ABOUT THE PARITY LAW AND REGULATIONS

The Paul Wellstone and Pete Domenici
Mental Health Parity and Addiction Equity Act
As of May 2011

THE FEDERAL PARITY LAW
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was signed into law on October 3, 2008, as part of the Emergency Economic Stabilization Bill. This landmark legislation became effective, basically, January 1, 2010.

Key Provisions
• Applies to 113 million employed Americans, including individuals in ERISA plans (self-insured companies)
• Requires equity in financial requirements
• Requires equity in treatment limits
• Requires out-of-network mental health and addiction parity coverage if out-of-network coverage is offered by the health plan for medical/surgical benefits
• Requires health plans to make available criteria for medical necessity determinations to any participant or contracting provider upon request
• Explicitly permits medical management of health benefits
• Does not mandate mental health benefits
• Exempts certain businesses
  o With 50 or fewer employees
  o Posting an overall cost increase due to parity requirements (2%+ in first year; 1% in subsequent years)
  o Exemption only lasts one year; need to reapply the following year (or comply)
• Does not preempt stronger state parity laws
• Requires the Government Accountability Office to conduct a study on the mental health and addiction parity requirements

PARITY REGULATIONS (Interim Final Rule)

Key Provisions
• Three agencies have responsibility for parity implementation and enforcement:
  o U.S. Department of Health and Human Services
  o U.S. Treasury Department
  o U.S. Labor Department
• The regulation basically went into effect for all health plans on January 1, 2011.
Definitions
• The regulations specifically define:
  o predominant (generally greater than half) and
  o substantially all (at least two-thirds of the benefits).
• To comply with the law, a health plan cannot impose, for example, a treatment limit on inpatient psychiatric care unless they apply a treatment limit on two-thirds of inpatient medical/surgical benefits.
• If health plans have different treatment limits on different inpatient services for medical/surgical services, then a second step would be needed.
  o They would have to determine the “predominant” treatment limit (more than 50%) and then that would be the comparison used for the inpatient psychiatric inpatient treatment limit.

Treatment Limitations
• The regulations go further with respect to treatment limitations. The regulations define treatment limitations as:
  o Quantitative treatment limits (QTLs):
    ▪ Are numerical (e.g. 30 inpatient days)
  o Non-quantitative treatment limitations (NQTLs):
    ▪ Are such things as (NOTE: This list is not exhaustive):
      • medical management standards, including standards for admission to participate in a network;
      • determination of usual, customary, and reasonable charges, requirement for using lower cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols), conditioning benefits on the completion of a course of treatment.

Comparison of Medical/Surgical and Psychiatric Benefits
• Plans are only permitted to compare medical/surgical and mental health benefits for purposes of applying parity requirements using six specified categories:
  1. inpatient, in-network
  2. inpatient, out-of-network
  3. outpatient in-network
  4. outpatient out of network
  5. emergency care
  6. prescription drugs
• An issue that is not yet 100% clear (until final regulations are written): Within each category, how does parity apply? For example, if inpatient medical/surgical benefits cover hospital, rehab, and SNF, do you need similar levels of care on the mental health side? The Parity Implementation Coalition interpretation is that you would, but final regulations will likely clarify this issue.

One Combined Deductible
• The regulations require health plans to have one combined deductible for mental health and medical/surgical services.
  o You could not have a separate but equal deductible for mental health and one for med/surg. This is an important step towards integration. Also most people who have a mental disorder will also have medical issues; having one combined deductible will be more cost-effective for the individual.

Disclosure Requirements
• Two new disclosure requirements are included in the interim final rule:
  o Criteria for medical necessity determinations must be made available upon request to any beneficiary or contracting providers.
  o Health plans are required to disclose the reason for any denial of service upon request of the beneficiary.
**NEXT STEP: FINAL PARITY REGULATIONS (TO COME)**

The Departments of Labor, Treasury, and Health and Human Services are reviewing comments submitted following publication of the interim final rule, with the intent of – at some point – issuing a final regulation to clarify gray areas not addressed in either the law or interim final rule. Some of the areas that the Parity Implementation Coalition and NAPHS have asked for clarity on include the following:

**Exception to NQTLs**
- An exception to the non-quantitative treatment limitations is if there is a “recognized clinically appropriate standard of care” that would permit a difference in how a health plan managed the benefit, for example.
  - The NAPHS recommendation: It needs to be an independent process, not something done internally by the health plan.

**Scope of Services**
- While the regulations set up six classifications, the interim final rule also states that it does not address scope of services. The agencies do not specify a list of mental health services that would be compared to medical/surgical services.
  - The NAPHS recommendation: It is our view that the law is clear on scope of treatment, so arbitrary exclusion of a level of care (RTC) would potentially be a violation.

**Non-quantitative Treatment Limits**
- What is the parity standard for comparison? The regulations establish a standard of comparable / no more stringent to judge whether an NQTL can be applied to mental health and substance use disorder benefits. However, final regulations will need to further clarify this standard.
  - The NAPHS interpretation: It is our view that if an NQTL is applied only to a small portion of the medical/surgical benefit, it cannot be applied to the entire mental health/substance use benefit. Also, even if a medical/surgical NQTL is comparable, we believe it would be out of compliance with the regulatory standard if it is applied more stringently to mental health/substance use disorder benefits.