Mills Benefit Group, LLC

801 Broadway NW, Suite 203
Grand Rapids, MI 49504
(616) 459-1069
or (888) 823-0334

Benefit Information Release
Jamie R. Mills, President
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www.millsbenefitgroup.com

Mental Health & Substance Abuse (MHSA) Parity October 3, 2009

All of us remember the 1996 Mental Health Parity Act which required us to make some changes to dollar limits, associated with mental health benefits. This prior legislation is minor as compared to the changes that we will have to implement on your **renewal/plan date following October 3, 2009. The act is for all employers who offer health plans with more than 50 employees.** One of the major differences between the prior legislation and this legislation is the fact that substance abuse parity is now included. Previous legislation only addressed mental health benefits.

How will this affect your benefit plan?

- Equity coverage for MHSA will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses. It will also apply to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

- A plan may not apply separate cost sharing requirements or treatment limitations to mental health and/or substance abuse benefits.

- If a plan offers two or more benefit packages, the requirements of this Act will be applied separately to each package.

- As under the current federal parity law, mental health or substance abuse benefit coverage is not mandated. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act. You can:
  1. Remove all mental health and sub stance abuse benefits; or
  2. Have Parity the same as all other benefits provided under your plan.

Out-Of-Network Benefits. A group health plan that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/ substance abuse treatment. This is a large concern for many employers. How do you control the cost of out-of-network treatment? Many plans have a requirement that in order to receive mental health or substance abuse benefits, you must remain in-network, even though out of network benefits are available for other medical procedures. Also, some plans require pre-certification for mental health and substance abuse benefits while it is not required for other medical conditions.

There are many clinics that offer free trips to "warm climates" for substance abuse rehabilitation. Under our strict current guidelines if those establishments are not in-network they were not covered under the plan.

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Preservation of State Law. The current Health Insurance Portability and Accountability Act (HIPAA) preemption standard applies. 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. Most state laws are not as liberal as the federal mandate so the federal will preempt the state. Most states have very limited substance abuse benefits such as Michigan that only requires $4,000 per year for treatment expenses.

We fully anticipate a rise in fully insured health care premiums and self-funded healthcare costs. Actuaries are pointing at about 1-1.5%. For a plan of $10 million this is an additional $100,000-$150,000 cost. Not a small number! If a group health plan (or coverage) experiences an increase higher than 2 percent, the plan can be exempted from the law for the following year. However the requirement to obtain the exemption is not that easy: If your plan is exempted the following options will occur:

- An employer may elect to continue parity coverage regardless of this cost increase.
- You can take a one year exemption.

How do you get an exemption:

- A qualified actuary (member of American Academy of Actuaries) shall determine and prepare a written report regarding a plan's cost increase after a plan has complied with the Act for the first six months of the plan year involved.
- A plan shall promptly and timely notify the Department of Labor (if self-funded) or the Department of Health and Human Services (if fully-insured), the appropriate State agencies, and participants and beneficiaries when it elects an exemption. Plan notification to Labor or HHS is confidential and will provide a description of covered lives in the plan and the actual costs for which the exemption is sought.
- Labor or HHS (as appropriate) and State agencies **may audit a plan to determine compliance with the Act when the plan has elected an exemption.**

HOW CAN MILLS BENEFIT GROUP HELP REDUCE THE POTENTIAL EXPOSURE TO THE PLAN? STRONG CASE MANAGEMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE!

1. The requirement for medical necessity still remains in effect as it does for all other procedures. Therefore, if medical necessity only calls for inpatient detoxification with follow up out-patient care versus 30 days of inpatient care, the claim for a 30 day inpatient stay will not be approved. As with standard medical care, case management will ask the attending physician to document the medical necessity for treatments both in-patient and out-patient.

2. Mils Benefit Group will be in contact with all the carriers we work with to assure strong case management in these areas. We are asking for detailed proposals on how they intend to monitor treatments to assure medical necessity. As the benefits are currently limited there is not a great need for strong management. Your exposure is limited. We need to make sure that your carriers are prepared as of your renewal date to monitor all claims for mental health and/or substance abuse as they will for all other potential high claim costs.

3. We will require insurance carriers for our fully insured experience rated plans and self-funded plan administrators to provide experience information (claim dollars spent) specific to mental health and substance abuse on a monthly basis.

4. **Split Co-payments:**
   a. Most of our carriers are now willing to consider split co-payments for physicians based upon type of service:
      i. Internist/OBGYN/Family Physician/Pediatrician: Co-payment of $20.00 or $25.00
      ii. Specialist Co-payment of $30.00 or $35.00 (mental health and substance abuse providers do fall under Specialists)

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5. **Inpatient Co-payments:**
Consider adding an in-patient copayment of 100.00 to $500.00 per admission. The copayment would be applicable to all hospitals and rehabilitation centers.

