

MHPAEA: Status Update and Review

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Purpose

- Status of parity implementation
- Interim Final Rule (IFR)
- APA Advocacy Activities
- Q&A protocols

Overview

- Review key parity statute provisions
- Review interim final parity regulations
- Discuss application of regulations
- Reporting, compliance, and enforcement
- APA parity implementation advocacy

MHPAEA – the Statute

Integrated text for US Code 29 USC Section 1185A Parity in application of certain limits to mental health benefits is posted on www.mentalhealthparitywatch.org.

- **Effective date (October 03, 2009)**
- **Entities covered**
 - ERISA and health insurance
 - Average of 51 or more full-time employees
 - State/local government plans
 - Medicaid MC, SCHIP, FEHBP
- **Extends parity to substance use disorders (SUD)**

MHPAEA (continued)

- **Not a coverage mandate – can cover either or both or none**
 - State law may affect choice
 - ERISA plans: insured or self-funded



MHPAEA (continued)

Primary requirements when coverage provided:

- Applicable financial requirements (FRs) and treatment limitations (TLs) can be no more restrictive than the predominant FR or TL applied to substantially all medical and surgical benefits
- No separate FRs or TLs applicable only with respect to MH or SUD benefits

MHPAEA (continued)

- **Preemption**

- The preemption provisions of section 731 of ERISA and section 2723 of the PHS Act added by HIPAA (1996) and implemented in 29 CFR 2590.73(a) and 45 CFR 146.143(a) apply so that the MHPAEA requirements are not to be

“construed to supersede any provisions of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard of requirement prevents the application of a requirement” [of MHPAEA.]



MHPAEA (continued)

Medical necessity criteria disclosure and claim denials

The criteria for medical necessity determinations made under the plan with respect to MH or SUD benefits. . . shall be made available by the plan administrator. . . in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request.

The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to MH or SUD benefits in the case of any participant or beneficiary shall, on request or as otherwise required, be made available by the plan administrator . . . to the participant or beneficiary in accordance with regulations.

MHPAEA (continued)

Out-of-Network benefits

In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network (OON) providers, the plan or coverage shall provide coverage for MH or SUD benefits provided by OON providers in a manner that is consistent with the requirements of this section.

MHPAEA (continued)

Cost Exemption

- (i) 2 percent in the case of the first plan year in which this section is applied; and
- (ii) 1 percent in the case of each subsequent plan year.

Required Reports

The Comptroller General of the United States (GAO) shall conduct a study that analyzes the specific rates, patterns, and trends in coverage and exclusion of specific mental health and substance use disorder diagnoses by health plans and health insurance.

MHPAEA Interim Final Rule [IFR]

[Federal Register /Vol. 75, No. 21/ Tues, 2.2.1010 Rules and Regs posted on <http://www.mentalhealthparitywatch.org>]

Key regulatory terms

- **Effective date:**
 - These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010.
- **MH/SUD benefits:**
 - means benefits with respect to services for MH [for SUD conditions], as defined under the terms of the plan and in accordance with applicable Federal and State law.
 - Any condition defined by the plan as being or as not being a mental health condition [a substance use disorder] must be defined to be consistent with generally recognized independent standards of current medical practice.



MHPAEA Interim Final Rule Key Regulatory Terms (continued)

Classification of Benefits

- Six classes of benefits used
 - Inpatient, in-network
 - Inpatient, out-of-network
 - Outpatient, in-network
 - Outpatient, out-of-network
 - Emergency care
 - Prescription drugs

These regulations do not define inpatient, outpatient, or emergency care. These terms are subject to plan design and their meaning may differ from plan to plan. Additionally, State health insurance laws may define these terms.



IFR Key Regulatory Terms (continued)

- **Six class coverage rule**

If a plan provides MH or SUD benefits in any classification of benefits described in (c)(2)(ii), MH or SUD benefits must be provided in every classification in which medical/surgical benefits are provided.



