# Mental Health Parity

## EXECUTIVE SUMMARY

Mental health parity describes the equal treatment of mental health conditions and substance use disorders (MH/SUDs) compared to medical/surgical benefits by insurance plans. As of 2014, all non-grandfathered[1] individual and small group health plans[2] are required to cover MH/SUD services, and are required to cover them at parity with medical/surgical benefits. Large group plans that offer MH/SUD benefits must also cover those services at parity with medical/surgical benefits. In addition, many individual states have enacted similar laws requiring mental health parity.

## BACKGROUND

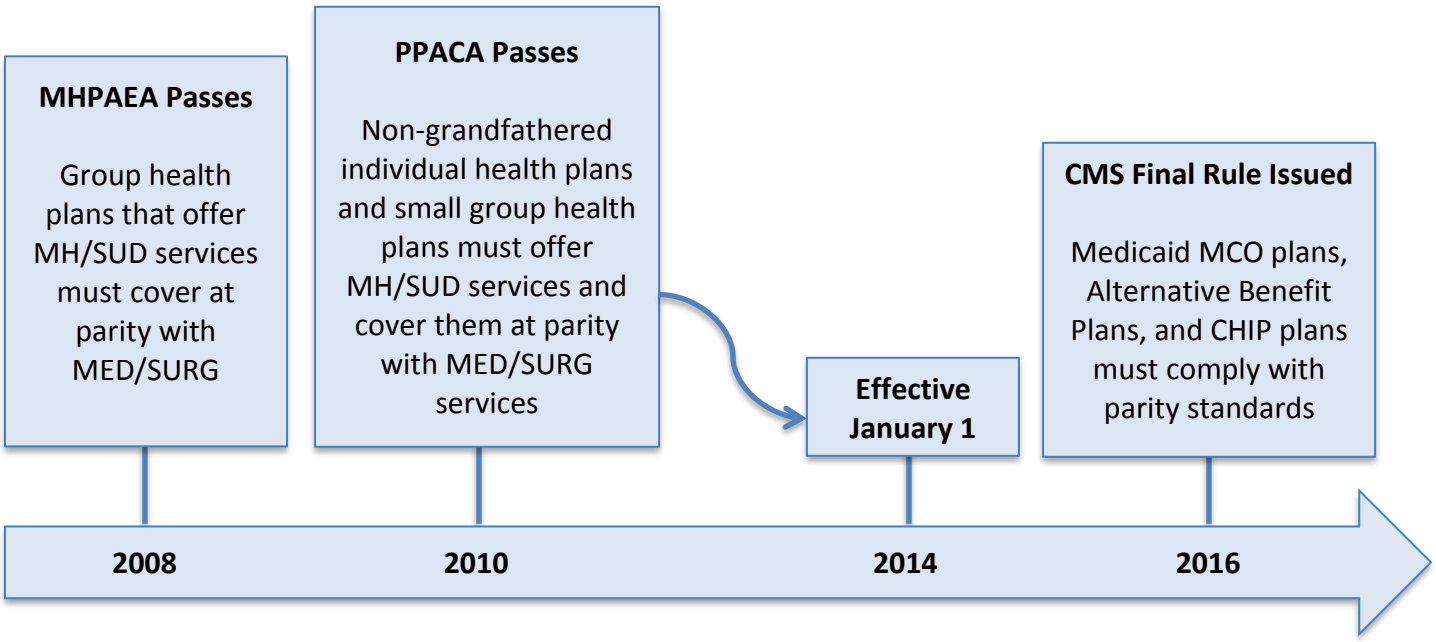
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 is a federal law that generally prevents group health plans that provide MH/SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.[3] As originally enacted, the MHPAEA did not require plans to offer MH/SUD benefits, but required them to be offered at parity with medical/surgical benefits if they were offered. Requirements under the MHPAEA include[4]:

