Achieving the Promise of the Mental Health Parity and Addiction Equity Act

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The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, the Parity Act) ushered in a new era for health insurance coverage for mental health and substance use (mh/sud) disorders. The foundation for this was laid by the Mental Health Parity Act of 1996, and, significantly, the Patient Protection and Affordable Care Act (the ACA) that was passed in 2010 contains a number of provisions that expand the reach of the mental health parity requirements of MHPAEA through yet-to-be-established health plans .

These laws have the potential to create significant changes in the coverage for and medical management of individuals with mh/sud conditions. However, experience and research tell us that the requirements and potential of the law will not be fulfilled without our involvement. It is vital that we understand the law and target our intervention priorities based on that understanding.

The law and the regulations for its implementation are complex, and it is a difficult task to create practitioner and patient/consumer awareness of what is covered in them. Health plan provisions will likely flow from narrow rather than broad interpretations of the law's requirements. Federal and state authorities have limited resources for overseeing compliance and enforcement. The advocacy community clearly has its work cut out for it.

In brief, the Parity Act bars health plans from having separate cost sharing or treatment limits for covered mh/sud benefits than for medical and surgical (med/surg) benefits. The Act also prohibits a plan from imposing any financial or treatment limitations that are more restrictive than those in place for medical surgical benefits. These parity requirements apply to both in- and out-of-network benefits.

The Parity Act generally covers all insured or self-insured group health plans that offer medical and surgical as well as mh/sud benefits, and this includes plans where the mh/sud disorder benefits are managed by "carve-out" companies such as ValueOptions or Magellan.

It is important to understand that plans are not required to offer mh/sud coverage, and that plans offering these benefits may limit the range of disorders they do cover. However, insured health plans remain subject to state insurance and mental health parity laws in addition to the federal Parity Act requirements. The parity requirements also apply to Medicaid managed care plans and state CHIP programs. CMS has regrettably not yet issued definitive guidance to states to assure compliance with the Interim Final Rule (IFR) implementing the Parity Act.

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The IFR was issued on February 3, 2010, and the regulations became effective for health plan years beginning on or after July 1, 2010. The regulations are far reaching, including both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs), but since space precludes a complete analysis, our primary focus here is given to the provisions regarding:

- *NQTLs*
- *Scope of services*
- *Medical necessity and coverage criteria*

NQTLs

The regulations define treatment limitations to include both QTLs and non-quantitative limitations (NQTLs). The NQTL provision is critical. An NQTL is a limitation that, while not expressed numerically, otherwise limits the scope or duration of benefits for treatment under the plan. The regulations include the following as illustrations of NQTLs:

- *Standards for provider admission to participate in a network, including reimbursement rates;*
- *Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;*
- *Plan methods for determining usual, customary, and reasonable charges; and*
- *Refusal to pay for higher cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first or step therapy protocols).*

It is highly significant that the regulations have identified these non-quantitative elements as parity issues. It is clear this creates the potential for redressing many existing health plan practices that are discriminatory.

Despite the advent of these parity regulations, we have witnessed a number of health plans instituting new non-quantitative requirements that limit access to mental health and substance use disorder services.

The IFR sets forth a special test for determining whether an NQTL is acceptable, but at this point there is still ambiguity about how this test will be applied. The implications of this for bringing health plan practices into alignment with the parity regulations are discussed more fully below.

Scope of Services

Respecting scope of services, the IFR establishes a classification of benefits scheme that includes inpatient and outpatient care, both in-network and out-of-network; as well as emergency care and prescription drugs. A plan that provides mh/sud must provide those benefits in every classification in which it provides medical/surgical benefits.

The regulations, however, are silent on the scope of services a plan must provide within each classification and how comparable they must be to the scope offered for med/surg benefits within the same classification. The regulators have made it

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clear that this will not be addressed until the final regulations are issued in the future. This has presented a number of problems for mh/sud services coverage. As the rule currently stands, a plan may offer just one service within a classification and still be in compliance. For example, for psychiatric inpatient care, it can offer care only in a general hospital and no other settings or levels of care. Some health plans have dropped specialty hospital care and residential care because there is no medically analogous service. Similarly, many plans have dropped partial hospitalization coverage, stating that because there is no medically analogous service, the Parity Act does not require them to cover this. These developments are alarming, and proper resolution of this "scope" issue will require considerable work by the advocacy community. Without satisfactory resolution , the parity requirement could result in some adverse, unanticipated consequences for the delivery of mental health care.

Medical Necessity and Coverage Criteria

The regulations require that the criteria for medical necessity determinations made under the plan for mh/sud benefits be made available to any current or potential participant, beneficiary, or contracting provider upon request. It is important to note that medical necessity determinations are NQTLs and are subject to the regulations' comparability test. It is critical to be able to compare the criteria for denial of mh/sud services with the criteria used for med/surg services.

While the reason for any specific denial of reimbursement or payment for mh/sud services must be made available by the plan upon request, it will be critical to determine if these denials, in fact, meet the NQTL test. Discovery, review, and analysis of discriminatory medical review issues will be essential.

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