Federal Mental Health Parity Rules Finally Being Implemented

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With all the furor over health care reform over the past nine months, it is easy to forget that we had another major development in mental health regulation over a year and a half ago, with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The process of implementing a law in rule generally takes about 12-18 months following a bill's passage, and we are at about 18 months now. Interim rules were issued in the summer of 2009 and had a two-month comment period. The draft final rules were issued in February 2010, and have a three month comment period, ending on May 18, 2010. These rules, with any last changes, will go into effect on July 1, 2010, and will be applied to insurance plans as they enter new enrollment periods through January 1, 2011.

There has been ongoing confusion about the way that MHPAEA affects an individual state. In short, if a state has a mental health parity law governing large business insurance plans that is stronger than MHPAEA standards, it remains in place. If a state has a mental health parity law that is weaker than MHPAEA for this group of plans, the state laws are replaced by MHPAEA. Here are the main provisions of MHPAEA:

- MHPAEA applies to the *insurance plans of all large businesses* (50 or more employees), both self-funded ERISA plans and non-self-insured large business insurance plans. MHPAEA does not require that mental health and substance abuse treatment be covered, but that they be 'offered.' If a mental health/substance use disorder (MH/SUD) benefit *is* included, it must be 'at parity' with medical/surgical benefits (MED).
- The *formula* for comparing the two sets of benefits is that any MED benefit that covers at least two-thirds of all MED procedures must be applied at the same level to MH/SUD benefits. There cannot be separate deductibles for MED and MH/SUD services.
- All six types of coverage, or *classifications*, must be covered equally for MED and MH/SUD, i.e., inpatient/in-network, inpatient/out-of-network, outpatient/in-network, outpatient/out-of-network, emergency care, and prescription drugs. A health plan must provide out-of-network MH/SUD benefits, at parity, when it provides out-of-network MED benefits.
- *Nonquantitative treatment limits* are prohibited, in the ways that MH/SUD providers are selected and paid. This is the area where there had been the most pushback from insurers, as the rules would prohibit their right to pay providers at lower rates for MH/SUD services than for MED services. This rule could also lead to equal pay for equal codes, a long-fought for priority of CSWA.
- Other *nonquantitative treatment limits* that are prohibited include:
  - » Provider network participation standards (including reimbursement);
  - » Plan methods for determining usual, customary and reasonable charges;
  - » Plan refusal to pay for higher cost therapies until it can be shown that a lower-cost therapy is not effective.

  A good *New York Times* article by Robert Pear (May 9, 2010) on insurance objections to the MH/SUD Rules can be found at: http://www.nytimes.com/2010/05/10/health/policy/10health.html
- Limits on *coverage based on diagnosis* are prohibited, as long as mental health conditions and disorders are consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*).

These excellent rules were supported by CSWA, as a member of the Mental Health Liaison Group. We are delighted to have such strong rules guiding this important step toward comprehensive mental health parity. ❖