



Assessing Compliance with the Mental Health Parity and Addiction Equity Act

While the regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA) are under development, health plans and insurers are supposed to be in “good faith compliance with a reasonable interpretation of the law”. This grace period generally applies until the next calendar year when most new plan years begin and the regulations take full effect. The following questions for assessing current compliance with the new parity law are based on the provisions of the statute that went into effect in October 2009.

Threshold Questions:

First establish that the new parity law applies to the company or organization sponsoring the plan by determining --

- Does the sponsor have more than 50 employees?
- Does the plan provide any coverage for mental health or substance use services or treatment?

If the answer is yes to both of these questions, then the new parity law applies to this health plan. Proceed with the following checklist of questions to learn whether the plan complies with the new law.

If you answered no to either of these questions, then the MHPAEA does not apply to this health insurance plan. However, state laws requiring coverage of mental health and/or substance use treatment and/or state laws imposing parity requirements often do apply to smaller businesses. Your state insurance commissioners office may have more information on whether a state law applies to the plan in question.

Checklist:

Health insurance plans subject to the new parity law are prohibited from applying higher financial requirements or stricter treatment limitations to mental health and substance use disorder benefits than they apply to most medical and surgical benefits. The terms “financial requirements” and “treatment limitations” are described in more detail below and a glossary is included at the end for further explanation of other terms used in this checklist.

If the answer is YES to any of the following questions, the plan is most likely not in compliance with the new law.

A. Financial requirements:

Financial requirements are defined in the law as including deductibles, copayments, coinsurance, and out-of-pocket expenses (see glossary). These kinds of financial requirements must be no higher for mental health and substance use disorder benefits than they are for most medical and surgical benefits. The MHPAEA also states that there shall not be “separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits”.

1. Is the deductible for mental health and/or substance use treatment higher than the deductible for most medical/surgical care?
2. Are the plan’s co-payment requirements for mental health and substance use treatment higher than those for most medical/surgical benefits?
3. Are the co-pays for medications used to treat mental health and substance use conditions higher than the co-pays for most medications used to treat other conditions?
4. Is there a higher co-insurance rate for mental health and/or substance use treatment than is required for most medical and surgical care?
5. Does the plan set a higher out-of-pocket maximum or limit for mental health and/or substance use disorder treatment beyond which more comprehensive coverage applies?

B. Treatment limits

Treatment limits are defined in the new parity law as including “limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.” These kinds of treatment limitations must be no lower or more restrictive for mental health and substance use disorder benefits than they are for most medical and surgical benefits.

1. Does the plan impose more restrictive limits on how often treatment for mental health and/or substance use treatment will be covered compared to treatment for medical and surgical care?
2. Does the plan set a lower limit on the number of visits allowed for mental health and/or substance use treatment compared to the number of visits covered for most medical or surgical care?
3. Does the plan place a lower limit on the number of days covered for mental health and/or substance use treatment than are covered for most medical and surgical care?

C. Out-of-Network Coverage

Under the new parity law, if an insurance plan covers medical or surgical benefits provided by out-of-network providers, it must also cover mental health and substance use benefits provided by out-of-network providers. The parity requirements also apply to this out-of-network coverage meaning that insurance plans subject to the law may not impose higher financial requirements or stricter treatment limits for out-of-network mental health or substance use care than apply to most out-of-network medical or surgical benefits.

1. Does the plan cover out-of-network medical or surgical care but *not* out-of-network mental health and substance use disorder treatment?
2. Does the plan apply higher financial requirements or stricter treatment limitations for out-of-network mental health or substance use disorder care than apply to most out-of-network medical and surgical benefits?

Glossary of Terms:

Deductibles: A deductible is the amount of money that the insured person must pay before any benefits from the health insurance policy can be used. When the deductible has been paid, this is often referred to as having “met” or “satisfied” the deductible. Deductibles are usually a yearly amount—you have to satisfy the deductible again at the beginning of each policy year before you receive the benefits of the plan. Some insurance plans require beneficiaries to satisfy an additional deductible for mental health or substance use services and treatment.

Co-pays: Co-payments are set dollar amounts the insured person has to pay for each office visit, prescription or other treatment. Co-pays are often higher for mental health or substance use services and treatment, including medications. This is not allowed under the new parity law.

Prescription co-pays: These co-pays will often depend on whether a medication is generic, and insurance plans often have lists of “preferred” drugs that have lower co-pays than other, “non-preferred” medications.

