

Federal Mental Health Parity and Addictions Equity Act (MHPAEA) FAQ

Q: What is the definition of Parity under the MHPAEA?

A: MHPAEA requires that any benefits offered by an insurer for mental health and substance use disorders are no more restrictive than the benefits offered for general medical and surgical benefits. This means that for mental health and substance use care, treatment limitations (e.g., limits on the number of inpatient or outpatient days) and financial requirements (e.g., deductibles, co-payments or coinsurance, and annual and lifetime dollar limits) must be equal to those applied for general medical/surgical benefits.

The above items are considered “quantitative treatment limitations.” MHPAEA also requires parity in “nonquantitative treatment limitations.” Nonquantitative treatment limitations include: medical management standards; prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary, and reasonable amounts; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment.

It is important to note that insurers are still permitted to use these nonquantitative cost-control methods, however they must be applied no more stringently for mental health and substance use treatment benefits than they are for general medical and surgical benefits.

Q: How does this new MHPAEA differ from the old federal Mental Health Parity Act (MHPA) of 1996?

A: The MHPA of 1996 only required parity with regard to annual and lifetime dollar limits. It did not prohibit insurers from providing more stringent limits on mental health inpatient or outpatient days, co-payments, co-insurance and deductibles. In addition, the MHPA did not extend to coverage for substance use disorders or psychiatric prescription drugs, nor did it address any of the non-quantitative treatment limitations referred to above.

Q: Does MHPAEA apply to all health plans and insurers?

A: No. MHPAEA applies to those group health plans of 50 or more employees. It does not apply to small group plans (fewer than 50 employees) or to the individual insurance market. Also, certain governmental plans may request a waiver from federal parity requirements under the self-insured government plan special exemption.

Q: Has NJ requested a waiver from MHPAEA for the State Health Benefit Plan (SHBP) under the self-insured government plan special exemption?

A: Yes. The NJ State Health Benefits Commission submitted a waiver from MHPAEA for both the State Health Benefits Plan (SHBP) and the School Employee’s Health Benefits Plan (SEHBP) in December 2009. At this time we do not know if this waiver request has been approved.

Q: When do these regulations go into effect?

A: These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after July 1, 2010.

There are some exceptions for certain collectively bargained plans which delay the effective date until the current collectively bargained plan terminates.

Q: Does the MHPAEA require that an insurer or health plan offer benefits for mental health and substance use disorder treatment?

A: No. Nothing in these regulations mandates a plan or issuer to provide any mental health or substance use disorder benefits. However, if an insurer or health plan chooses to offer mental health or substance use benefits, such benefits must be provided at parity with the general medical and surgical benefits offered by the plan.

Q: Does the MHPAEA require coverage of any and all mental health and substance use disorders (i.e., all disorders listed in the DSM-IV-TR)?

A: No. Under MHPAEA the provision of benefits for one or more mental health conditions or substance use disorders does not require the provision of benefits for any other condition or disorder. MHPAEA merely requires that benefits for those disorders where coverage is offered be equal to the coverage for general medical and surgical benefits in that plan.

Q: Who determines what mental health and substance use disorders will be covered?

A: MHPAEA leaves the determination of which mental health and substance use disorders should be covered to the various State laws and regulations and/or the health plans and issuers. States may continue to apply existing State law requirements except to the extent that such requirements would prevent the application of the MHPAEA requirements. Essentially, State parity law may be more stringent than MHPAEA, but not less stringent.

Please also note, these regulations provide that a permanent exclusion of all benefits for a specific condition or disorder is not a treatment limitation.

Q: How will MHPAEA impact my practice in New Jersey?

A: While this is still a developing issue, it is fairly safe to assume that those plans currently subject to regulation in NJ (primarily Horizon BCBS of NJ plans) will most likely continue operating under NJ's limited mental health parity law which requires insurers to offer coverage at parity for certain biologically-based mental illnesses only. Plans chartered and regulated outside of NJ will most likely continue to follow the regulations and requirements of the state in which they are chartered.

Q: How does MHPAEA measure and enforce parity within a particular plan?

*A: MHPAEA sets forth **six classifications of benefits**: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs. MHPAEA regulations provide that the parity requirements for financial requirements and treatment limitations are applied on a **classification-by-classification basis**.*

Under these regulations, if a plan elects to provide any benefits for a mental health condition or substance use disorder, benefits must be provided for that condition or disorder in each classification for which any medical/surgical benefits are also provided; however coverage levels may differ between classifications.

Example: a plan that chooses to provide mental health and substance use benefits offers general medical and surgical coverage in all six of the above classifications. This plan may NOT decide to offer mental health and substance use coverage for in-network, in-patient treatment only; this would be considered a treatment limitation and would violate parity provisions of the MHPAEA. To satisfy MHPAEA, mental health and substance use benefits would have to be offered in all six classifications because medical and surgical benefits are offered in all six classifications by this plan. However, this same plan could set different co-pays and deductibles between the various classifications, provided co-pays and deductibles within the classifications are equal. Therefore the in-network co-pay for all benefits (general medical, surgical, mental health, and substance use) could be set at \$10 and out-of-network co-pay for all benefits \$25.

Q: May insurers apply separately accumulating deductibles for general medical/surgical benefits and mental health/substance use benefits?

A: No. MHPAEA requires plans to use a combined deductible for all general medical, surgical, mental health, and substance use benefits for each covered individual.

Q: Does MHPAEA do anything to increase the transparency of the insurance reimbursement process?

A: Yes. MHPAEA contains two new disclosure provisions for group health plans that must be provided free of charge.

*(1) **Medical necessity disclosure.** MHPAEA requires plan administrators to make the plan's medical necessity determination criteria available upon request to potential participants, beneficiaries, or contracting providers.*

*(2) **Claims denial disclosure.** MHPAEA requires that the reason for any denial of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available upon request or as otherwise required by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary.*

NASW-NJ will continue to provide information about MHPAEA provisions as they become available. If you have specific questions regarding MHPAEA, please email managedcare@naswnj.org.