6. **Elimination of Benefits:**
You are permitted to eliminate mental health and substance abuse benefits from your health plans. We have not yet determined if you will be permitted to eliminate just substance abuse benefits and retain mental health benefits. We do not believe so, but we will not be certain until the final regulations are announced.

7. Consider increasing your EAP program visits and requiring employees and or dependents to utilize the EAP Program prior to receiving benefits under the health care plan. We believe this will be acceptable under the new legislation and are waiting for final guidelines. We are working with our health carriers to determine how they would pend claims for MHSA pending documentation that the participant has eliminated all benefits under the EAP. The EAP would also have to be involved by providing proof to the participant that the EAP limit had been reached. It might be more cost effective to extend your EAP outpatient visits versus having them fall under the health care plan.

8. Random employment alcohol and drug abuse testing. This of course does not help with dependent costs, but many employers are moving to a zero tolerance and immediate grounds for termination.

There are positive aspects of the legislation for which we are in agreement. There are many individuals with serious mental health illness, such as schizophrenia dyslexia, adult ADD, autism, etc., where longer term treatments are necessary to achieve excellent results. Those in need of longer term treatment are denied that under the current benefit structure.

We also know, as supported by the following article, that depression has an effect on business. Productivity decreases with depression and now employees will have the opportunity to find the best treatment with the best providers. This in turn helps your organization.

We will be meeting with each of you to discuss the implication of the legislation and how to best protect the financial integrity of the plan along with providing the appropriate care.

Jamie R. Mills, GBA
President

Integrated Benefits Institute Research Finds Employers Severely Underestimate the Prevalence and Lost Productivity

Lost productivity for depression sufferers is a considerable and largely undetected problem. Employees disabled by depression are away from work significantly longer than other employees on disability leave according to new research by the non-profit Integrated Benefits Institute. The true lost-time costs of these cases -- including disability payments and lost productivity -- are 2-1/2 times the costs of medical care and pharmacy benefits combined; lost productivity is the largest single cost component, making up 60% of these "full costs." In addition, the research finds that twice as many employees develop depression after filing a disability claim, and again lost productivity is the biggest single cost driver of these disabled employees.

But most significantly according to the research, lost productivity is greatest for those employees still at work as more than 80% of all productivity losses for depressed employees are associated with sick leave and presenteeism (employees who are not fully functioning while at work due to ill health).

The analysis examines the relationship between depression, disability and productivity and presents unanticipated employer costs and significant challenges. The new study comes at a critical time for U.S. employers struggling to improve both the productivity and health of their employees as they work to remain competitive in the global economy. Depression-related short-term disability (STD) claims can be expensive, extended and hard to manage; they also are common and

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constitute the second leading cause of disability worldwide.

A summary of the report, The Full Costs of Depression in the Workforce, is publicly available and can be accessed on IBI's Web site: https://ibiweb.org/UserFiles/File/Depression_Brief.pdf.

KEY FINDINGS

Approximately 10% of the more than 400,000 workers studied received medical treatment for depression during the three-year study period. Only 30% of workers reporting depression receive current professional medical care according to employee self reports. Nearly two-thirds of depression-related productivity losses are due to inappropriate or lack of treatment. Employees in the depression group have 44% more lost time than employees who had no depression treatment during their disability leave which cost employers $3,408 more per case.

IBI'S EMPLOYER MEMBER SOLUTIONS BOARD RECOMMENDS

"Increase early depression screening for disability sufferers," recommends IBI's Member Solutions Board, a group of employers and suppliers that review research findings and provide actionable recommendations. The Board for this research also suggests that employers engage a disability supplier to look at claims horizontally and get beyond the disability diagnosis to probe for claimant family and social or work/life issues. Mental health parity requirements represent an opportunity for employers to fine-tune mental health benefits and treatment as a productivity instrument.

For this study, IBI used an Ingenix master research database on 400,928 unique employees from six companies, distributed across all ten geographic regions of the U.S. and a large, national database from employee self reports using the Health and Work Performance Questionnaire (HPQ), a tool developed by Dr. Ronald Kessler of Harvard Medical School and the World Health Organization.

ABOUT THE INTEGRATED BENEFITS INSTITUTE

The Integrated Benefits Institute (IBI) provides employers and their supplier partners with resources for proving the business value of health. As a pioneer, leader and nonprofit supplier of health and productivity research, measurement and benchmarking, IBI is a trusted source for benefits performance analysis, practical solutions, and forums for information and education. IBI's programs, resources and expert networks advance understanding about the link between -- and the impact of -- health-related productivity on corporate America's bottom line. For additional information visit: ibiweb.org.

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