Implementation of the Federal Parity Law

This special section of Good Practice focuses on implementation of the federal mental health parity law, the Wellstone-Domenici Mental Health Parity & Addiction Equity Act (MHPAEA) of 2008. The federal rule pertaining to implementation of this federal parity law takes effect on January 1, 2011, for most health plans to which MHPAEA applies.

The APA Practice Organization (APAPO) and the American Psychological Association offer an array of informational resources for members and the public about the parity law.

PARITY RESOURCES

FOR MEMBERS
See pages 17–18 of this magazine for answers to common questions from members about the federal parity law and its implementation. Our Practice Central website at apapracticecentral.org (see box on this page) contains considerably more information tailored for psychologists, including a detailed summary of the federal rule available to members of the APA Practice Organization (APAPO). In addition, the PracticeUpdate e-newsletter from APAPO periodically includes information and updates about MHPAEA.

FOR CLIENTS AND CONSUMERS
The FYI fact sheet found at the end of this special section is designed to help your clients and other consumers of psychological services understand how mental health insurance coverage is affected by MHPAEA. The page is perforated for easy removal. Members are encouraged to photocopy and distribute this fact sheet to their clients as well as disseminate it as appropriate during public education events and other community outreach activities.

The APA Help Center at apa.org/helpcenter has additional information for the public about the mental health parity law and mental health insurance. The mirror site, Centro de Apoyo de APA en Español at apa.org/centrodepoyo, contains Spanish-language versions of Help Center material.

FOR EMPLOYERS
The Psychologically Healthy Workplace Program (PHWP) website—phwa.org—contains information and resources for employers and the psychologists who work with them. The site prominently features “An Employer’s Guide to the Mental Health Parity and Addiction Equity Act.” In addition, the PHWP’s Good Company Podcast from October 2009 focuses on MHPAEA while a posting from the same month to the Good Company Blog contains a presentation on understanding the federal parity law.

The Mental Health Parity section of apapracticecentral.org contains extensive information about MHPAEA.

FIND MORE AT PRACTICE CENTRAL

The Mental Health Parity section of the Practice Central website at apapracticecentral.org contains numerous resources related to the Wellstone-Domenici Mental Health Parity & Addiction Equity Act. Visit apapracticecentral.org/advocacy/parity for detailed information about implementation of the law, the history of organized psychology’s quest to achieve parity legislation and additional resources.
The Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act (MHPAEA) became law in October 2008. The federal government published its Interim Final Rule (IFR) in February 2010 to implement this full mental health insurance parity law. The IFR provides clear guidance and strong consumer protections that become effective for health plan years beginning on or after July 1, 2010. For most plans, this means that the IFR will apply on January 1, 2011.

A group of managed behavioral health organizations filed a lawsuit against the federal government in the spring of 2010 to block implementation of the IFR. On June 21, a judge with the U.S. District Court for the District of Columbia dismissed the lawsuit, allowing the regulatory process governing the federal parity law to proceed.

Practicing psychologists have raised numerous questions about MHPAEA and its impact on practitioners and consumers of psychological services. This question-and-answer article addresses several common inquiries.

Q: Can I assume that all my patients are covered by the federal parity law?
A: No. MHPAEA covers most but not all health plans. The federal law applies to employer-sponsored group health plans of more than 50 employees. State and local government employee plans may opt out of the federal parity law, though few of these plans have done so.

If a plan does not cover mental health benefits, MHPAEA would not pertain to your patients in such a plan. Fortunately, nearly all employer-sponsored health plans cover mental health services.

Q: Is it true that health plans may drop mental health benefits rather than comply with the new parity law?
A: MHPAEA does not mandate the inclusion of mental health or substance use benefits in insurance plans. Instead, the parity law contains “coverage conditions” that apply only if a plan covers such services. We do not expect implementation of the rule governing the federal parity law to have any substantial impact on the nearly universal extent of mental health services coverage. The Kaiser Family Foundation’s 2010 survey of health coverage found that less than 2 percent of firms with more than 50 employees—those to which MHPAEA applies—dropped mental health insurance coverage because of the federal law.

