Keenan & Associates

BRIEFING
JANUARY | 2012

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ADDITIONAL IMPLEMENTATION GUIDANCE

The Departments of Health and Human Services, Labor and Treasury have jointly issued guidance about the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in the form of Frequently Asked Questions (FAQ). The FAQ addresses questions regarding the application of "nonquantitative treatment limitations." You may access the FAQ at the following link:

http://www.dol.gov/ebsa/faqs/faq-aca7.html

As a general rule, a group health plan may not impose "financial requirements" (i.e., copayments/coinsurance) or "quantitative treatment limitations" (e.g., visit limitations) on mental health/substance use disorder benefits that are more restrictive than the limitations placed on at least two-thirds of medical/surgical benefits in the same classification (e.g., inpatient, in-network).

MHPAEA added similar restrictions on non-numerical limitations which affect the scope or duration of benefits referred to as "nonquantitative treatment limitations." Examples are:

- Medical management standards
- Prescription drug formulary design
- Standards for provider admissions to a network, including reimbursement rates
- Plan methods used to determine usual, customary and reasonable amounts
- Requirements for using lower-cost therapies before the plan will cover more expensive therapies
- Conditioning benefits on completion of a course of treatment

Any processes, strategies, evidentiary standards, or other factors used in applying a nonquantitative treatment limitation for mental health/substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in the application of such limitations to medical/surgical benefits. The terms of the plan as written and in operation must comply with this requirement.

IMPERMISSIBLE NONQUANTITATIVE TREATMENT LIMITATIONS

Plans that apply stricter limitations to all mental health/substance use disorder benefits but not to any medical/surgical benefits violate the MHPAEA. Examples include:

- A plan that requires prior authorization to determine medical necessity of all mental health/substance use disorder benefits but not for medical/surgical benefits.

- Routine approvals for inpatient stays that allow a greater number of days for medical/surgical stays than for mental health/substance use disorder stays.

NONQUANTITATIVE TREATMENT LIMITATIONS – RED FLAGS

We recommend further review of plans that appear to apply nonquantitative treatment limitations more stringently to mental health/substance use disorder benefits than for medical/surgical benefits. For example:

- A plan that requires prior authorization for all outpatient mental health benefits but only a few types of outpatient medical/surgical benefits such as outpatient surgery, speech, occupational and physical therapy and skilled home nursing visits.

In this example, while there may be some differences with respect to prior authorization based on clinically appropriate standards of care, it is unlikely that the processes, strategies, evidentiary standards and other factors considered by the plan in determining that outpatient surgery, speech/occupational/physical therapy and skilled home nursing visits would also result in all outpatient mental health/substance use disorder outpatient benefits needing prior authorization.

PERMISSIBLE BASIS FOR CERTAIN NONQUANTITATIVE TREATMENT LIMITATIONS

Differences in nonquantitative treatment limitations within a plan are to be expected and are not in violation of the MHPAEA if arrived at in an equitable manner. Examples include:

- A plan that considers a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits and arrives at prior authorization standards for some (but not all) mental health/substance use benefits, as well as for some medical/surgical benefits

- Application of concurrent review to inpatient care based on high levels of variation in length of stay (e.g., as measured by a coefficient of variation exceeding 0.8). Although the application of the standard affects 60% of mental health conditions and only 30% of medical/surgical conditions, it has been applied no more stringently to mental health than for medical/surgical even though it results in an overall difference.

- Recognized clinically appropriate standards of care with respect to individual conditions or treatments

STATE LAW/FEDERAL LAW

California's Mental Health Parity Act remains in force with respect to insured plans and plans subject to state law to the extent greater benefits are mandated. The federal law, MHPAEA, does not mandate coverage for any mental health condition or substance use disorder; however, if a plan sponsor does offer mental health/substance use disorder benefits those benefits must be in parity with medical/surgical benefits.

Keenan & Associates is not a law firm and no opinion, suggestion, or recommendation of the firm or its employees shall constitute legal advice. Clients are advised to consult with their own attorney for a determination of their legal rights, responsibilities and liabilities, including the interpretation of any statute or regulation, or its application to the clients' business activities.