



What the Federal Parity Law Means for You

Co-Sponsored by:

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Andrew Sperling

Director of Federal Legislative Advocacy
NAMI

andrew@nami.org

Parity Implementation – the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- P.L. 110-343, signed on October 3, 2008
- Attached to the financial market rescue and tax extenders legislation
- Becomes effective in new group health plan years starting after October 3, 2009
- Expands the 1996 federal parity law and requires equity in coverage with respect to:
 - Durational treatment limits (caps on inpatient days and outpatient visits)
 - Financial limitations (higher cost sharing, deductibles, out-of-pocket limits)



What Does the New Law Apply To?

- Group Health Plans and Health Insurers That Provide Coverage to Group Health Plans (employers with over 50 employees)
 - Fully-insured plans (via Section 2705 of the Public Health Service Act)
 - ERISA self-insured plans (Section 712)
- Medicaid Managed Care Plans
- State Children's Health Insurance Program
- Non-Federal Governmental Plans (HIPAA waiver still available) --
<http://www.cms.gov/SelfFundedNonFedGovPlans/>
- Federal Employees Health Benefits Program

Parity in Group Health Plans

- Includes both mental health and substance abuse “as defined by the plan” “in accordance with applicable federal and state law”
- No preemption of state mandates or parity laws above the new federal standard
- Small employer exemption for firms with 50 or fewer workers
- Cost increase exemption available, unlikely to be used
- Full parity will now reach more than 85 million covered lives in ERISA self-insured plans sponsored by firms >50 employees (v. less than 35 million in fully insured state regulated group health plans >50 employees)

Parity in Group Health Plans

- Out of network requirement for mental health and substance abuse – Where offered on the medical-surgical side
- Disclosure of plan information including medical necessity criteria for mental health and substance abuse
- Biennial reports from the Secretary on compliance beginning in 2012
- Notice and Assistance – Secretary required to publish guidance on parity compliance and widely disseminate to employers, plans, NAIC, consumers, etc. AND provide assistance on continued operation of state laws
- GAO report on coverage and exclusion of mental health and substance abuse benefits (including exclusion of specific diagnoses) – due in 2 years

What Does Parity Mean?

- Mental health and substance use disorder benefits must be “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan...” and “there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorders benefits.”

Parity in the Affordable Care Act

- Essential benefits requirements – As defined in Section 1302, the essential benefits package includes (among a menu of services) emergency treatment, prescription drugs, mental health and substance abuse treatment services.
- Parity requirement in state-based exchanges – Section 1311(j) required all “qualified health plans” offered through state-based Exchanges to comply with the Domenici-Wellstone Mental Health Parity and Addiction Equity Act of 2008

Parity – Compliance and Enforcement

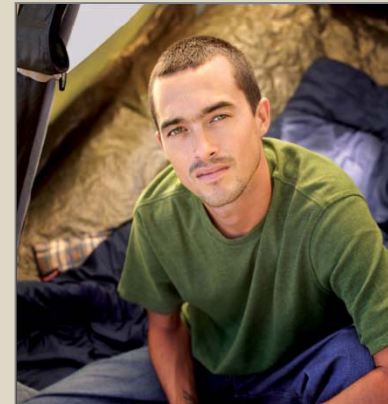
- NAMI National will be tracking stories – both positive and negative
- Compliance and enforcement is across HHS, DoL, Treasury and state insurance commissioners
- DoL – 866-444-EBSA
- CMS – 877-267-2323, x61515



Chuck Ingoglia

**Vice President, Public Policy
National Council for Community Behavioral
Healthcare**

ChuckI@thenationalcouncil.org





Introduction

- Interim Final Regulations issued February 2, 2010 (75 Fed. Reg. 5410)
 - Agencies requested comments — may issue revisions
 - Most health plans will need to be reviewed and possibly amended in light of these rules
- Affordable Care Act of 2010
 - Beginning in 2014, applies MHPAEA to most plans



General Information on the Interim Final Regulations

- Regulations apply for plan years beginning July 1, 2010
- Collectively bargained plans have slightly different dates
- General rule — parity applies if a plan offers medical/ surgical and MH/SUD benefits (> 50 employees)
- A plan may not apply any **financial requirement** or **treatment limitation** to mental health or substance use disorder benefits **in any classification** that is more restrictive than the **predominant** financial requirement or treatment limitation for **substantially all** medical/surgical benefits in the same classification



Requirements/Limitations

- **Financial requirements** – e.g., deductibles, copayments, coinsurance, out-of-pocket maximums
- **Treatment limitations** – limit benefits based on frequency of treatment, number of visits, days of coverage, days in a waiting period, and **“other similar limits on the scope and duration of treatment.”**
 - **Quantitative treatment limitation** – expressed numerically, e.g., annual limit of 50 outpatient visits
 - **Nonquantitative treatment limitation** – not expressed numerically but otherwise limits the scope or duration of benefits, e.g. prior authorization policies