Q: Some state parity laws apply only to the “biologically based” disorders involving serious mental illness (SMI) such as schizophrenia or bipolar disorder. Is it true that the new federal parity law requires insurance companies to extend parity coverage to a broader range of mental health services?
A: Under MHPAEA, parity requirements apply to all diagnoses covered by a plan, not just a narrow list of SMI diagnoses. The federal law “wraps around” state laws like New York’s Timothy’s Law. For example, insurance plans in

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New York must still cover the state’s list of “severe mental illnesses” in their benefit packages. For health plans in New York provided by employers of more than 50 people, MHPAEA further requires any additional mental health/substance use services covered by the plan to be at parity with medical/surgical services.

Although not a common practice, an insurer may exclude coverage of particular diagnoses—for example, autism or ADHD—in its coverage agreement with an employer. Check with the employer’s human resources office to verify that a diagnosis exclusion applies.

Q: My patient’s insurance plan has an arbitrary limit on the number of outpatient mental health sessions per year. What should I do?

A: A plan that continues to use a prior mental health benefit limit—for example, 30 inpatient days and 20 outpatient sessions per year—is in violation of MHPAEA if the same limits are not placed on medical/surgical benefits. You or your patient may wish to contact the health plan to urge compliance with the law. Alternatively, your patient may want to contact his or her human resources office for assistance.

Q: My patient’s insurance company does not require pre-authorization for outpatient medical/surgical visits to primary care physicians such as internists and family physicians, but does require pre-authorization of outpatient psychotherapy visits in order to be reimbursed for these services. What should I do?

A: The Interim Final Rule goes beyond what many people normally think of as benefits requirements. Under the Wellstone-Domenici parity law, a health plan may manage benefits under the terms and conditions of the plan. If a plan does so, the IFR requires that management of benefits must be at parity.

The Interim Final Rule stipulates that mental health benefits may not be managed more stringently than medical/surgical benefits. Pre-authorization requirements are one form of benefits management. If a plan imposes pre-authorization requirements on mental health benefits that it does not impose on most medical/surgical benefits, that plan would be violating the parity law. Pre-authorization requirements and other “non-quantitative treatment limitations” (NQTL) that may be applied to mental health services must be comparable to NQTLs that apply to medical/surgical benefits.

Insurance companies seem to be interpreting and applying this requirement differently, and they may continue doing so after January 1, 2011. Staff for the APA Practice Organization is working with state psychological associations to help resolve situations where insurance companies appear to be applying the “comparable to” standard inappropriately. We will continue to keep members informed about relevant developments.

Q: My patient’s health plan is requiring a higher patient copayment for my services because the plan considers me a “specialist.” Does the new law consider me a specialist?

A: No. The Interim Final Rule explains that a plan that requires mental health providers to be classified as specialists for the purposes of calculating copayments is violating the law.

Q: Should my patient or I report non-compliance by an insurer to the government?

A: Beyond speaking with a human resources office and the insurance company, you and/or your patient may file a formal complaint with the federal government.

Complaints about insurance plans regulated under state law may be made via a toll-free Health & Human Services help line at 1-877-267-2323, extension 61565 or by emailing phig@cms.hhs.gov.

For “self-funded” plans governed by the federal law known as ERISA (generally those of large employers), the Labor Department may be reached at 1-866-444-3272 or with an online form found at askebsa.dol.gov/SecInit.

A word of caution to temper expectations: There may not be adequate staffing to investigate each complaint received.
What is the Mental Health Parity and Addiction Equity Act?

The Mental Health Parity and Addiction Equity Act, or MHPAEA, requires private health insurance plans to provide equal coverage for mental and physical health services. Congress passed MHPAEA so adults and children suffering from mental health disorders, such as anxiety and depression, and substance use disorders, such as those related to alcohol use, would have better access to the treatment they need.

When does MHPAEA take effect?