- For plans offering MH/SUD benefits, the financial requirements (e.g., deductibles, co-payments) and treatment limitations (e.g., number of visits, days of coverage, prior authorization) on MH/SUD benefits must be no more restrictive than the predominant requirements or limitations that substantially apply to all medical/surgical benefits covered by the plan.
- MH/SUD benefits may not be subject to separate cost-sharing requirements or treatment limitations that only apply to such benefits.
- If out-of-network benefits are provided for medical/surgical conditions, then out-of-network benefits must also be provided for MH/SUD expenses.
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

The Patient Protection and Affordable Care Act (ACA) of 2010 amended the MHPAEA to extend the law's requirements to individual health insurance coverage.[5] Significantly, the ACA also included MH/SUD services as an "essential health benefit" that all non-grandfathered individual and small group health plans must cover, both inside and outside of the Exchanges, beginning with plan years starting on or after January 1, 2014.[6] Final regulations implementing MHPAEA, as amended by the ACA, were published in the Federal Register on November 13, 2013, and outline 6 "benefit classifications" against which the parity requirements must be assessed.[7]

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) finalized regulations extending parity requirements into the Medicaid Managed Care space. These regulations require that all Medicaid managed care organizations, alternative benefit plans, and Children's Health Insurance Program (CHIP) plans comply with parity standards, regardless of whether these services are provided through the managed care organization or another service delivery system.[8]

## Evolution of Federal Mental Health Parity Requirements




Outside of federal regulations, all states and the District of Columbia have also enacted laws regulating coverage of mental health benefits, though these laws vary considerably. Some states require parity for MH/SUD benefits, while others require at least some level of coverage for MH/SUD services.[9]

## HEALTH PLANS AFFECTED

While much progress has been made with mental health parity in recent legislation, there are still significant gaps and variances depending upon the type of payer. Below is a general overview of applicability of mental health parity laws by payer type.

| Payer | Subject to State Parity? | Subject to Federal Parity? |
|---|---|---|
| **Medicaid*** | Varies by state | Yes, if managed care plan or alternative benefit/benchmark plan |
| **Medicare** | No | Yes, if Medicare Advantage plan offered through an ERISA-covered plan |
| **State Children's Health Insurance Program (CHIP)** | No | Yes |
| **Individual non-Governmental Plans** | Varies by state | Yes, if non-grandfathered plan (must cover MD/SUD services) |
| **Small Group non-Governmental Plans** | Varies by state | Yes, if non-grandfathered plan (must cover MD/SUD services) |
| **Large Group non-Governmental Plans** | Varies by state | Yes (subject to exemption)[10] |
| **Small, Self-insured non-Governmental Plans** | Varies by state | No |
| **Small, Self-insured Small Private Employers** | Varies by state | No |
| **Large, Self-funded Non-Federal Governmental Employers** | Varies by state | Yes (but can opt out)[11] |

* Federal parity requirements only apply to the Medicaid benefits that Medicare-Medicaid dual-eligible beneficiaries receive through Medicaid managed care plans or alternative benefit (benchmark) plans. Federal parity requirements do not apply to Medicare A, B, or D services covered by Medicaid managed care plans.[12]

## WHAT DOES PARITY MEAN?

The MHPAEA and its implementing regulations require insurers to provide mental health parity with respect to financial requirements (e.g., deductibles, co-payments, coinsurance, or out-of-pocket maximums) and treatment limitations, which limit the scope or duration of benefits for treatment. There are two types of treatment limitations relevant for determining parity: (1) quantitative treatment limitations (QTLs); and (2) non-quantitative treatment limitations (NQTLs).

| **Quantitative Treatment Limitations (QTLs)**<br><br>***Numerical*** | **Non-Quantitative Treatment Limitations (NQTLs)**<br><br>***Non-numerical*** |
|---|---|
| • Visit limits<br>• Frequency of treatment<br>• Number of days | • Scope or duration of benefits<br>• Prior authorization<br>• Medical management standards limiting benefits based on medical necessity<br>• Formulary design for prescription drugs<br>• Network tier design<br>• Fail-first policies or step therapy protocols<br>• Exclusions based on failure to complete a course of treatment<br>• Restrictions on geographic location, facility type, or provider specialty<br>• Standards for provider admission to a network |

