LEGAL ACTION CENTER

Frequently Asked Questions on the Federal Mental Health Parity and Addiction Equity Act

November 2013

What is the federal parity law?

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) became Public Law 110-343 in October 2008. MHPAEA, or the federal parity law, seeks to eliminate discriminatory access to mental health and substance use disorder (MH and SUD) benefits in certain health insurance coverage. Plans subject to the federal parity law are precluded from providing MH and SUD benefits in a more restrictive way than other covered medical and surgical benefits.

How does the federal parity law work?

The federal parity law prohibits plans from applying financial requirements or treatment limitations to MH and SUD benefits that are more restrictive than those applied to other medical/surgical benefits covered by the plan. Financial requirements include co-pays, deductibles, co-insurance, and other out-of-pocket costs. Treatment limitations include both quantitative treatment limitations (including day or visit limits or frequency of treatment limits) and non-quantitative treatment limitations (medical management tools). A parity analysis requires a comparison of a plan's covered MH and SUD services and the treatment limitations and financial requirements applied to those benefits, with the plan's covered medical and surgical benefits and the treatment limitations and financial requirements imposed on those benefits.

Which programs must comply with the federal parity law?

When the federal parity law passed in 2008, it applied only to large group health plans (including federal and non-federal employer-funded plans, and self-funded ERISA plans) and Medicaid managed care plans that offer coverage for MH and/or SUD benefits.

The requirements of the federal parity law were extended to the Children's Health Insurance Program through CHIP reauthorization in 2009.

The Affordable Care Act (the federal health care reform law) also extends the requirements of the federal parity law to plans in the individual and small group markets, and to Medicaid Alternative Benefit Plans (ABPs), including those that will be provided to the Medicaid expansion population.

When does the final parity rule go into effect?

The final parity rule is effective for health plans and issuers with plan years beginning on or after July 1, 2014. Since most plans operate on a calendar year basis, the final parity rule will become effective for most plans on January 1, 2015. Until then, the interim final parity rule issued in 2010 remains in effect.

What are the major areas the final parity rule addresses?

The final parity rule seeks to provide additional clarity about how private insurance plans must comply with the parity law. The final parity rule builds on previous guidance by the federal regulators by giving greater detail on how parity relates to the scope of covered MH and SUD services, more information on transparency and disclosure requirements, and additional examples of medical management tools that constitute non-quantitative treatment limitations that must be subject to a parity analysis.

How does the final parity rule address scope of service?

Following release of the 2010 parity rule, there were a number of questions about how the requirements of the federal parity law applied to services on the continuum of care that fell between inpatient and outpatient services. The 2010 parity rule identified six categories of benefits: 1) inpatient care provided in-network, 2) inpatient care provided out-of-network, 3) outpatient care provided in-network, 4) outpatient care provided out-of-network, 5) emergency care, and 6) prescription drugs. The 2010 parity rule stated that health plans offering benefits for an SU or MH condition or disorder must provide those benefits in each classification for which any medical/surgical benefits are provided; if the plan provided medical/surgical benefits in one of the classifications but did not provide SUD or MH benefits in that classification, that would constitute a treatment limitation.

The final parity regulations are clear that, with the 2010 rule's explicit discussion of only "inpatient" and "outpatient" services, the federal regulators "did not intend that plans and issuers could exclude intermediate levels of care covered under the plan from MHPAEA's parity requirements." The final regulations identify intermediate MH and SUD services as intensive outpatient, partial hospitalization, and residential treatment.

The final regulations are clear that plans and issuers must fit all medical, surgical, MH, and SUD benefits (including intermediate services) the plan covers into the benefit classification framework established in the 2010 parity rule. The final parity regulations further state that plans and issuers must assign intermediate MH and SUD services to the six benefit classification framework in the same way that they assign comparable intermediate medical/surgical benefits to these classifications.

The final parity rule provides examples that make clear that coverage of intermediate levels of care, including residential treatment, must be subject to a parity analysis. The final regulations cite as an example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must also treat any covered care in residential treatment facilities for mental health or substance use disorders

as an inpatient benefit. In addition, if a plan or issuer treats home health care as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.

Does the final parity rule discuss residential treatment?

As discussed above, the final parity regulations discuss coverage of intermediate MH and SUD services, including residential services, and make clear that the requirements of the federal parity law extend to coverage of residential services. Plans must classify residential services as either inpatient or outpatient benefits based on how they classify analogous medical/surgical services. The final parity regulations, as one example, state that if a plan classifies skilled nursing facilities or rehabilitation hospitals as inpatient benefits, the plan or issuer must also treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. Once the residential treatment benefit is classified in the appropriate benefit category, a parity analysis of the financial requirements and treatment limitations imposed on that benefit can be compared with the financial requirements and treatment limitations applied to the corresponding medical/surgical benefit.

In addition, the final rule identifies a number of additional NQTLs that have specific implications for coverage of and access to residential treatment services. One example provided clarifies that a plan that generally covers medically appropriate treatments would violate parity if it automatically excludes coverage for inpatient SUD treatment outside of hospitals (including freestanding or residential centers), but conditionally excludes inpatient treatment outside of hospitals for other conditions. Another example clarifies that excluding out of state inpatient, out-of-network SUD treatment without a similar exclusion for medical/surgical benefits within the same classification would also be a parity violation.

Does the final parity rule give additional guidance on the application of the parity law to non-quantitative treatment limitations?

The final parity rule reaffirms that non-quantitative treatment limitations (NQTLs), or medical management tools, must also comply with requirements of the parity law. While the final parity rule includes additional examples of medical management tools that constitute NQTLs, the rule is clear that all NQTLs applied to MH and SUD benefits must be applied in compliance with the parity law.