IFR Key Regulatory Terms (continued)

Out of Network (OON) Rule

- a plan (or health insurance coverage) that provides MH or SUD benefits in any classification of benefits must provide MH or SUD benefits in every classification in which med /surg benefits are provided, including OON classifications.

IFR Key Regulatory Terms (continued)

- **Financial requirements (FRs)**
 - include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar amounts.
- **Treatment limitations (TLs)**
 - include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period or other similar limits on the scope or duration of treatment. TLs include both quantitative treatment limitations (QTLs), which are expressed numerically and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under the plan.

IFR Key Regulatory Terms (continued)

Substantially all rule

A type of FR or QTL is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification.

Predominant rule

- If a type of FR or QTL applies to at least two-thirds of all medical/surgical benefits in a classification, the level of the FR or QTL that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation.

IFR Key Regulatory Terms (continued)

The NQTL rule

- A group health plan may not impose an NQTL with respect to MH or SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL limitation to MH or SUD benefits in the classification are comparable to, and are applied no more stringently than [those] used in applying the limitation with respect to med/surg benefits in the classification.
- Exception: to the extent that recognized clinically appropriate standards of care may permit a difference.

IFR Key Regulatory Terms (continued)

NQTLs include (but are not limited to)

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary, and reasonable charges;
- 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 policies or step therapy protocols); and
- Exclusions based on failure to complete a course of treatment.

Potential Parity Reimbursement Issues

- Rate calculation methods for psych/SUD in- or outpatient, in/out-of-network which differ from those for med/surg.
- Contractual fee schedules for physicians which include automatic inflation adjustments but not for psych/SUD fee schedules.
- All physicians except psych/SUD are allowed to bill any CPT E/M code (99xxx). Psych/SUD physicians are usually limited to the psychiatry codes (908xx).
- Psych/SUD physicians are paid a flat fee regardless of the code billed—e.g., 90804, 90805, and 90862 are all paid at \$100 despite varying relative value units (RVUs) assigned to these codes. All other physicians are paid differentially, and the payments reflect the RVUs assigned to the various codes.



IFR Key Regulatory Terms

- **Special rule for multi-tiered prescription drug benefits**
 - If a plan applies different levels of FRs to different tiers of prescription drug benefits based on reasonable factors relating to requirements for NQTLs and without regard to whether a drug is generally prescribed with respect to med/surg benefits or with respect to MH or SUD benefits, the plan satisfies the parity requirements with respect to prescription drug benefits.
 - Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

IFR Key Regulatory Terms (continued)

- **Cumulative FRs and TLs**

A cumulative FR is a financial requirement that typically operates as a threshold amount that, once satisfied, will determine whether, or to what extent, benefits are provided.

- aggregate lifetime and annual dollar limits are excluded from being cumulative financial requirements (because the statutory term financial requirements excludes aggregate lifetime and annual dollar limits)

A cumulative QTL is defined as a treatment limitation that will determine whether, or to what extent, benefits are provided based on an accumulated amount.

- **Deductibles**

For purposes of deductibles, the dollar amount of plan payments includes all payments with respect to claims that would be subject to the deductible if it had not been satisfied.



IFR Key Regulatory Terms (continued)

- **Out-of-pocket Maximum**

For purposes of out-of-pocket maximums, the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that were taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.

- **Preemption**

A State law that mandates that an issuer offer a minimum dollar amount of mental health or substance use disorder benefits does not prevent the application of MHPAEA. Nevertheless, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.

IFR Key Regulatory Terms (continued)

- **Medical Necessity Disclosure**

The first disclosure requires plan administrators to make the plan's medical necessity determination criteria available upon request to potential participants, beneficiaries, or contracting providers.

No definition of medical necessity criteria is provided by the IFR.

- **Claims Denial Disclosure**

The reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to MH or SUD benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator . . . to the participant or beneficiary. The Department of Labor's ERISA claims procedure regulation requires, among other things, such disclosures to be provided automatically to participants and beneficiaries free of charge.