Co-insurance rates: Some insurance plans have co-insurance rates instead of co-payments. A common co-insurance rate is “80/20.” This means that the insurance will cover 80 percent of the cost of treatment, while the patient is responsible for 20 percent. Plans often have different co-insurance rates for mental health or substance use services and treatment that require the patient to pay a higher percentage of the cost of care. This is not allowed under the new parity law.

Out-of-pocket expenses: This is the cost one would pay out of their own pocket. An out of pocket expense can refer to how much the co-payment, coinsurance, or deductible is. When

the term annual out-of-pocket maximum or limit is used, that is referring to how much the insured person would have to pay for the whole year out of their pocket, not including premiums. Some insurance policies require a person to spend a certain amount of money out of their own pocket before more comprehensive coverage kicks in. For example, an insurance plan may require a person to spend \$500 out-of-pocket for substance use treatment before the plan will cover 80 percent of costs going forward. In another example, a plan could limit the out-of-pocket expenses a person has to pay for heart surgery recovery to \$500, after which the plan will cover 100 percent of all treatment. Under the new parity law, out-of-pocket expenses cannot be higher for mental health and substance use treatment than they are for medical and surgical care.

Frequency of treatment: Insurance plans often place limits on how often treatment will be covered. For example, the plan may cover only one psychotherapy session per week. If the insured person has a second therapy session in the same week, the insurance company will deny coverage.

Number of visits allowed: Insurance plans may limit access to mental health or substance use services and treatment by restricting the number of visits covered. A common restriction is to place an annual or lifetime limit on the number of psychotherapy sessions covered. For example, a plan may limit coverage to 15 sessions a year or 45 sessions total during the time a person is covered by that insurance plan.

Days of coverage: Another way to limit coverage for certain treatments is to place limits on how many days of treatment are covered. A common example would be a limit of 30 days of coverage for hospitalization. Such limits can be annual and/or lifetime.

Out-of-network coverage: Most people with health insurance are covered by managed care plans (e.g., health maintenance organizations (HMOs) and preferred provider organizations (PPOs)). Managed care plans sign contracts with certain doctors and hospitals to care for their plan members. This group of providers is the plan's "network." The insurance company might not pay for visits to a provider who is not in its network. If it does pay for providers outside the network, it may pay less than it would for a network provider. The insured person is responsible for the part of the bill that the plan doesn't pay. Many managed care plans do not provide coverage for out-of-network visits for mental health or substance use services and treatment, or they may have higher coinsurance rates or co-pays for such visits.

Other Issues to Consider:

Additional Requirements Under State Laws

State laws that are stronger than the new federal parity law – for example benefit mandate laws that require plans to cover mental health or substance use disorder benefits – may also

apply to the insurance plan you are assessing. However, state laws only apply to certain health insurance plans. Plans offered by large employers are often not subject to these kinds of state laws. Your state health insurance commissioners office may be able to help determine which plans are subject to state parity and benefit mandate laws in addition to the federal parity laws.

Any provision of the state law that provides less protection than the new federal parity is no longer valid. For example, if your state parity law required insurance plans to cover a minimum of 10 days for in-patient detoxification from drugs or alcohol, this provision would not apply if insurance plans would be required to provide more coverage under the federal law. Under the federal parity law, if an insurance plan placed no limits on in-patient treatment for medical/surgical care then presumably it would have to provide the same unlimited coverage for in-patient detoxification treatment. Likewise, if your state parity law requires insurance plans to cover all “medically necessary” in-patient detoxification, without any day limits, then it would provide more coverage and thus would override an insurance plan that limits in-patient treatment to 60 days per year.

Does your state parity law mandate coverage for mental health and/or substance use conditions? Does it require that certain conditions be covered? Because the MHPAEA does not do either of these things, these provisions of the state parity law would still be in effect for health plans that are covered by state law.

Increased Transparency Under the New Parity Law

Under the new law, current or potential participants, beneficiaries, and contracting providers may request information about what criteria are used to determine if a particular service or treatment is medically necessary. Upon such a request, plan administrators must provide the medical necessity criteria for mental health and substance use benefits. Consider asking about medical necessity criteria for a sample of both medical/surgical benefits and comparable mental health/substance use benefits. Is the response timely? Do the criteria seem comparable and reasonable?

Upon request or when required, plan administrators must also provide the reasons for denials of reimbursement or payment to participants and beneficiaries.

Has the plan administrator put in place a process for informing beneficiaries about their right to request an explanation and to ensure that every request is answered? Are beneficiaries satisfied with the explanations they receive?