In addition, the final parity rule removes an exception from the 2010 parity rule that allowed plans to use different standards in applying NQTLs to their benefits. To determine whether the NQTLs imposed on MH or SUD benefits are more restrictive than those imposed on other covered medical/surgical benefits, the 2010 parity rule required an analysis of the processes, strategies, criteria, and evidentiary standards used to apply the NQTLs, and whether they are 1) comparable to and 2) applied no more stringently than those applied to medical/surgical benefits. However, under the 2010 parity rule, plans were permitted to use different standards in applying their NQTLs if there was a clinically recognized standard of care that permitted the difference. The final parity rule removes this exception. Therefore, plans must use comparable standards in managing their medical, surgical, MH, and SUD benefits and cannot be more restrictively managed than the MH or SUD benefits without violating the parity law.

Does the final parity rule give additional examples of NQTLs?

The final rule includes a number of additional specific examples that constitute NQTLs that must be subject to a parity analysis. Additional examples provided include treatment limitations based on geography, facility type, provider specialty, and the criteria limiting the scope or duration of benefits or services.

How does the final parity rule address provider rates?

The final parity rule affirms that provider rates are a form of NQTL that must meet the requirements of the parity law. In examining rates for MH and SUD service providers, the rule states that a number of factors that must be considered, including service type, the geographic market, demand for services, supply of providers, provider practice size, Medicare rates, training, experience, and provider licensure.

Under the final parity rule, what are plans required to disclose to consumers?

The 2010 parity rule made clear that criteria for medical necessity determinations for SUD or MH benefits must be made available to participants and beneficiaries, and that reasons for denial of reimbursement or payment for SUD or MH services must be made available to participants and beneficiaries.

The final parity rule builds on the 2010 rule by requiring plans to disclose in writing an analysis of how non-quantitative treatment limits (NQTLs) are applied to medical/surgical, MH, and SUD benefits covered by the plan, including what processes, strategies, evidentiary standards and other factors plans use to apply NQTLs. The final rule also requires plans to provide claimants with any new additional evidence used to make benefit determinations during appeals. The final rule also makes clear that this information must be provided within 30 days to any current or potential enrollee or contracting provider.

Who has primary monitoring and enforcement oversight over the parity law?

The final parity rule reasserts that states are primarily responsible for monitoring and enforcing the federal parity law for group and individual market coverage. Should a state not enforce the law, the federal agency with jurisdiction over the corresponding insurance program would have primary oversight.

The federal Department of Health and Human Services (HHS), through HHS's Center for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in states that are not enforcing the law. The final parity regulations state that, "CMS believes that most States have the authority to enforce MHPAEA and are acting in the areas of their responsibility. In States that lack the authority to enforce MHPAEA, CMS is either directly enforcing MHPAEA or collaborating with State departments of insurance to ensure enforcement."

The Departments of Labor and the Treasury have primary enforcement over private sector employment-based health plans that are subject to ERISA, while HHS has primary enforcement authority over non-Federal governmental plans, such as those sponsored by State and local government employers.

How does the final parity rule address the relationship between the federal parity law and state laws?

The final parity rule affirms that state laws providing greater protections than the federal parity law remain in effect and are not preempted by the federal parity law.

Which types of plans must comply with the final parity regulations?

Since the federal parity law applies to a number of different types of plans that are overseen by different federal agencies, different sets of guidance have been issued on how the parity law applies to these various insurance programs.

The final parity regulations were issued in November 2013 by the three federal agencies with jurisdiction over the federal parity law, the Departments of Health and Human Services, Labor and Treasury. The final parity regulations apply to commercial plans in the large and small group and individual markets.

Prior to the issuance of the final parity rule, the federal regulators issued the interim final parity rule ("the 2010 parity rule") on how large group plans should comply with the law. In addition, the Department of Labor has issued a number of Frequently Asked Questions to further guide implementation.

What guidance governs other types of coverage that has to comply with the federal parity law?

The final parity regulations state that they are not intended to apply to Medicaid managed care plans, Medicaid ABPs, and CHIP plans. Although these plans must comply with the federal parity law, separate guidance governs how the parity law applies to these programs.

The Centers for Medicare and Medicaid Services (CMS) issued guidance in January 2013 on how the federal parity law applies to Medicaid managed care plans, Medicaid ABPs, and CHIP plans. The January 2013 guidance explains that states should analyze financial requirements and both quantitative and non-quantitative treatment limits imposed on MH and SUD benefits and medical/surgical benefits, and bring parity violations into compliance. CMS has said it will release additional guidance to further clarify how the federal parity law applies to Medicaid and CHIP.

Where can I find pieces of regulations and other forms guidance the government has issued on the federal parity law?

The Mental Health Parity and Addiction Equity Act of 2008 statute is available at: http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/MHPAEA.pdf

The interim final parity rule is available at: http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf

The final parity rule can be found at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-27086.pdf

The January, 2013 guidance from CMS on the application of the parity law to Medicaid and CHIP can be found at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

The Department of Labor's FAQs on the final parity rule are available at: http://www.dol.gov/ebsa/faqs/faq-aca17.html

The Substance Abuse & Mental Health Services Administration (SAMHSA) has additional materials on parity that can be found at: http://beta.samhsa.gov/health-reform/parity

The Parity Implementation Coalition's summary of the final parity rule is available at: http://parityispersonal.org/sites/default/files/PIC%20summary%20final%20rule.pdf