individual insurance policies as well obviously, because it’s less than 50 employees, it’s just the individual. There are some other areas where it does not apply. For example, it does not apply to Medicare patients -- there’s additional legislation to equalize and create more parity in Medicare mental health benefits. It doesn’t apply to Medicaid except that many states have moved towards Medicaid managed care plans. And in that case those are more like fully insured plans, and it does apply to Medicaid managed care plans where states are using that as a delivery mechanism for coverage for Medicaid patients.

Ballard: And there’s a cost exemption built into this law as well, correct?

Bachman: That is true, and I worked closely as an actuary, I worked closely with the APA and the Practice Directorate and the other advocacy groups to be sure that the loophole was very, very tight. The cost exemption is basically that if a plan can show that actual experience, not projected experience, not presumed experience, but actual experience shows that the costs go up by more than two percent in the first year, or more than one percent in subsequent years, they can get an exemption. But what happens there is again we’re able to tighten this loophole potential by saying if they get an exemption they get it for one year, and then they have to start over again. So, they have to implement mental health parity, they would have to go through the actual experience for a period of time of six months or a year and then see if the costs are still in excess of the two percent or in excess of the one percent. So, while there is a cost exemption, it is one that’s structured such that very few companies would even want to try to utilize that to exempt themselves.

Ballard: Are there good estimates out there in terms of what cost increases are anticipated?

Bachman: Well the cost increases for any one plan obviously can vary depending upon where their starting point is. The good news is that most large employers, again 97 percent of plans, have substantial mental health benefits. There are only a few companies around that don’t put in much, if any, mental health benefits, mainly because mental health and physical health go hand in hand. So the reality is that the marketplace and most employers have recognized that you can’t have health without mental health. The Congressional Budget Office took a look at the costs nationally and because so many have mental health benefits, the estimated cost nationally was 0.4 percent, so it’s a very, very small number. And I think what we’ve seen across the country in many of the states that have implemented mental health parity to various extents, is that the cost increases that they’ve found were so minimal that they really couldn’t even be measured. And so some of the opponents of mental health parity nationally who were crying wolf and saying this was going to be a five percent or an eight percent or a ten percent cost increase, just have no facts to prove that. We wound up with passing mental health parity at the state level, again at various levels and various types that are unified under this national program now, that in those states there’s not a single example of mental health benefit cost increases being so large that the
industry or employers were raising the issue as a problem. In most cases, they said we couldn’t even determine after it was passed, a cost differential from before it was passed. That’s not to say that there aren’t some companies again that have very limited mental health benefits that when they put in mental health parity there wouldn’t be a two or three percent increase. But they would wind up again with much better benefits and much greater interaction between mental health and medical benefits that will wind up saving them.

Ballard: And that doesn’t even take into account improvements in performance and productivity and things that are related to having better physical and mental health.

Bachman: Absolutely. And there are a lot of studies for that. Unfortunately, I guess when we put pencil to paper as an actuary or an economist, we’re not really allowed under the guidelines of pricing to fully factor in all those interactions that can occur, because so many people claim those things, and they don’t always seem to come out. What we have found with actual experience though in states, is that we have seen much more of those interactions that save money. And so, there is those dollar savings in a hard sense, but also in the soft dollar sense, which wind up benefiting a company in increased productivity, on fewer unscheduled sick days, lower impaired presenteeism, and all those things that make a company productive. The experience with mental health parity over the last 15 years as it has gone from state to state and now the federal level has been to reinforce the reality of those other issues that make mental health parity logical for companies, and why many companies had been moving along this line towards better and more expansive mental health benefits that are closer to true parity. And now that the law says you have to have parity, it’s really not that big of a leap for them to go from where they are to meeting the standards of this law.

Ballard: So when does this go into effect?

Bachman: It goes into effect January 1, 2010. So it’s right around the corner. We’re at the end of 2009, and most plans, insurance plans, have an effective date of January 1, 2010. So for many, they have been making plans, they have made the changes in their programs and they are in the process of informing their employees about these changes to be effective just in a few months.

Ballard: So are regulations out yet, what groups are going to have oversight, and how will all of this get enforced?

Bachman: Well, the regulations were supposed to be out in an October/November time frame. There was a lot of feedback, and this is a relatively simple law in some ways, but very complex in other ways, and had a lot of feedback to the departments and agencies that will ultimately control this at the federal level, which are the Departments of Labor; Treasury; and Health and Human Services. They now tell us that they won’t have final regulations out until January. Unfortunately, that doesn’t help employers who are trying to implement today. So, what employers have been doing is doing the best they can. Reading through the law, listening to their consultants, listening to
insurance agents and trying to comply in the best way they can, and many of the vendors out there have been offering their best advice on how to meet the standards of the mental health parity act. But we really won’t have official governmental regulations until January.