Classifications of Benefits

- 6 classifications of benefits:
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drugs
- These are the only classifications used for MHPAEA
- Distinctions between generalists and specialists are not separate classifications (eg. same copays required)



Classification of Benefits (cont'd)

- A plan must provide MH/SUD benefits in each classification where it provides medical/surgical benefits
 - **The complete exclusion of coverage in a classification is considered a treatment limitation**
 - Rules do not require an expansion of the range of conditions/disorders covered under the plan
 - **This is a clear example of the regulations requiring parity in scope of services**
 - Inpatient, outpatient, and emergency care are defined by the plan – must be applied uniformly



Poll Question

- Example: A plan covers psychiatric medications for the treatment of depression but does not cover outpatient treatment services for depression. The plan covers both outpatient treatment and prescription drugs for most medical/surgical needs.
- Is this a violation of parity?
 - Yes
 - No
 - Not sure



Analyzing Plan Benefits

- **Part 1** - A requirement/limit applies to substantially all medical/surgical benefits in a classification if it applies to at least 2/3 of the benefits in that classification
 - *If not, it cannot be applied to MH/SUD benefits in that category*
- **Part 2** - The predominant level is the one that applies to more than 1/2 of medical/surgical benefits subject to the requirement/limit in that classification
- Measurement is performed on medical/surgical benefits alone and then applied to MH/SUD benefits
- Type (eg. copays) or level (eg. dollar amount, days, or percent) of limitation or financial requirement



Poll Question

- Example: In a benefits package, 70% of spending for inpatient, in-network medical/surgical benefits was subject to a \$15 copay.
- What is the allowable copay for inpatient, in-network MH/SUD benefits?
 - No greater than \$15 for all such benefits
 - No greater than \$15 for 70% of such benefits
 - No limitations on how high the copay may be



Cumulative Requirements

- Definitions:
 - **Cumulative financial requirements**
 - e.g., deductibles (does not address lifetime and annual dollar limits)
 - **Cumulative quantitative treatment limitation**
 - e.g., annual or lifetime day or visit limits
- MH/SUD and medical/surgical benefits must accumulate toward the same, **combined deductible** (or other cumulative requirement/limit) within a classification
 - In other words, **separate but equal deductibles are not allowed**



Nonquantitative Treatment Limitations

- Definition - Not expressed numerically but otherwise limits the scope or duration of benefits
- Non-exhaustive list of examples:
 - Medical management (e.g., utilization review, preauthorization, concurrent review, retrospective review, case management, etc.)
 - Prescription drug formulary design
 - Standards for provider participation in a network, including reimbursement rates
 - Fail-first or step therapy protocols
 - Conditioning benefits on completing a course of treatment
 - “Other similar limits on the scope and duration of treatment”



Nonquantitative Treatment Limitations (cont'd)

- Any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitations to MH/SUD benefits in a classification **must be comparable to, and applied no more stringently** than, those applied to medical/surgical benefits
- Cannot require to exhaust EAP benefits unless have a similar gatekeeper requirement for medical/surgical benefits



Poll Question

- Example: A plan requires patients to fail first on oral medications for MH/SU disorders before reimbursing for MH/SUD injectables. However, a majority of the time, the plan pays for injectables on the medical side without requiring a failed trial of oral medications first.
- Is this a violation of parity?
 - Yes
 - No
 - Not sure



Prescription Drug Benefits

- Tiering: A plan satisfies the parity requirements if it has different levels of financial requirements on different tiers of prescription drugs **based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical or MH/SUD benefits**
 - Reasonable factors: e.g., cost, efficacy, generic vs. brand, mail order vs. pharmacy
 - Reasonableness must be determined in accordance with requirements for nonquantitative treatment limitations



Expect Additional Guidance from Federal Agencies

- State law pre-emption
- Application to Medicaid managed care plans
- Cost exemption — if plan can show 2% increased cost, it can be exempt for one year—
 - Future Years can be exempted based on a 1% increase
- Enforcement: Private enforcement started Oct 3 ,2009
 - Self-insured = Dept. of Labor and IRS
 - Non-federal government employees: HHS
 - Fully insured employer plans = State Ins. commissioner & HHS



Parity Resources

- [FAQ](#)
 - Has your insurance plan violated the parity law?
 - Find out specific examples of parity law noncompliance
- [Parity Toolkit](#)
 - Step by step, walks you through the process of filing an appeal & strategies for winning disputes
 - Includes model letters, checklists, helpful tips
- Example: [APA Letter](#) to BCBS of Illinois
- National Council [Parity Website](#)
- Questions? RebeccaF@thenationalcouncil.org



Questions?

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