NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

# Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

# Why Parity?

- In any given year:
  - About six percent of adults have a serious mental disorder
  - A similar percentage of children have a serious emotional disturbance
  - More than nine percent have substance abuse/dependence.

- Mental disorders are the leading cause of disability in the U.S. for individuals ages 15 to 44 (World Health Organization, 2004).
- The most often reported reasons for not receiving treatment were no health coverage and could not afford cost.
- Forgoing mental health/substance abuse benefits can adversely impact medical costs by 25 to 50 percent. And, one third of sick days associated with chronic conditions have been attributed to mh/su disorders.

# Mental Health Parity and Addiction Equity Act of 2008

- Included in the Emergency Economic Stabilization Act of 2008
- Signed into law on October 3, 2008
- Goes into effect January 1, 2010
  - Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate.
- Requires the Depts. Of Labor, Health & Human Services and Treasury to write regulations.

# Building on the 1996 Parity Law

- The Mental Health Parity and Addiction Equity Act of 2008 builds upon the 1996 Parity Act.
  - Applicable plans must provide comparable annual or lifetime dollar limits for mental health and physical health services.
- It amends the 1996 Parity Act to include substance use disorders (SUDs).
- The 1996 Parity Law remains in effect through 2009.

# Covered Entities

- Group plans sponsored by private-sector employers and unions
- Church-sponsored plans (can assess tax penalties on employers that don’t comply)
- Medicaid managed care
- Some SCHIP plans
- Some state and local health plans

# Mental Health Parity and Addiction Equity Act of 2008

- **Equity Coverage for both mental health and addictions treatment services**
  - **Financial Limitations:** including, deductibles, copayments, coinsurance, and out-of-pocket expenses.
  - **Treatment Limitations:** Prohibits "limitations on the frequency of treatment, number of visits or days of coverage, or other similar limits on the duration or scope of treatment" under the plan that are more restrictive than the "predominant limitations applied to substantially all the medical-surgical benefits"…
- **Out-Of-Network Benefits**
  - Group health plans (or coverage) that provides out-of-network coverage for medical/surgical *must also* provide out-of-network coverage, *at parity*, for MH/substance use disorder benefits

# Mental Health Parity and Addiction Equity Act of 2008

- **Preservation of State Law**
  - The current HIPAA preemption standard applies. This standard 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.**
- **Small Employer Exemption**
  - As w/ 1996 law, small employers of 50 or fewer employees are exempt from the Act requirements. **State parity laws continue to apply** to these employers, as well as to individual plans

# This Law Does Not…

- This law does not apply to Medicare
  - There is parity in Medicare through the Medicare Improvements for Patients and Providers Act (MIPPA)
- This law does not mandate in-network MH/SUD coverage
  - Instead, if a plan provides MH/SUD in-network coverage, the costs and limits must be at parity to those of physical health coverage
- Does not mandate coverage of all mental health and SUD conditions.
  - Only those conditions as defined under the terms of each plan.

# What's Next?

- RFI Issued April 28th; Comments in by May 28th
- Regulations Soon After
- Parity is just the beginning…
- Key areas:
  - Outreach to purchasers and consumers
  - Scope of Treatment/Services – what's covered? EBP/VBS's
  - Medical Necessity – how is it defined? How implemented?
  - Access for high-risk or special needs clients/patients.

# Examples from Providers & Patients Limitations on MH/SU Care

- Annual and lifetime caps
- Deductibles; Coinsurance
- Out-of-pocket expenses
- Limits on frequency of treatment (Tx), # of visits, days of coverage
- Utilization review (UR)
- Coverage based on completing review assessment with very short timeline
- Pre-authorization practices
- Utilization review by professionals without training in MH or addiction
- Medical necessity criteria: unclear definitions for levels of care; changing
- "Fail first" policies : e.g. must fail 1 – 2 times at outpatient to be eligible for "xyz"
- Coverage based on patient completing an entire course of Tx
- Exclusions: examples:
  Levels of care e.g. partial hospital
  Experimental
  Not evidence-based or cost-effective
  Conditions: eating disorders, autism
  Court-ordered treatment
- Fee schedules that do not enlist enough providers to assure access
- Limits on specific provider-types or licensure requirements
- Preferred provider networks that eliminate providers if they allow self pay for care deemed "not medically necessary"

# National Council Parity Work Group Recommendations: In-Network Access

- Include guidance to health plans on how to ensure in-network access to mental health and addiction services
- Require that applicable health plans enroll “essential community providers” in their network
- Provide guidance to plans on how to conduct ample outreach and education to consumers/patients and their families
- Ensure that there are standards that require networks to have sufficient enrolled, participating providers

