Parity Update

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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
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?

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