Ballard: So a couple of detailed questions. First, are all diagnoses covered, and second, does it apply to both in-network and out-of-network services?

Bachman: What is covered at parity is defined by the plan. The law says that if you have a mental health benefit, then it has to be at parity. But it doesn’t completely define and require all the diagnoses. As far as out of network, that’s actually one of the most important areas. This legislation does apply to all out-of-network coverages. So if a plan has out-of-network medical and surgical benefits, it would also have to have out-of-network mental health benefits and they would have to be paid the same as the out-of-network reimbursements for medical and surgical. So now out-of-network coverage is going to be much more affordable. In many cases in the past, insurance companies would not have out-of-network benefits for mental health while they had out-of-network benefits for medical and surgical. Now the exception to that rule, if you want to call it an exception, is that if the insurance plan is already a closed panel, a staff model HMO is sometimes the word used, that they hire doctors and there is no out of network. You only, when you buy that insurance policy, can use in-network providers. There is no out-of-network benefit for medical or surgical. There’s no requirement under the law to provide an out-of-network mental health benefit. There is no out-of-network medical-surgical, therefore the law says you don’t have to provide any out-of-network mental health benefits, as well.

Ballard: So with no official guidance out and employers heading into open enrollment, what do they need to be thinking about? What do they need to talk to their insurance providers about to make sure they have their bases covered?

Bachman: Well, the APA actually has a pretty good list that we helped put together for employers. Because as we said earlier, the employers don’t have official guidelines. There’s no regulations out there by the Department of Labor or Treasury or Health and Human Services. So they’re flying a little bit in the dark. But what we’ve recommended are what we consider to be best practices. There’s actually 14 of them, and I’ll mention a few. Just go ahead and equalize the benefit structures. People know what parity is, they know what equalizing the financial and treatment limits are. That’s pretty easy for them to understand and recognize that you can’t have limits on outpatient visits or inpatient stays, etc. Ensure that there’s adequate access to hospitals, offices, and other access points of care. Be sure that the mental health network that you’re contracting with, whether it’s an insurance carrier or a specialized vendor, that they have enough specialists in that network so people can in fact access them, and it’s not a distance or a time problem that would be the limiting factor of people getting the right care. Eliminate all those office visit and hospital day limits on mental health services. Use common deductibles. Don’t try to say, well, there’s a deductible for a medical, so a $500 or whatever it might be, and say well I’m
going to put a $500 deductible on mental health benefits. That’s not really parity. A single deductible is what is the best practice, as would be a single amount of what’s called a maximum out of pocket. Maximum out of pocket would be the total of the coinsurance, the 20 percent is sort of a common coinsurance amount, the coinsurance and the deductible in total would be a maximum out of pocket. So just equalize those for any condition. You wouldn’t differentiate between cancer and diabetes for example with different deductibles or maximum out-of-pocket costs; so just equalize all of those factors. And what you want to do again, we mentioned coordinated care between the primary care physicians and the specialists, so you get the right referrals; you’re getting the right treatment from the right specialist. Also improve the coordination between disease management programs -- the diabetes, the hypertension, all those kinds of conditions that are commonly being dealt with in many employer plans that are under the title of disease management programs -- be sure that your mental health services are properly coordinated with those as well as the general medical care that we mentioned. Encourage preventive mental health services and early intervention. We overlook this in many cases, and there’s some good opportunities to be sure that you have good preventive mental health services. Address the high-risk comorbidities. Again, you can’t deal with a diabetic, as an example, without treating their underlying mental health. So there’s a whole list of items there, and I would say that the last is probably the most important, as employers look to implement a program without specific federal guidelines having been written. And I would say that’s “don’t play games looking for loopholes” -- taking the language that’s intended to mean one thing and reinterpreting it to mean something that they would prefer it mean but that it doesn’t mean. The loopholes don’t save you anything. The real lesson those Petri dishes of experimentation at the state level tell us over and over and over again is that mental health is good for health. It saves money, it saves on issues of productivity and absenteeism and unscheduled sick days. Just equalize the benefits, watch your data and experience, watch your referrals, watch your system, be sure everything is coordinated and employers will come out big winners in the whole process.

Ballard: Well thanks for joining us today, Ron. Our Employer’s Guide to the Mental Health Parity and Addiction Equity Act is online on the episode details page of this podcast at phwa.org/podcast. That way employers can dig into those recommendations you were talking about; and I want to thank you again for taking the time out of your schedule to talk with us today, Ron.

Bachman: My pleasure. I enjoyed it.