According to Ron Bachman, president and chief executive officer of Healthcare Visions, Inc., legislation has a four-step life cycle.

In the first phase, legislation gets passed. In the second, regulations fill in the details of how the new law will actually be put into practice. In the third, those covered under the law either comply — or don’t. And in the final stage, the courts settle any disputes about what the law’s language means.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, which requires private health insurance to cover mental and physical health services equally, is in the compliance phase. Most of the covered plans had to start complying with the law on January 1 this year. Are they?

For most employers, says Bachman, the answer is yes. But while the vast majority of employers have implemented parity without a hitch, some have reacted to the law by creating aggressive ways to manage mental health and substance abuse benefits.

The law’s impact

Passed in 2008, the law requires group health plans covering 51 or more employees to ensure that financial and treatment limits for mental health and substance use benefits be no more restrictive than those applied to medical and surgical benefits. In 2010, the government issued a rule giving detailed instructions about how to implement the law. (See “Implementation of the Federal Parity Law” in the Winter 2011 issue of Good Practice.)

“Regulators went a bit further than the law’s statutory requirements,” says Doug Walter, JD, counsel for legislative
and regulatory affairs at the American Psychological Association’s (APA) Practice Directorate. In addition to requiring parity in such quantitative areas as deductibles, annual and lifetime dollar limits and the number of sessions allowed per year, the regulations also require parity in nonquantitative areas. These include differences in medical management and provider network participation.

How have employers and insurers reacted? Despite fears that the law would prompt employers to ditch mental health coverage, says Bachman, just 1.6 percent of affected employers have done so.

And while “they grumbled the whole time they were doing it,” he says, most have made changes, improved benefits and implemented the law without problems. For some, parity has meant bringing “carved out” behavioral health benefits back in-house to facilitate common deductibles and cost-sharing. As for costs, says Bachman, the impact was minimal. As one insurer told him, “It wasn’t even a blip on our radar screen.”

Assessing compliance

 Nonetheless, there are some companies that aren’t complying with the law. Alan Nessman, JD, senior special counsel for legal and regulatory affairs for the Practice Directorate, fields calls from psychologists concerned that their clients’ employers or insurers are violating the law.

“The main thing we hear are questions about management of the benefit,” says Nessman. “What we’ve seen is that once the parity law took away companies’ ability to limit care to, say, 20 sessions a year, some companies appeared to panic.”

But not everything that seems to be a violation actually is, warns Nessman. He guides APA Practice Organization members to a checklist of questions to help psychologists determine whether a company is complying with the law as it relates to mental health benefits management. (See companion article on page 4.)

For one thing, some plans are not subject to the parity law. For plans that are covered, even though you might think a company’s management of mental health benefits is intrusive, it has to be more intrusive than management of medical benefits to qualify as a violation.

That can be tricky, says Nessman. “One problem is that we’re so used to dealing with the mental health side, we often don’t know what’s happening on the medical side,” he says. And it can be hard to compare restrictions — such as having to get reauthorization after 10 sessions — because of differences in the way people use care. “Most people don’t see their primary care provider 10 times per year or get surgery that often,” Nessman points out.

For quantitative limitations, the regulations say that any limit on behavioral health benefits needs to also apply to “substantially all” — generally defined as two-thirds — of medical and surgical benefits. In nonquantitative areas, limitations must be “comparable,” a standard Nessman hopes will eventually be clarified as enforcement agencies and courts take on questionable insurance company practices.

You also need to determine whether a practice represents a barrier to treatment. “Many people will call and say, ‘This is a real nuisance,’” says Nessman. “That’s unfortunate, but the real point of parity is, ‘Is this creating a barrier to patients accessing mental health care?’”

This article is based on a session called Parity in Practice: Health Plan Compliance with the Mental Health Parity Law and Challenges Ahead at the APA Practice Organization’s 2011 State Leadership Conference.