The law took effect on January 1, 2010. The following month, the federal government published a rule that provides guidance for group health insurance plans on how to comply with MHPAEA. For most health plans affected by the federal parity law, the federal rule pertaining to MHPAEA will begin to apply on January 1, 2011.

Does the law apply to my health insurance plan?

The law applies to all group health insurance plans for more than 50 employees that provide mental health or substance use disorder benefits as part of the plan. MHPAEA does not apply to smaller group health plans or to Medicare. State and local government employee plans may opt out of the federal parity law, though few of these plans have done so. Importantly, plans for 50 or fewer employees are subject to the requirements of state mental health parity laws.

Does MHPAEA require my health plan to provide mental health benefits?

MHPAEA does not require private health insurance plans to include mental health benefits. Even so, nearly all employer-sponsored health plans in the United States include these important benefits.

Is my employer likely to stop providing mental health benefits as a result of MHPAEA?

Employers are very unlikely to do so. The Kaiser Family Foundation's 2010 survey of health coverage found that less than 2 percent of firms with more than 50 employees – those to which MHPAEA applies – dropped mental health insurance coverage because of the federal law.

What does “mental health and substance use parity” mean?

Mental health and substance use parity means that coverage for mental health and substance use benefits must be at least equal to coverage for physical health benefits. In other words, all of the financial requirements and treatment limitations applied to mental health and substance use benefits may be no more restrictive than those applied to physical health benefits.

Financial requirements include lifetime and annual dollar limits, deductibles, copayments, coinsurance and maximum out-of-pocket expenses. Treatment limitations include frequency of treatment, number of visits, days of coverage and other similar limits.
What kinds of treatment limitations and financial requirements are prohibited under MHPAEA?

A health plan may not place a treatment limitation or financial requirement on mental health and substance use benefits unless the same limit is placed on physical health benefits.

For example, a plan covered under MHPAEA may not apply a 20-visit annual limit to seeing a psychologist but no annual limit to seeing a physician. If annual office visits to your physician are not limited, annual office visits to a psychologist may not be limited.

Another example: A patient may not be required to make a $50 copayment for a psychotherapy session but only a $20 copayment for a physician's office visit. The patient's out-of-pocket expense must be the same for both visits.

Does a health insurance company have to tell me why it has denied an insurance claim?

An insurance company may deny a claim for a variety of reasons. A common reason is that health plans only pay for services that they consider to be “medically necessary.” MHPAEA requires insurance plans to make their medical necessity criteria available to current or potential participants. A health plan must inform participants why a claim has been denied, whether due to decisions about medical necessity or other reasons.

Is MHPAEA limited to coverage of certain mental health diagnoses?

No. MHPAEA does not exclude any mental and substance use disorders diagnoses. Under the federal law, parity requirements apply to all services covered by a health plan.

MHPAEA does not prohibit a health plan from denying coverage of individual mental health or substance use disorder diagnoses. Although not a common practice, a health plan may disallow coverage for individual diagnoses as specified in the terms of its coverage contract with an employer.

Does MHPAEA apply to out-of-network services?

Yes. When people have access to “out-of-network” (OON) services through their health plan, it means they may receive services from health care providers such as psychologists and physicians who do not participate in the health plan's network of providers. If a health plan that must comply with MHPAEA provides both OON physical and mental health/substance use disorder benefits, these benefits must be provided at parity. If a plan offers OON benefits only for medical/surgical services, the parity law requires the plan to add OON mental health and substance use disorder benefits, at parity.

What should I do if I think my health plan may not be complying with MHPAEA?

Speak with the human resources staff person or other employee in your company or organization who oversees the health insurance plan. You may also want to contact a representative of the insurance company that administers the health plan to raise your questions and concerns.

Further, you have the option of filing a formal complaint with the federal government. Complaints about insurance plans regulated under state law may be made via a toll-free Department of Health and Human Services help line at 1-877-267-2323, ext. 61565. For “self-funded” plans governed by the federal law known as ERISA (generally those of large employers), you may contact the Department of Labor at 1-866-444-3272.

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