



Background Information with Questions & Answers regarding the Parity Regulations

March 10, 2010

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Background to Parity Regulations

- ◆ The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act (MHPAEA) became public law 110-343 in October 2008.
- ◆ Key legislative champions included Reps. Patrick Kennedy (D-R.I.) and Jim Ramstad (R-Min.) and Sens. Edward Kennedy (D- Mass.), Pete Domenici (R-N.H.), Michael Enzi (R-WY.) and Chris Dodd (D-Conn.).
- ◆ The essence of MHPAEA is that it prohibits group health plans that currently offer coverage for drug and alcohol addiction and mental illnesses from providing those benefits in a more restrictive way than other medical and surgical procedures covered by the plan.
- ◆ The three federal agencies with jurisdiction over this legislation are: The Department of Health & Human Services; The Department of Labor and the Department of Treasury. These three agencies requested comments from interested parties in the spring of 2009. NAATP and over 400 other interested parties submitted comments.
- ◆ On February 2, 2010, the three agencies issued an “interim final rule” on MHPAEA. Public comments on these regulations will be accepted until May 3, 2010. The interim final rule itself is legally binding for health plan years after July 1, 2010. A copy of the regulations can be found at: <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>

Highlights of Federal Parity Regulations

- ◆ Within the “interim final rule” the Departments released guidance including a preamble discussion that defines certain terms and explains how the rule was formulated; the rule also includes numerous specific examples of practices that would and would not meet the requirements of the MHPAEA statute and regulations.
- ◆ The Departments state that they expect the MHPAEA to affect approximately:
 - 111 million participants in 446,400 ERISA – covered group health plans
 - 29 million participants in the estimated 20,300 public, non-federal employer group health plans sponsored by State and local governments
 - 460 health insurance issuers providing substance use disorder (SUD) or mental health (MH) benefits in the group health insurance market
 - 120 Managed Behavioral Healthcare Organizations (MBHO’s) providing SUD or MH benefits to group health plans.
- ◆ Medicaid Managed care plans offering SUD/MH benefits are also covered by the MHPAEA. However, these regulations do not apply to such plans. The Centers for Medicare and Medicaid Services (CMS) will issue separate guidance at a latter date.

Questions submitted by NAATP Member Organizations concerning the Interim Final Rule for MHPAEA

Will state laws be preempted or usurped by MHPAEA?

The regulations affirm that MHPAEA does not preempt any State laws. The guidance provided in the regulations states that the Departments tried to “balance the States interests in regulating health insurance issues, and Congress’ intent to provide uniform minimum protections to consumers in every State. The regulations also state “State insurance laws that are more stringent than the federal requirements are unlikely to ‘prevent the application of the MHPAEA,’ and be preempted. States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the federal law.” Therefore MHPAEA has become the “floor” in terms of regulations.

A state may mandate inclusion of specific benefits to be included in any policy written in that state or it may mandate a specific level of service available to all beneficiaries; that policy does not prevent the implementation of MHPAEA.

Can insurance plans be exempted from MHPAEA?

There are two types of exemptions:

1. Employers who average 50 or fewer employees on business days during the previous calendar year are exempt from the regulations of MHPAEA. **They must comply with state laws!**
2. There are two cost exemptions to protect health plans from rapid cost increases. The first says that if a plan’s costs rise 2% in the first year after implementation of MHPAEA because of increased SUD/MH costs, it may apply for a one-year exemption. The second says that if a plan’s costs ever rise 1% in one year because of SUD/MH costs, it may have a one year exemption. In both cases, after the one-year exemption the plans must re-institute MHPAEA for at least one year. At the most, plans can only claim exemptions in alternating years!

For practical reasons, it is unlikely that cost exemptions will be a common practice.

Is Scope of Services defined in the Regulations?