# National Council Parity Work Group Recommendations…

- **Treatment Limitations:** Articulate that limitations of services have to meet the "requirements of the Act" i.e., should prohibit restrictive limitations on scope of treatment that have the effect of shifting risk to the consumer or to secondary coverage.
- **Scope of Treatment (SoT):** provide guidance and clarification on the types of covered treatment and how other services whether new or long established become accepted
- SoT: The regulations should articulate that the covered services and level of care should be appropriate to the covered diagnoses. Services recognized as community standards or evidenced-based practices for a given condition should be covered.
- SoT: Recognize that the scope of treatment for mental illness and addiction disorders should be no more restrictive than what is available substantially for other chronic health conditions

# Parity Work Group: Medical Necessity

- Regulations must provide guidance and predictability to health plans, consumers and providers regarding how medical necessity is defined and criteria used to make utilization management decisions.
- Clinical criteria for admission/authorization, continuing care and discharge should be used for utilization decisions and these criteria must be available to enrollees and their providers at the initiation of treatment.
- There must not be a “fail-first” policy. If a service is necessary and appropriate, failure in another service should not be required as a prerequisite to authorization.

# Parity Work Group: Medical Necessity

- No pre-emption of stronger State laws: Federal regulations regarding utilization review and definition of medical necessity should not pre-empt criteria defined in state statute that provides more benefit and consumer protections.
- Medical necessity should be based on local community standards and expert consensus opinion. Benefits and scope of services covered should be defined to include those necessary to sustain or maintain functioning when without the service the patient would deteriorate.

# Parity Work Group: Appeals and Independent Review

- To be effective, information about how to access internal member services or ombudsman assistance, appeals procedures and independent review must be made readily available to enrollees and easily accessible.

- The MHPAEA regulations must provide guidance and standards for appeals and independent review that provide no less consumer protections than those that would exist for other health services.

Thanks! What questions do you have?

202.684.7457, ext. 243

Alexae@thenationalcouncil.org

Ron.Brand@MACMHP.org

# Why parity?

- It's the right thing to do— treating equals, equally
- Modernizes out-of-date, discriminatory practices
- Shifts focus to "global cost" of covered lives and society
- Earlier intervention has potential to reduce burden of disability and social consequences
- Politically, citizens were ahead of lawmakers-overwhelming support for parity 'at the kitchen table'
- Takes advantage of ROI for newer medications, technology, and treatment methods
- 'Brainpower is fuel for the new economy'

# Implications of Parity for Providers

- Increased outpatient ‘volume’, competition, price pressure - less co-pays
- More coverage may decrease demands on ‘safety net' providers.
- Short-term, cost concerns may increase interest in carve-outs.
- Longer-term, potential for cost-offsets increases interest in integration of with both primary health care and chronic disease management.
- Package “public sector services” for private market—ACT, intensive case management, psycho-social- illness management; crisis services
- Package pricing may be attractive—predictable, comprehensive, effective
- Solutions: hospital follow-up; diversion; disease management/chronic care
- Services designed to assist overwhelmed primary care MD’s: consults, care mangm’t, referral protocols, registries, illness mangm’t.
- Consumer-friendly, low cost services, e-health, telehealth, etc.
- Services tailored to specific groups: dual eligibles; children in SCHIP
- EHR’s and registries to help manage continuity and total cost of care
- More federal standards, health record specs, data privacy, licensure, accreditation, service definitions and practice models

# Pre-emption Issues: Interactions between state and federal statutes and regulations

- Federal law/regs do not weaken stronger state-level parity that provides more consumer protections
- Which conditions/diagnoses are covered by Federal statute?
- What happens if state has MH parity, but have no or limited substance abuse requirements?
- In Federal law, plans determine which conditions are covered vs. some state laws specify certain diagnoses;
- What about national vs. state-level “community standards” for access, benefits, scope of Tx, provider credentials?

# State-Level concerns

- State advocates should monitor whether healthplans increase other efforts to control utilization & cost:
  - More rigorous utilization review procedures, criteria
  - Limited provider networks
  - Exclusions: (court-ordered, evidenced-based, experimental)
  - Provider credentialing & program certification standards
  - Tiered providers, tiered cost-sharing
  - Gatekeeper/ referral requirements that limit direct access
  - Other(s)
- Public sector issues: cost-shifting from private to public, Medicaid managed care, parity and carve-outs

# Roles for State Provider Associations

- Clarify state-level regulatory authority for parity:  Medicaid managed care, Insurance Commissioner, HMO's
- Monitor pre-emption issues and influence state implementation
- Allies and coalitions
- Anticipate **Opportunities** for community providers
- Anticipate **Threats** for community providers
- Monitor unintended consequences— big change is unpredictable
- Assist with provider "readiness" strategies: competition, service capacity, competence and quality
- Advocacy on interaction of parity and health reform agendas