

Mental Health Parity and Addiction Equity Act: Overview of the Interim Final Rule

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Overview

- New Parity Standard and Important Dates
- Flexibility in Defining Mental Health and Substance Use Disorder Benefits
- Classification of Benefits for Parity Assessment
- Application of the New Parity Standard
- Interaction with State Laws
- Enforcement and Opportunity for Comment

New Parity Standard

- MHPAEA requires group health plans and group health insurance issuers to ensure that financial requirements (e.g., copayments, deductibles) and treatment limitations (e.g., visit limits) applicable to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations applied to substantially all medical/surgical benefits.

New Parity Standard

- “Substantially all” medical/surgical benefits defined as 2/3rds of the dollar amount of all plan payments for med/surg benefits expected for the plan year
- “Predominant” financial requirement or treatment limitation is defined as the level that applies to more than 1/2 of medical/surgical benefits
- No separate cost-sharing or limits for mh/sud benefits
- Out-of-network benefits must be provided for mh/sud if covered for med/surg

Important Dates

- Interim Final Rule published in Fed Register Feb. 2nd, 2010
- Effective Date – April 5th 2010
- Applicability Date – July 1, 2010 – applies to new plan years beginning on or after that date
- “Good faith compliance with reasonable interpretation of the law” until next year

Flexibility in Defining a MH/SUD Benefit

- No mandate to cover mh or sud benefits -- plans decide which services to cover
- State laws may mandate benefits for fully insured plans
- Regs do require use of “generally recognized independent standards of current medical practice” eg, DSM, ICD, State guidelines
- No scope of service or continuum of care requirement

Classification of Benefits for Parity Assessment

- Six classes of benefits within which parity will be assessed:
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drugs

Classification of Benefits for Parity Assessment

- Financial requirements or treatment limitations for a mh or sud benefit must be compared to requirements and limits for med/surg benefits in the same category
- If mh or sud benefits are provided in any of these categories, they must be provided in all categories for which med/surg benefits are provided
- Categories are not further defined but must be applied uniformly to mh/sud and med/surg and state laws may apply

Application of Parity Standard

- 1st test – whether treatment limit or financial requirement applies to substantially all med/surg benefits (2/3rds) in the benefit category
 - If not, the limit or requirement cannot be applied to mh/sud benefits in same category
- 2nd test – what level of treatment limit or financial requirement applies to most med/surg benefits in the category (predominant level is $>1/2$)



Application of Parity Standard

- No separate classification of generalists and specialists in determining predominant financial requirement for substantially all med/surg benefits in each category
 - Issue of mh/sud treated as specialists with higher co-pays
- Separately accumulating financial requirements (eg, deductibles) or treatment limits are prohibited
- Different application to aggregate lifetime or annual benefits:
 - allows separately accumulating lifetime or annual dollar limits for mh/sud and med/surg benefits that are equivalent or combined



Different Kinds of Treatment Limits

- Quantitative (eg, 30 outpatient visits) v. non-quantitative
- Examples of Non-Quantitative:
 - Medical management standards
 - Prescription drug formulary design
 - Standards for provider admission to participate in a network
 - Determination of usual, customary, and reasonable amounts
 - Fail first or step therapy requirements
 - Conditioning benefits on completion of a course of treatment

Different Kinds of Treatment Limits

- Different parity test for non-quantitative treatment limits:

Any processes, strategies, evidentiary standards or other factors used in applying these limits may not be applied more stringently with regard to mh/sud than for med/surg benefits

Except to the extent recognized clinically appropriate standards of care permit a difference



Different Kinds of Treatment Limits

- Tiering in prescription drug coverage is allowed as long as placement in a tier is not based on use for mh or sud condition
- Requiring enrollees to use EAP benefit before accessing health plan mh or sud benefits is prohibited unless similar requirement applies to med/surg
- Separate mh/sud and med/surg benefit packages or plans considered single combined plan – to prevent avoidance of parity

Disclosure Requirements for Med Necessity and Coverage Denials

- Plans must disclose criteria for making med necessity decisions with respect to mh or sud benefits upon request from a current or potential beneficiary or participant or contracting provider
- Plans must disclose reason for a coverage denial regarding a mh or sud benefit to any participant or beneficiary
 - Regs clarify this must be done automatically and free of charge for self-insured plans; other plans encouraged to do the same



Interaction with State Laws

- “States may continue to apply State law requirements except to the extent that such requirements prevent the application of the MHPAEA requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the federal requirements are unlikely to “prevent the application of” MHPAEA, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.” [p. 5430]



Interaction with State Laws

- Both fully insured and self-insured plans providing mh or sud benefits are subject to MHPAEA
 - Fully insured = benefits provided through insurance
 - Self insured = employer pays for claims directly not through insurance
- Fully insured are also subject to state insurance laws
- Nonfederal government employer that provides self-funded health plan may opt out of the federal parity requirements

Additional Guidance

- Federal regulators are developing additional guidance on following issues:
 - State law preemption
 - Application to Medicaid managed care plans
 - Cost exemption – if plan can show 2% increased costs due to parity, may apply for exemption for following year
 - Only lasts one year and thus regulators assert may only be claimed for alternating years



Enforcement

- Dept of Labor and IRS have enforcement authority over self-insured private employer plans
- HHS has authority over non-federal government employee plans
- States have primary authority over fully insured employer plans and HHS has secondary authority



Enforcement

- DOL has hundreds of investigators charged with ensuring compliance with MHPAEA and other consumer protection laws
 - To file a complaint call 1-866-444-3272
- CMS help line also taking complaints: 1-877-267-2323; extension 6-5511
- We are collecting stories on our website



Opportunity for Comment

- 90 day comment period ending May 3rd
- Regulators asking for comment on:
 - Need for additional examples of non-quantitative treatment limits
 - Whether and how MHPAEA addresses scope of services issue
 - Need for further clarification on disclosure requirements regarding med necessity and coverage denials or new cost exemption