The regulations **do not** define a scope of services or continuum of care for SUD or MH benefits; the regulations indicate that group health plans can define which services are covered in SUD and MH benefit packages; those definitions must be consistent with “generally recognized independent standards of current medical practice” which include the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases and State guidelines.

The regulations **do not** define what constitutes inpatient, outpatient or emergency care but leave it up to the health plans and State health insurance laws to define those terms; the regulations do require group health plans to apply these terms uniformly for medical/surgical benefits and SUD and/or MH benefits.

The regulations do acknowledge that not all treatments and treatment settings for SUD/MH correspond with medical/surgical ones.

What is the role of EAP as defined by the Regulations?

- ◆ The comments that the Departments received raised questions regarding whether the MHPAEA requirements apply to the practice of requiring an individual, in order to access his/her SUD or MH benefits, to first exhaust a set number of SUD or MH counseling sessions offered through an EAP program.
- ◆ The regulations do explicitly state that “requiring participants to exhaust the EAP benefits –making the EAP a gatekeeper- before an individual is eligible for the program’s SUD or MH benefits would be considered a non-quantitative treatment limitation” that would be subject to the below discussed parity analysis to determine compliance with MHPAEA.
- ◆ The regulations also state that if other gate keeping processes with similar exhaustion requirements, whether offered through an EAP or not, are not applied to medical/surgical benefits, the exhaustion requirement related to EAP’s would violate the rule that non-quantitative treatment limitations be applied comparably and not more stringently to SUD and MH benefits.

How do you determine whether Financial Requirements and Treatment Limitations imposed on SUD and MH benefits comply with the MHPAEA?

- ◆ The MHPAEA statute prohibits group health plans/insurers offering SUD or MH benefits from applying financial requirements or treatment limitations to SUD or MH benefits that are more restrictive than the *predominant* financial requirements or treatment limitations applied to *substantially all* medical/surgical benefits.
- ◆ According to the regulations, a financial requirement or treatment limitation applies to “substantially all” medical/surgical benefits if it applies to at least *two-thirds* of the benefits, based on the dollar amount of all plan payments expected in the coming year. If a plan reduces a financial requirement to \$0 or offers an unlimited quantitative treatment limitation, then those benefits are not included in calculating whether a given requirement applies to two-thirds of benefits in a classification.
- ◆ If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of medical/surgical benefits in a classification, that type of requirement or limitation cannot be applied to SUD/MH benefits in that classification.
- ◆ **Example A.** A plan with estimated benefits payment of \$1 million expects \$800,000 of benefits to be subject to copayments. This represents 80% of the plans benefits costs, which is greater than the two-thirds requirement. Therefore copayments apply to “substantially all” of the plans benefits and can be applied to SUD/MH benefits.
- ◆ **Example B.** For in-network, outpatient visits for baby care, a plan reduces its normal copayment of \$15 to \$10. This benefit is not included in calculating whether two-thirds of in-network, outpatient benefits are subject to co pay.

What types of insurance practices must be at parity?

The regulations define three main insurance practices to which parity applies:

- ◆ **Financial requirements:** including deductibles, copayments, coinsurance, and out-of-pocket maximums.
- ◆ **Quantitative treatment limitations:** limitations that can be expressed numerically, such as day or visit limits or frequency of treatment limits.
- ◆ **Non-quantitative treatment limitations:** limitations that cannot be expressed numerically but nevertheless limit the treatment benefit, including medical management standards, standards for provider admission to participate in network, determination for usual customary, and reasonable reimbursements, fail-first policies, and conditioning benefit delivery on completion of a course of treatment.

In general, health plans must provide SUD/MH benefits that are at parity with medical/surgical benefits for each of these three types of benefits.

How are Classification of Benefits defined?