Non-ERISA covered plans subject to the PHS Act are not required to comply with the ERISA claims procedure regulation, these regulations provide that such plans . . . will be deemed to satisfy the MHPAEA claims denial disclosure requirement if they comply with the ERISA claims procedure regulation.



Apply the Rules: Illustrations

Illustration A: Plan does not cover residential treatment nor partial hospitalization because “they are not covered on the medical surgical side either.” That is, Plan says it is not required to cover because no medically analogous service.

Issue: Scope of services required to be covered within a classification. This issue is not fully resolved. May well implicate the NQTL requirements.

Illustration B: Plan’s policy exclusions include “services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention.”

“Treatment of mental illnesses that will not substantially improve beyond the current level of functioning or that are not subject to favorable modification or management according to prevailing national standards of clinical practice.”

Issue: NQTL which is ‘comparable’ to medical/surgical standard?

Apply the Rules: Illustrations

Illustration C: Patient with psych condition presents at the ER of OON hospital. PA required and sought. Patient must be transferred/admitted to in-network hospital. No payment will be made to OON hospital.

Patient with med/surg condition presents at ER of same OON hospital. PA approved and admitted. Payment to hospital at non-par rate.

Issue: Noncomparable NQTL on its face and second test—”how applied”—is not relevant.

Illustration D: Patient with psych condition presents to in-network hospital for admission. PA with full medical necessity review required.

Patient with med/surg condition presents at the same hospital. No PA required, administrative only data must be filed within 48 hours of admission.

Issue: Noncomparable NQTL on its face and second test—”how applied”—is not relevant.

Apply the Rules: Illustrations

Illustration E: Prescription drug benefit requires multiple failures on Tier 1 for antidepressant drugs before PA consideration for Tier 2 or higher. No requirement for multiple failures for other types of drugs.

Issue: Noncomparable NQTL which requires further review.

Illustration F: Plan imposes PA requirements for outpatient mental health visits (varying thresholds).

Examples include: 1) all outpatient visits must be authorized; 2) first 8 visits must be authorized then additional PA for 9th visit and beyond; 3) numerous other variations.

Issue: Is this comparable to a NQTL requirement on the med/surg side? What is comparable in this context? Regulatory test for this requires further analysis.

Reporting

- Key agencies:
 - The Departments of Labor (DOL), Health & Human Services/Center for Medicare & Medicaid Services (HHS/CMS), and Treasury (IRS).
- Reporting directly to DOL or to CMS:
 - DOL: 866.444.3272; email: <http://askebsa.dol.gov>; website: <http://www.dol.gov/ebsa>;
 - CMS: 877-267-2323 ext 6-5511; phig@cms.hhs.gov
- Reporting directly to OHSF/APA: [hsf @psych.org](mailto:hsf@psych.org); voice mail 866.882.6227.



Compliance and Enforcement

Compliance

- The provisions of the Statute (MHPAEA) are in effect now and are applicable to group health plans and group health insurance issuers beginning on/after October 3, 2009. The IFR regulations, however, are not applicable until July 1, 2010.
- Since MHPAEA (the statute) provisions are self-implementing, plans with contract years beginning after October 3, 2009 but before July 1, 2010 will not be expected to be in full compliance with the requirements of the IFR until the beginning of their new contract year.
- The requirements of the IFRs (Regulations) are effective April 5, 2010 and generally become applicable to plans and issuers for plan years beginning on or after July 1, 2010, when they must be in full compliance.

Enforcement

- The Departments will take into account good-faith efforts by group health plans and group health insurance issuers to comply with a reasonable interpretation of the statutory requirements with respect to a violation that occurs before July 1, 2010.



APA Implementation Activities

- OHSF
 - Karen Sanders, 703.907.8590; ksanders@psych.org
- DGR
 - Jenny Salzberg Tassler, 703.907.7842 ; jtassler@psych.org
- OCPA
 - Jaime Valora, 703.907.8562 ; jvalora@psych.org
- Partnership for Workplace Mental Health
 - Clare Miller, 703.907.8673 ; cmiller@psych.org
- www.mentalhealthparitywatch.org
- Parity Implementation Coalition