Parity Update

Holly Merbaum
Parity Implementation Coalition
Capitol Decisions, Inc.
March 19, 2012

Parity Implementation Coalition

- Coalition of mental health and addiction consumer and provider organizations committed to the full implementation & enforcement of the Mental Health Parity & Addiction Equity Act

American Academy of Child & Adolescent Psychiatry

American Society of Addiction Medicine Founded 1954 ASAM

CH Cumberland Heights

Hazelden

MHA Mental Health America 100 years

TeenScreen® National Center for Mental Health Checkups at Columbia University

American Psychiatric Association Benjamin Rush, M.D. 1844

Betty Ford Center

Faces & Voices of Recovery

NAMI National Alliance on Mental Illness

National Association of Psychiatric Health Systems

The Watershed Addiction Treatment Programs www.thewatershed.com

MedPro

National Council for Community Behavioral Healthcare

Why should your organization care about parity implementation & enforcement?

- Greater private sector reimbursement for providers' services & reduced drain on state & county budgets
- Greater access to care for individuals & families
- ACA will be greatly diminished if MHPAEA is not fully implemented & enforced
- Without clarity, plans are limiting or excluding access to intermediate levels of care (intensive outpatient, partial hospitalization & residential)
- Without a consistent field-wide effort, nearly 2 decades spent fighting for MHPAEA & ACA will yield limited utility

Status of Parity Implementation

- The Interim Final Regulations went into effect on January 1, 2011
- Full federal implementation and enforcement is lagging
- DOL & HHS Secretaries have promised final regulations, but release is not expected until after Nov. elections
- Under ACA, MHPAEA is expanded to cover:
  - Benefits provided in the new “exchanges”
  - Benefits provided by small group & individual plans
  - Benefits provided to the new Medicaid population

4 Key Parity Regulatory Issues

- Disclosure of medical criteria used to make benefit determinations
  - Without disclosure beneficiaries are unable to see if their plan complies with parity
- Non-quantitative treatment limits
  - Need quantitative floor (i.e. 50%) to operationalize parity in medical management
- Scope of service
  - Plans are excluding levels of care; Agencies say regulations did not include a scope of service requirement
- Medicaid managed care parity

Issue 1: Disclosure of Medical Criteria

- Unless health plans disclose the medical criteria (and how the criteria are applied) used to make adverse benefit determinations, plan participants/providers cannot determine whether a plan has provided MH/SUD services in the "comparable and no more stringent than" manner required by MHPAEA
- DOL issued sub-regulatory guidance on disclosure in Dec. '10, but non-compliance remains the norm

Coalition Disclosure Recommendation

- The Departments must issue clear & specific regulatory guidance in this area & enforce the sub-regulatory guidance issued in December. 2010

Issue 2: Non-Quantitative Treatment Limits (NQTLs)

- Background
  - The IFR defined two categories of treatment limitations: quantitative & nonquantitative
  - Examples of financial requirements & quantitative treatment limits:
    - Day and visit limits, annual & lifetime caps & co-pays & deductibles
  - Quantitative test: financial requirement or quantitative treatment limit must be applied to at least 2/3 of its med/surg benefit in order to apply the same type of a financial requirement or quantitative limit to MH/SUD benefits

NQTLs Continued

- The IFR, established a “comparable to” & “applied no more stringently than” test w/respect to the imposition of NQTLs, but failed to include a quantitative test to operationalize the provision.
- The statute gives only 1 definition of a treatment limit – i.e. that it must be “predominant” and applied to “substantially all” the medical benefit, before it may be applied to the behavioral benefit.
- The IFR did not clarify a general quantitative test (or floor) that must be met before a plan can apply a NQTL to the MH/SUD benefits; a precedent has already been set for how to do this as the regulators used a quantitative guideline in one of the examples listed in the IFR when defining NQTLs

Coalition NQTL Recommendations

- Sub-regulatory guidance or final regulations should provide a quantitative floor and compliance tests to operationalize MHPAEA's NQTL provisions. The Coalition believes there should be a 3 part test for applying NQTLs:
  1. A type or subtype of NQTL must be applied to more than 50% of the medical/surgical benefits in a classification in order to be applied to that classification of benefits on the MH/SUD side;
  2. An NQTL that has first met the more than 50% test, must then be comparable to a type or subtype of NQTL applied to the MH/SUD benefit and must be applied in a comparable manner as to magnitude;
  3. The comparable type of NQTL must be applied no more stringently to a classification of MH/SUD benefits than it is applied to that classification of medical/surgical benefits.