Parity analysis must compare financial requirements/treatment limitations imposed on SUD or MH benefits with same type imposed on Medical/Surgical benefits in the same classification:

- ◆ The rule first identifies six categories of classification of benefits
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drugs
- ◆ The regulations specifies that when examining whether SUD or MH benefits are being offered at parity with other medical/surgical benefits, a financial requirement or treatment limitation must be compared only to financial requirements or treatment limitations of the same type with in the same classification.
- ◆ This review must take place separately (i.e. copayments must be compared with copayments, annual visit limits with annual visit limits) within each above listed classification.
- ◆ The regulations do not define inpatient, outpatient, or emergency care, and they may differ depending on a specific plan's design; however, plans must apply their terms uniformly for medical/surgical and SUD/MH benefits.
- ◆ If a plan provides outpatient, in-network addiction treatment benefits but not outpatient, out-of-network benefits, yet does provide outpatient, out-of-network benefits for medical/surgical conditions, then the plan is in violation of the regulations. It must provide SUD/MH benefits in all the categories in which medical/surgical benefits are offered.

How will parity in deductibles and out-of-pocket costs be calculated?

This area represents a major departure from prior practice!

Deductibles generally function by requiring that certain threshold of expenses must be paid by the beneficiary before the insurance plan will pay for benefits. Many insurance companies recommended allowing separate deductibles for medical/surgical and SUD/MH, as long as the deductible was equivalent. However, the regulation writers decided that this was against the spirit of the MHPAEA, and instead require that deductibles in any *classification of benefits* apply to both medical/surgical and SUD/MH. This will make it significantly easier for many people, especially those with co-occurring medical and addiction treatment needs, to access benefits. However, this will make it more difficult for insurance plans to integrate their records, especially in a *carve out* plan.

The same procedure applies to other cumulative financial requirements, including out-of-pocket maximums.

Example: If there is a \$500 deductible for inpatient, in-network, medical/surgical benefits, then there cannot simultaneously be a separate \$500 deductible for inpatient, in-network SUD/MH benefits. There can, however, be a single \$500 deductible that applies to all inpatient, in-network benefits.

How does parity apply to non-quantitative benefits?

Any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitations for SUD/MH benefits must be comparable to, and no more stringent than, those used in applying limitations on medical/surgical benefits. Variations are allowed only insofar as widely recognized, clinically appropriate standards of care permit a difference. This is true both of the plan as written and as it actually operates.

- ◆ A claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve medical/surgical benefits while denying SUD/MH benefits, and there are no recognized clinical standards of care to justify such a difference, then the process used to apply medical necessity criteria is being applied more stringently to SUD/MH benefits than medical/surgical ones. This violates MHPAEA.
- ◆ A plan requires prior approval that a course of treatment is medically necessary for all outpatient, in-network services. For SUD/MH treatment that did not receive prior approval benefits are paid. For medical/surgical services without prior approval, the plan pays 75% of the normal rate. This violates parity, even though, the same non-quantitative treatment limitation- medical necessity- is in effect. The penalty for failure to demonstrate medical necessity is not equivalent between SUD/MH and medical surgical services.
- ◆ A plan limits benefits to treatment that is medically necessary. The plan requires concurrent review of SUD/MH services delivered on an inpatient, in-network basis. It has no equivalent requirement for medical/surgical benefits, performing retrospective reviews instead. This violates parity because it does not apply the concurrent and retrospective review policies equivalently between SUD/MH and medical/surgical services.

How will medical management occur under parity?

Common medical management practices include preauthorization, concurrent review, retrospective review, case management, and utilization review. All of these are allowable under the MHPAEA, provided they are not applied in ways that create greater financial requirements or treatment limitations for SUD/MH benefits.

Will there be new transparency requirements for insurance plans?

Yes. The MHPAEA requires that plans disclose the reason (medical necessity criteria) for any denial of reimbursement for SUD/MH services *upon request* by the plan beneficiary or provider organization. These disclosures must be provided automatically and free of charges, in accordance with existing ERISA claims procedure regulations.

What are the penalties for non-compliance?

Plans are expected to exercise “good faith” as they implement parity in 2010, given that regulatory guidance was not available as plans were being written. However, once these regulations go into effect for plans starting after July 1, 2010 (effectively January 1, 2011 in most cases), there is a \$100 penalty for each day of violation. There is also the possibility of penalties under ERISA and personal lawsuits to recover benefits.

How much will it cost insurance plans to implement parity?

Including the start-up costs and annual maintenance, the regulation writers estimate that parity implementation will cost \$115 million over 10 years.

Because MBHO carve-out and medical/surgical plans will have to share more information to properly administer benefits at parity (for example, by counting all SUD/MH and medical/surgical payments towards a single deductible), the regulation writers estimate that it will cost \$39.2 million to develop the interfaces necessary for this information-sharing and \$3.9 million per year to maintain them. Given that 70 million people are covered by MBHO’s this works out to \$0.06 per beneficiary for the set-up cost and less than \$0.01 per beneficiary, per year for maintenance.

Compliance review to ensure that plans are not violating parity is estimated to cost \$27.8 million in the first year.

Medical necessity disclosures are estimated to cost about \$1 million annually.

The regulation writers estimate that MHPAEA will cause insurance premiums to rise by about 0.4%. This is equivalent to \$25.6 billion over ten years.

Some Observations, Comments and Implications which may impact Operations?

1. One of the immediate observations is that the regulations do not use the term “benefit package”. This term has been used in the past to suggest that there were several distinct benefit components which together make up the “package”. The language used in the regulations is consistent – group health plan. The regulations apply to each combination of medical/surgical coverage and substance use disorder and mental health coverage that any participant (or beneficiary) can simultaneously receive from an employer’s or employee organization’s arrangement or arrangements to provide medical care benefits and all such combinations constitute a single group health plan for the purposes of parity requirements. *It will not be possible to “carve out” the SUD and MH benefits and treat it as a separate benefit plan. The parity regulations will force greater interaction between medical/surgical benefits and SUD and MH benefits.*
2. Plans and payers cannot use EAP as the gatekeeper to SUD/MH benefits since the EAP does not serve in that capacity for all other medical and surgical conditions. This will necessarily change the relationship that many providers have had with EAP organizations. It will be important *for providers to communicate directly with plan and payer provider relations and network administrators to better understand this new process.*
3. Because the implementation of the parity regulations is dependent on understanding the practices applied to medical/surgical benefits, it will become critical for providers to completely understand the language and practice as applied to medical/surgical benefits. Providers seeking to join networks will want to take this opportunity to update their credentials, understand how Usual, Customary and Reasonable rates are determined locally.
4. *“Generally recognized independent standards of current medical practice”* is language in the regulations which has the potential to be a roadblock for SUD providers. Such providers will need to advocate for the inclusion of their own relevant standards in discussion with commercial and employer based plans.
5. It will be important for providers to familiarize plans and payers with their treatment, services, methodologies and evaluation of services processes.

Challenges and Questions that remain

1. The regulations do not define scope of services. Providers will need to monitor the activities by plans and employers as they determine which diagnoses, conditions and disorders to cover and which treatment services to extend benefits to.
2. The regulations do not define levels of care, provider types of service levels beyond some general descriptions. The regulations are also silent on access thresholds or information on clinically appropriate continuum of care. The Departments responsible for the regulations do encourage comments from provider organizations about “*whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage*”.
3. The ambiguity around of scope of services only adds to the complexity of implementation of the regulations as there will not always be an analogous medical or surgical benefit from which to gauge parity.
4. The regulations make it clear that medical management tools may be used to manage benefits, but prohibit their more stringent application in the review of MH/SUD benefits. However through the use of the term “*generally accepted medical criteria*” they leave room for interpretation that will result in conflicting practices as competing plans in a single state may issue very different criteria. **Establishing professional and facility standards such as credentialing is left to the States and health plans where variability already exists.**