AMERICAN PSYCHIATRIC ASSOCIATION
DEPARTMENT OF GOVERNMENT RELATIONS

MENTAL HEALTH PARITY'S IMPACT ON PSYCHIATRISTS

AT A GLANCE ::: NOVEMBER 2013

The Wellstone-Domenici Mental Health Parity and Addiction Equity Act (the Act) passed Congress in 2008. The Act was operationalized by an Interim Final Rule which went into effect on January 1, 2011 for most employer-sponsored health plans.

The Act's relation to the recent health reform bill, the Affordable Care Act (ACA):

- ACA expands the Act's reach to plans offered through the individual market, qualified health plans (QHPs) as defined and designed by ACA that will be sold in the state insurance exchanges, and Medicaid non-managed care benchmark and benchmark equivalent plans (known as "expanded" Medicaid plans).
- ACA requires mental health/substance use disorder (MH/SUD) benefits to be part of the essential benefits package offered in QHPs sold by state insurance exchanges.
- The Act itself, and as part of ACA, is a floor; states may enact more generous parity laws.

The Act directly addresses discriminatory quantitative treatment limitations for MH/SUD:

- The regulations prohibit the establishment of "separate but equal" deductibles for MH/SUD.
- A health plan may not have separate financial requirements or treatment limitations, quantitative or non-quantitative, for MH/SUD use benefits.
- A health plan's financial requirements and treatment limitations can be no more restrictive than the predominant financial requirement or treatment limitation applied to *substantially all* medical/surgical (med/surg) benefits incurred in the same classification of health care *(e.g.*, financial requirements on an outpatient/out-of-network MH/SUD service cannot be any more restrictive than the predominant financial requirement or treatment limitation applied to *substantially all* med/surg benefits provided in the outpatient/out-of-network treatment classification.

The Interim Final Rule is expected to be updated with a Final Rule in 2013. The APA seeks a Final Rule that will address the following:

- When health plans' application of non-quantitative treatment limitations[1] violates the Act.
- The scope of services that must be covered in the MH/SUD benefits category of a health plan governed by the Act.[2]

[1] Examples of non-quantitative treatment limitations include insurers' refusal to pay for higher cost therapies until shown the absence of effective lower cost therapies, setting differing standards for MH/SUD providers to participate in a network, including reimbursement rates, using different "usual, customary, and reasonable" (UCR) rate calculation methods for MH/SUD providers than for med/surg providers delivering services within the same classification, and not permitting psychiatrists to bill CPT E/M codes (99xxx).

- An explanation of when the Act's "recognized and clinically appropriate standard of care" exception can be claimed by the insurer[3] to except it from covering a MH/SUD treatment.

APA RECOMMENDATION

The APA recommends that final guidance operationalizing the Mental Health Parity and Addiction Equity Act address instances when an insurer's application of non-quantitative treatment limitations to a health plan's MH/SUD benefits may violate the Act, the scope of services that must be offered by health plans governed by the Act, as well as the "recognized and clinically appropriate standard of care" exception and what insurers must assert to apply it.

[2] Current guidance in the way of the Interim Final Rule only provides for six classifications of MH/SUD services that must be covered. These include: inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency services, and pharmaceuticals. There is presently no requirement in the Interim Final Rule operationalizing the Act mandating certain DSM-5 diagnoses or levels of care be covered.
[3] A Vermont federal district court has ruled the "recognized and clinically appropriate standard of care" exception is an affirmative defense for which the insured's health plan has the burden of proof.