Issue 3: Scope of Service

- Without final regs on scope of service, plans claim to be MHPAEA compliant by providing sparse or single levels of MH/SUD services, while providing a full scope of services & continuum of care of med/surg benefits
- Agencies say IFR did not include scope of service requirement, but IFR requires plans to offer benefits in 6 categories
  - inpatient, in-network/inpatient, out-of-network;
  - outpatient, in-network/outpatient, out-of-network;
  - emergency care; and
  - prescription drugs
- Due to the lack of a scope requirement, we are seeing plans exclude residential treatment for addiction and eating disorders

Coalition Scope Recommendations

- Final regulations must address scope and clarify that:
  - The term “treatment limitation” includes both quantitative & nonquantitative treatment limitations & includes limits on the scope & duration of treatment. Scope is an explicit aspect in the definition of a treatment limitation in the statute

Issue 4: Medicaid Managed Care Parity

- MHPAEA requires Medicaid managed care plans to comply if they offer a MH/SUD benefit
- CMS issued guidance in 2009 that all SCHIP & Medicaid managed care plans that have any MH/SUD benefit have to be compliant with MHPAEA
- However, CMS has not issued more detailed regulations on MHPAEA for Medicaid managed care plans
- **Coalition's Recommendation**
  - CMS should issue final regulations or sub-regulatory guidance clarifying that MHPAEA is in effect for Medicaid managed care plans

Next Steps for Organizations

- 6 upcoming parity field hearings around the country
  - Tentative cities:

West Palm Beach, FL	Kalamazoo, MI
LA/San Diego	DC Metro
Minneapolis, MN (7/17)	Chicago, IL

- Fight “parity fatigue;” i.e. parity IS the issue & ACA will require even bigger fight
- Familiarize yourself with materials at www.parityispersonal.org
- Energize your organization to establish processes to teach providers/consumers how to appeal denied claims & file complaints

ACA Benefits for Addiction Payers & Patients

- If ACA is upheld:
  - 32 million Americans will have coverage for addiction in 2014
    - 25 million people covered through “exchanges”
    - 16 - 23 million people covered through Medicaid expansion
    - 6-10 million of the 32 million individuals will have some form of MH & SUD

Health Reform Implementation: Essential Health Benefit (EHB)

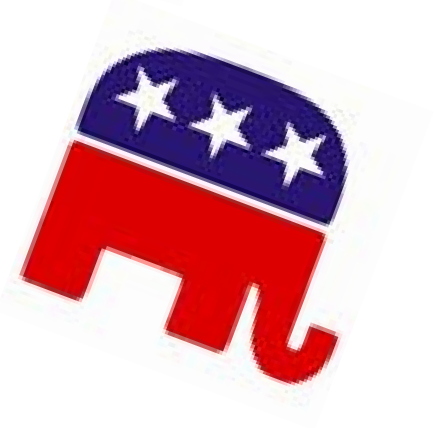
- HHS released a “bulletin” on essential health benefit on December 16, 2011
- Long process still to come; HHS may or may not release a rule before the November 2012 elections
- Key Provision: All “new” individual and small employer plans inside & outside exchange will have to offer MH/SUD at parity

Coalition for Whole Health's Key Comments on the Bulletin

- HHS should establish a "federal floor"
- HHS must aggressively enforce MHPAEA
- Benchmarking the EHB to small employer market leaves individuals with MH/SUD vulnerable & maintains burden on public sector
- Pleased that if states select a benchmark already covered by state mandates, state is not responsible for paying extra costs if the benefit exceeds the EHB
- HHS should limit plan flexibility across and within the 10 categories

Possible ACA Implementation Hurdles

- Supreme Court
  - Court will hear the case at the end of March
  - Will consider constitutionality of both individual mandate & Medicaid expansion
  - Decision expected by the end of June 2012
- 2012 Elections
  - Tight race for White House
  - Senate could flip – Of the 33 seats up for re-election, 10 are considered a toss up
  - As of press time, House projected to remain under Republican control



Action Items

- ✓ Continue to advocate for a robust addiction benefit in the ACA essential health benefit
- ✓ Identify & act on MH/SUD challenges & opportunities in ACA in DC & states
- ✓ Partner with experts to develop new procedure & facility codes for integrated care in medical parlance
- ✓ Work with researchers to publish new efficacy & cost offset data on MH/SUD treatment; some gold standard evidence is dated

Questions?

www.parityispersonal.org

info@parityispersonal.org