

# **Mental Health Parity—Are You Ready?**

April 2010



# 1996 Mental Health Parity Act

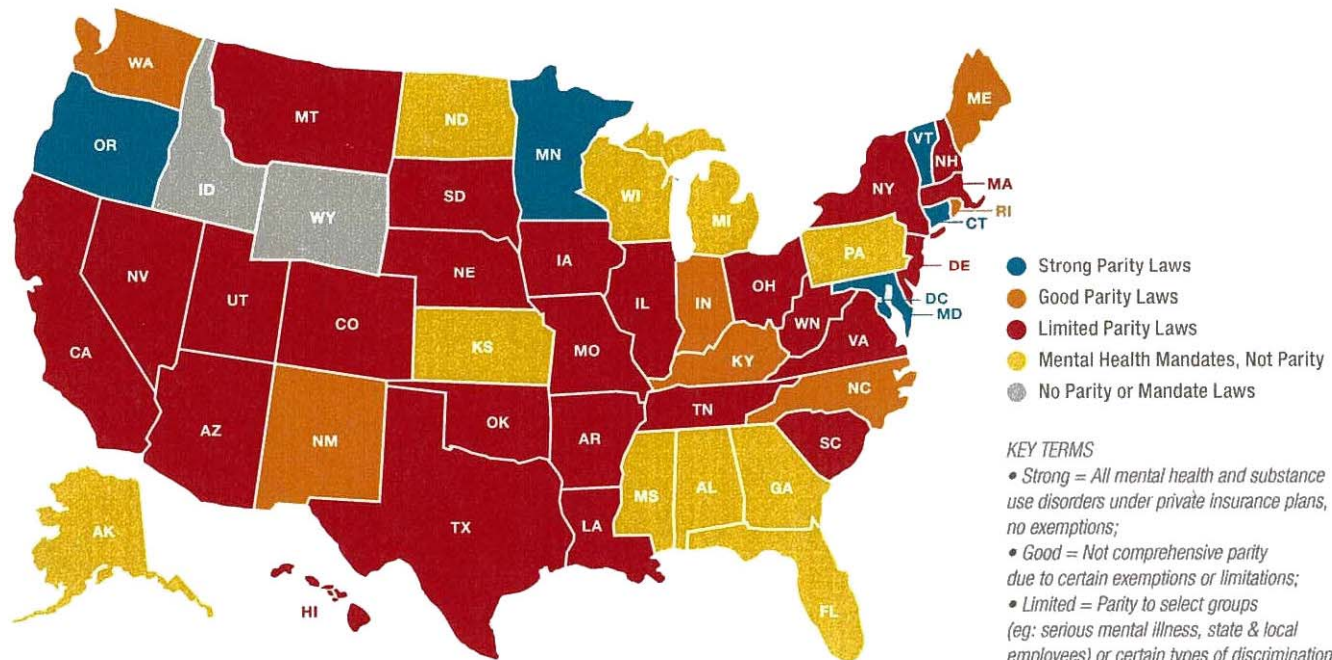
- Limited in scope
- Did not compel insurers to provide any mental health benefits
- Parity only required for annual/lifetime dollar limits on coverage
- Plans still able to impose more restrictive limitations and cost sharing requirements



# State Mental Health Parity Laws

NATIONAL COUNCIL  
FOR COMMUNITY BEHAVIORAL HEALTHCARE

PARITY AND MANDATE LAWS IN THE U.S.



# Mental Health Parity and Addiction Equity Act of 2008

- Applies to any group health plan of 50 or more employees that currently provides both medical/surgical *and* mental health and substance abuse disorder benefits.
- Main purpose: to ensure that financial requirements and treatment limitations are no more restrictive than those applied to med/surg benefits.
- Effective: January 1, 2010



# What financial changes will occur?

- There may be no separate cost-sharing requirements for MH/SA:
  - No separate deductibles
  - No separate co-payments
  - No separate coinsurance
  - No separate out-of-pocket expenses



# What treatment changes will occur?

- There may be *no* separate treatment limitations for MH/SA including:
  - Limits on the frequency of treatment
  - Limits on number of hospital days
  - Limits on number of visits
  - Limits on days of coverage
- If medical plan has out-of-network coverage, the MH/SA plan must also



## Other Changes-Transparency

- Criteria for medical necessity determinations must be made available to any current or potential participant, beneficiary, or contracted provider
- Reasons for denials of treatment shall be made available to the participant or beneficiary



# What will it cost employers?

- Depends on benefit plan/level of coverage
- Unmanaged vs. managed behavioral health plan
- Congressional Budget Office estimated utilization increases:

Facility based services      9.7%

Professional services      30.0%

(this will be offset by an est. 18% decrease to PCPs)



## What will it cost employers?

- Milliman, Inc. projects 0.6% increase in baseline costs for unmanaged plans
- Managed plans will see a similar increase but still cost 25-50% less than unmanaged plans



## Cost Exception

- If plan results in an increase of greater than 2% of *total* plan costs (first year), an exception may be applied for.
- Must be certified by a qualified and licensed actuary
- Must keep records available for inspection for 6 years
- Other regulatory requirements



# Guidance Issued 02/2010

- Addresses three specific areas:
- Aggregated lifetime and annual dollar limits
- Financial requirements and quantitative treatment limitations
- Non-quantitative treatment limitations



# Timeline

- MHPAEA effective for plan start date after 10/3/2009
- Regs issued 2/2/2010
- Become effective 4/5/2010
- Apply to group health plans for plan years beginning after 7/1/2010
- Collective bargaining units still have exemption until agreement expires



# Financial Requirements and Quantitative Treatment Limits

- The regs state that if a plan imposes any separate *type* or separate *levels* of financial requirement or treatment limitation for benefits in a classification, the parity rules apply separately to each classification for all financial requirements or treatment limitations.



# Six Identified Benefit Classifications:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescriptions drugs



# Rules include “Coverage Units”

- If the plan applies different levels of financial requirements to different coverage units, the predominant level that applies to substantially all med/surg benefits in that classification must be determined separately for each unit.
- Single, Single + One, Family, etc.



# How to Apply the Rules

- If a plan provides MH/SA benefits in *any* classification, it must provide them in *every* classification offered by the med/surg plan.
- Plans cannot limit MH/SA benefits to in-network only if out-of-network benefits are offered by the med/surg plan.



# Clarification on “Predominant” and “Substantially All”

- MHPAEA prohibits plans from applying any financial requirement or treatment limitation that is more restrictive than the “predominant” financial requirement or treatment limitation that is imposed on “substantially all” med/surg benefits in the same classification.
- Plans can apply financial requirements or treatment limitations to MH/SA benefit in a classification only if at least 2/3 of projected plan payments for med/surg in that classification are subject to the same. “Substantially all” interpreted to mean 2/3 or greater.
- “Predominant” interpreted to mean that it applies to more than 1/2 of the med/surg benefits in that classification.



# Example 1

- Med/Surg outpatient/in-network plan:
- \$20 copay for office visits
- 20% coinsurance on lab work
- Plan calculates that 75% of the plan payments for med/surg benefits are subject to copays and 25% coinsurance.
- Result: 2/3 threshold is met for copays so \$20 copay may be applied to MH/SA office visits; 2/3 threshold not met for coinsurance, so lab work would have to be subject to copay or have no type of cost sharing.



# Potential Effects

- Since some plans use multiple types of financial requirements in a classification, if the 2/3 threshold cannot be met, it is possible that no cost sharing can be applied for any MH/SA benefit in that classification.



## Example 2

- Plan has outpatient, in-network copays of \$20 for PCP and \$30 for specialist.
- Plan determines that 75% of the plan payments are subject to the \$20 copay, 25% subject to the \$30 copay.



# Potential Effect

- The plan must adopt the \$20 copay for MH/SA services because it is the “predominant” plan payment and satisfies the “substantially all” (2/3 of plan payments) requirement.
- Note: many mental health plans currently apply the specialist copay for MH/SA benefits; this will have to change if it does not meet the above requirements.



**What if no single level of financial requirement or treatment limitation applies to more than 1/2 of the plan payments in a classification?**

- The plan can combine levels to satisfy the more than 1/2 requirement and apply the least restrictive level in that requirement.
- Ex: \$10 copay-preventive 15%
- \$20 copay PCP 45%
- \$30 copay-specialist 40%
- Combine the second two levels = 85%; \$20 copay would be predominant



# Prescription Drug Benefits

- Tiered payments can only be based on “reasonable” factors and must be applied equally to MH/SA and med/surg benefits.
- Factors can include:
  - Cost
  - Efficacy
  - Generic vs. Brand
  - Mail Order vs. Pharmacy



# Effect on Employee Assistance Programs

- EAP cannot be used as a gatekeeper to MH/SA benefits
- If EAP is implemented in lieu of providing MH/SA benefits, then parity regs may apply to the EAP benefits



## Covered Conditions

- Comptroller General to conduct a 3 year study to analyze rates, patterns and trends in coverage and exclusions to Congress for further consideration.
- Departments of Labor, HHS, and the Treasury working together to solicit additional comments and possibly issue additional guidance.



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