QTLs are numerical in nature, such as visit limits or frequency of treatment. NQTLs are limitations that are not expressed numerically. Examples of NQTLs include prior authorization, medical management standards, formulary design for prescription drugs, network tier design, fail-first policies or step therapy protocols, and exclusions based on failure to complete a course of treatment.[13]

The U.S. Department of Health & Human Services (HHS) and the Department of Labor (DOL) issued joint guidance in May 2016 to highlight certain health plan features that might signal non-compliance with mental health parity requirements.[14]

| Examples: Plan Features that Would Trigger More Careful Scrutiny |
|---|
| Blanket prior authorization for all MH/SUD services |
| Prior authorization every 3 months for medications prescribed in connection with MH/SUD services |
| Fail-first protocols, such as covering intensive outpatient treatments only after a patient has not achieved progress with non-intensive outpatient treatment |
| Patient non-compliance protocols, such as excluding services for chemical dependency if the covered person fails to comply with the treatment plan |

Private advocacy organizations are also tracking compliance with parity laws.[15]

**References: 1.** For purposes of the Patient Protection and Affordable Care Act, a "grandfathered" health plan is a group health plan that was created, or an individual health insurance policy that was purchased, on or before March 23, 2010. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 1251. **2.** For purposes of the Patient Protection and Affordable Care Act, a "small employer" is generally defined as an employer who employed an average of 1-50 employees on business days during the preceding calendar year, but states have the option to extend the definition to include employers with up to 100 employees (i.e., California, Colorado, Connecticut, Maryland, New York, and Vermont). Protecting Affordable Coverage for Employees Act, Pub. L. No. 114-60 (amending the Patient Protection and Affordable Care Act). **3.** Pub. L. No. 110–343, §§ 511-512. The MHPAEA amended the Mental Health Parity Act of 1996, Pub. L. No. 104-204, which required parity only with respect to aggregate lifetime and annual dollar limits. **4.** *Id.* at § 512. **5.** Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 1311(j). **6.** *Id.* at § 1302. **7.** Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68,240 (Nov. 13, 2013), available at http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=27169&AgencyId=8&DocumentType=2. Accessed May 5, 2017. The benefit classifications include: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, and prescription drugs. **8.** Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 Fed. Reg. 18,390 (March 30, 2016), available at https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of. Accessed May 5, 2017 **9.** National Conference of State Legislatures, *State Laws Mandating or Regulating Mental Health Benefits*, http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx. Accessed May 5, 2017; Mental Health America, *The State of Mental Health in America: Ranking the States*, http://www.mentalhealthamerica.net/issues/2016-state-mental-health-america-ranking-states. Accessed May 5, 2017. **10.** Large group health plans and health insurance issuers may become exempt from MHPAEA for one year if they make changes to comply with the law and incur an increased cost of at least 2% in the first year or at least 1% in any subsequent year. CMS, The Center for Consumer Information & Insurance Oversight, The Mental Health Parity and Addiction Equity Act (MHPAEA), https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html. Accessed May 5, 2017. **11.** Large, self-funded non-Federal governmental employers can opt-out of MHPAEA. *Id.* **12.** 81 Fed. Reg. 18,390, 18,390 (March 30, 2016), available at https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of. Accessed May 5, 2017. **13.** 26 C.F.R. § 54.9812-1(c)(4)(ii); 29 C.F.R. § 2590.712(c)(4)(ii); 45 C.F.R. §§ 146.136(c)(4)(ii); 1470.60. **14.** Department of Health and Human Services and Department of Labor, Warning Signs - Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance (May 2016), available at https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf. Accessed May 5, 2017. **15.** In partnership with several other organizations, the Kennedy Forum has developed ParityTrack, a comprehensive resource for information about parity, including federal and state regulatory actions and litigation over parity requirements. See The Kennedy Forum, Parity Track, https://paritytrack.org/. Accessed May 8, 2017.