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Parity Regulations Final Rule – What You Need to Know

Compiled from the Parity Implementation Coalition release by Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, NAADAC Executive Director

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Through NAADAC's involvement with the Parity Implementation Coalition, we have learned more specifics regarding the final rule that was issued on November 8, 2013 through the Departments of Treasury, Labor, and Health and Human Services. These rules govern the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) that NAADAC aggressively advocated for, along with many other organizations. The following is a brief summary of key provisions of this 200-page document. The final regulations are available in full at www.dol.gov/ebsa/pdf/mhpaeafinalrule.pdf.

The final plan is effective for insurance plan years beginning on or after July 1, 2014. The reality is that the bulk of the insurance plans end on December 31st, thereby making the effective date for most insured to be January 1, 2015.

The final rule clarified the scope of service eligibility as follows: A) the six classifications of benefits (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) were never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential); therefore, expect these to be covered in insurance plans; B) the language in the final rule on scope makes it clear that each classification and sub-classification has to meet all parity tests within each classification. It further states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers." This language, coupled with the new specific examples around intermediate levels of care, makes it clear that mental health/substance use disorders (MH/SUD) services have to be comparable to the range and types of treatments for medical/surgical within each class; and C) although neither the Interim Final Rule (IFR) nor the final rule mandate specific services required to be offered by plans under the six classifications, the final rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assigned intermediate levels of services for medical/surgical conditions.

For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorders services and partial hospitalization must be considered outpatient benefits as well. The net effect of this provision is that parity requirements (as clarified by the FAQs issued by the Department of Labor) extend to intermediate levels of MH/SUD care and that such services must be treated comparably under the plan.

The final rule strikes the provision included in the Interim Final Regulations that permitted plans to apply discriminatory limits on MH/SUD treatment if there was a "clinically recognized standard of care that permitted a difference."

Under the final rule, parity requirements for nonquantitative treatment limitations (NQTLs) are expanded to include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). The net effect of this is plans will no longer be able to require a patient to go to a MH/SUD facility in their own state if the plan allows plan members to go out-of-state for other medical services.

The improvement in the final rule is that plan participants or those acting on their behalf will now be able to request a copy of all relevant documents used by the health plan to determine whether a claim is paid.

MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. New disclosure requirements in the final rule will require plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits.

The final rule clarifies, as codified in federal and state law, states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of enforcing implementation of MHPAEA. The Department of Health and Human Services, through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply. The Department of Labor has primary enforcement authority over self-insured ERISA plans.

These final rules do not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid

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27th Annual Advocacy in Action Conference Recap

Putting Addiction and the Needs of Addiction-Focused Professionals on the Agenda

By Jessica Gleason, NAADAC Communication Associate

Addiction-focused professionals from around the country descended on Washington, D.C. to join NAADAC, the Association for Addiction Professionals, for its 27th Annual Advocacy in Action Conference from March 2–4, 2014. Attendees received up-to-date information from top federal officials and industry experts on the critical issues that impact the addiction-focused profession, and then met with national lawmakers to share their rare insight and knowledge base regarding the true day-to-day issues created by recent healthcare reforms, and a shrinking and under-supported workforce.

"This year marks NAADAC's 40th year of working to advance the interests of addiction-focused professionals and organizations and our 27th Annual Advocacy Conference. Our advocacy conference provides a vehicle for addiction-focused professionals from across many different disciplines to advocate on a national level with a strong, united voice," said Gerry Schmidt, NAADAC Public Policy Chair. "We addressed funding for services and research, workforce development, improved technology for the treatment of all addictions, the implementation of parity and healthcare reform, and government initiatives to support the profession and ensure access to services."

"With the onset of the Affordable Care Act and related healthcare reform initiatives, over 25 million people are newly eligible for substance use and mental disorders services. Now more than ever, we need to address the dramatic need for workforce development in the medical specialty of addiction prevention, intervention, treatment and recovery support with a strong unified push for funding for services, minority fellowships, and tuition reimbursement for those wanting to pursue a career in addiction treatment," said Cynthia Moreno Tuohy, NAADAC Executive Director.

"Addiction is one of America's most serious public health challenges. With less than 10 percent of those needing addiction services receiving them, this health disparity is costing America over $600 billion a year and so much more in family and community losses! Attention to this health epidemic is crucial for the health of this generation and generations to come. We need Congress to clearly understand not just the need for continued funding, but the severity of addiction as a major healthcare issue," said Robert Richards, NAADAC President. "Almost one-in-four deaths in the United States can be attributed to alcohol, tobacco, or other drug use. Our work to prevent substance use disorders, treat the disease, and support recovery hastens people back to work, reunites families, and creates safer communities. Our work helps people get their lives back."

Presentations from this year's conference, as well as pictures and advocacy materials, are available at www.naadac.org/advocacyconference. Hope you will join us next year!

Jessica Gleason is the Communications Associate for NAADAC, the Association for Addiction Professionals. She is the Managing Editor for *Advances in Addiction & Recovery* and compiles NAADAC's two ePublications, the bi-weekly *Addiction & Recovery eNews* and weekly *Professional eUpdate.* She is also responsible for the NAADAC website's content, social media, and communications. Gleason holds a Juris Doctorate from Northeastern University School of Law in Boston, MA and a Bachelor of Arts Degree in Political Science from the University of Massachusetts at Amherst.

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Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The final rule states more guidance on this will be forthcoming. The PIC will be requesting this additional Medicaid guidance be issued within 180 days.

Under the final rule, regulations under the ACA and FAQs issued by the Department of Labor, plans and issuers must provide the claimant, free of charge, during the appeals process with any new additional evidence considered relied upon or generated by the plan or issuers in connection with a claim.[1]

The final rules give clear direction for plan parity requirements. It will be vital that the clients/patients you are planning to serve understand the provisions in their health benefit coverage, what the limits are for medical/surgical benefits and that the substance use disorder/mental health benefits are on par. If they are not, the State Insurance Commissioner or the Department of Health and Human Services are the departments with primary responsibility to enforce.

As more information becomes available, visit www.naadac.org/advocacy for updates.

Cynthia Moreno Tuohy, NCAC II, CCDC III, SAP, is the Executive Director of NAADAC, the Association for Addiction Professionals. She previously served as the Executive Director of Danya Institute and the Central East Addiction Technology Transfer Center and as Program Director for Volunteers of America Western Washington. In addition, she has over 20 years of experience serving as the administrator of multi-county, publicly funded alcohol/drug prevention/intervention/treatment centers with services ranging from prenatal care to the serving the elderly.

REFERENCES

[1]For more resources, please refer to: U.S. Department of Health and Human Services' Study: Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, available at www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf