

Delaware Developmental Disabilities Council

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MEMORANDUM

DATE: June 17, 2013
TO: The Delaware General Assembly
FROM: Diann Jones, Chairperson
Developmental Disabilities Council
RE: H.B. 164 [Mental Health Parity]

The Developmental Disabilities Council (DDC) has reviewed H.B. 164 which requires compliance with the federal mental health parity laws. As background, federal mental health parity legislation was first enacted in 1996. Delaware followed up with enactment of its original mental health parity legislation through H.B. 156 in 1998. The State law covers insurance coverage for both serious mental illness and drug and alcohol dependency. In the meantime, federal legislation was adopted in 2008 to close loopholes in the 1996 federal parity law and expand the scope of protections for group insurance plans covering more than 50 employees. See attached U.S. DOL and APA summaries of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. States are permitted to provide more protections than the federal law. The regulations are published at 45 C.F.R. Part 2590 and available at <http://www.gpo.gov/fdsys/pkg/FR-2010-02-02/pdf/2010-2167.pdf>. H.B. 164 would have two effects.

First, it updates the mental health parity law covering large (50+ employee) groups to require compliance with the 2008 federal law (lines 4-5).

Second, it requires such plans to cover a minimum of 30 consecutive calendar days per benefit year at an inpatient medical or residential facility that is approved by the Joint Commission on Accreditation of Healthcare Organizations (lines 11-13). The rationale for this change is highlighted in the synopsis:

Carriers only provide a limited amount of consecutive days in an inpatient facility (many times, 5 consecutive days) before requiring an insured to seek outpatient therapy. Oftentimes, 5 days is not a sufficient amount of time to diagnose and treat serious mental illness or to detoxify from an alcohol or drug addiction.

DDC strongly endorses the proposed legislation.

Thank you for your consideration and please contact Developmental Disabilities Council at 302-739-3333 if you have any questions regarding our position or observations on the proposed legislation.

cc: The Honorable Jack Markell
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
State Council for Persons with Disabilities



UNDERSTANDING IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

May 9, 2012

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires employment-based group health plans and health insurance issuers that provide group health coverage for mental health/substance use disorders to maintain parity between such benefits and their medical/surgical benefits. Specifically, MHPAEA and its implementing regulations generally:

- Provide that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits can generally be no more restrictive than the requirements or limitations applied to medical/surgical benefits.
- Include requirements to provide for parity for nonquantitative treatment limitations (such as medical management standards).
- Expand the parity requirements of an earlier law, the Mental Health Parity Act of 1996, such that **plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.**

The Departments of Labor, the Treasury, and Health and Human Services (HHS) (collectively, the Departments), administer MHPAEA together with the States. This document provides basic information about the Departments' MHPAEA implementation efforts.

More detailed information on MHPAEA's requirements is available at <http://www.dol.gov/ebsa/mentalhealthparity/>.

COMMON MHPAEA IMPLEMENTATION QUESTIONS

Q1: Who oversees MHPAEA implementation?

The Departments, as well as the States, all have important roles with respect to MHPAEA implementation to ensure that there are coordinated interpretive guidance and enforcement efforts.

The Departments share responsibility for interpretations under MHPAEA, including regulations and other guidance, which is generally developed and issued jointly to ensure consistency.¹

¹ See 64 FR 70164 (December 15, 1999) for a Memorandum of Understanding between the Departments regarding provisions of shared jurisdiction, which includes MHPAEA.

The Departments of Labor and the Treasury generally enforce these requirements for private, employment-based group health plans. States have primary enforcement responsibility with respect to health insurance issuers. If a State does not act in the areas of its responsibility, HHS may make a finding that the State has failed “to substantially enforce” the law and enforce directly. HHS also has direct enforcement authority over non-Federal governmental plans (those sponsored by State and local government employers).

Employees with questions about MHPAEA, including complaints about compliance by their employment based group health plans, can contact any of the Departments. The Departments will work together and, to the extent an issuer is involved, will work with the States, as appropriate, to ensure MHPAEA violations are corrected.

Q2: Have the Departments issued regulations implementing MHPAEA?

Yes. The Departments jointly issued interim final regulations on February 2, 2010.² These rules generally became applicable for plan years beginning on or after July 1, 2010.

Q3: What does it mean to issue an interim final regulation?

The Departments’ interim final MHPAEA regulations apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2010. The regulations are “interim” in the sense that public comments were invited, which is used to inform the Departments’ work. Comments received on the MHPAEA regulations have informed the issuance of guidance, including frequently asked questions (FAQs) addressing common questions regarding MHPAEA.³ Plans and issuers are required to comply with interim final regulations.

Q4: It is permissible for a health plan to define mental health coverage as consisting solely of inpatient care benefits?

No. The Departments regulations set 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.⁴ If a plan covers mental health or substance use disorder benefits in one of the six classifications, the plan must provide coverage in all of the classifications in which medical/surgical benefits are available. Therefore, a plan that provides medical/surgical benefits on an outpatient basis may not limit mental health or substance use disorder benefits to inpatient care only.

² 75 FR 5410 (February 2, 2010).

³ FAQs regarding MHPAEA were issued on June 30, 2010 (<http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>), December 22, 2010 (<http://www.dol.gov/ebsa/faqs/faq-aca5.html>), and November 17, 2011 (<http://www.dol.gov/ebsa/faqs/faq-aca7.html>).

⁴ In June 2011, the Departments released an FAQ that established an enforcement safe harbor for a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services. See <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

Q5: Does my health plan violate MHPAEA because it uses a separate managed behavioral health organization to provide utilization review and other services with respect to mental health and/or substance abuse benefits (sometimes called a carve-out arrangement)?

No, MHPAEA does not require that insurance arrangements be organized in any particular way. Instead, MHPAEA requires that mental health and substance use disorder benefits be covered and managed in a manner that is no more stringent than medical/surgical benefits. Managed behavioral health organizations may have specialized expertise in the treatment of mental health and substance use disorders and in organizing networks of specialty providers.

To comply with MHPAEA, group health plans, their health insurance issuers, and other service providers should work together to ensure that standards for financial requirements, treatment limitations and non-quantitative treatment limitations are being met. In particular, standards used in applying nonquantitative treatment limitations to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than the standards used in applying the limitations with respect to medical/surgical benefits, except to the extent that recognized clinically-appropriate standards of care permit a difference.

Q6: MHPAEA and its implementing regulations impose mathematical tests for determining whether a financial requirement or quantitative treatment limitation (such as a copay or visit limit) on mental health/substance use disorder benefits is permitted. Are nonquantitative treatment limitations, or NQTLs, (such as medical management standards) analyzed the same way?

No. While the Departments' regulations set forth mathematical rules for analyzing plan limitations that are expressed numerically, nonquantitative limitations are analyzed differently.

With respect to nonquantitative treatment limitations, the Departments' regulations provide that under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used by a plan or issuer in applying an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits, unless recognized clinically appropriate standards of care may permit a difference.

For more information and guidance regarding NQTLs, see the interim final regulations, as well as the FAQs available at: <http://www.dol.gov/ebsa/pdf/faq-aca7.pdf>.

Q7: How does MHPAEA interact with State mandates?

States generally may impose stricter requirements on health insurance issuers. For example, while MHPAEA does not require that plans provide benefits for any particular mental health condition or substance use disorder, a State law may mandate that an issuer offer coverage for a particular condition. To the extent a State law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition must be in parity with medical/surgical benefits under MHPAEA.

If health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State's insurance laws.

Q 8: Are there plans that are exempt from MHPAEA?

Yes. While MHPAEA applies to most employment-based health coverage, there are a few important exceptions. Specifically, MHPAEA does not apply to small employers who have fewer than 51 employees.⁵ There is also an increased cost exemption available to plans whose costs increase by more than a specified amount and who follow guidance issued by the Departments.⁶ Additionally, plans for State and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees).⁷ Finally, MHPAEA does not apply to retiree-only plans.⁸

Q9: What do I do if I think my plan is violating MHPAEA?

If you have concerns about your plan's compliance with MHPAEA, you can contact the Federal government or your State Department of Insurance. You may contact the Department of Labor at 1-866-444-3272 or on the web at:

<http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>. You may also contact the Department of HHS at 1-877-267-2323 ext 61565 or at phig@cms.hhs.gov or your State Department of Insurance at http://www.dol.gov/cgi-bin/leave-dol.asp?exiturl=http://www.naic.org/&exitTitle=State%27s_Health_Insurance_Laws.

Regardless of which agency or State you contact, the Federal Departments and the States work together to ensure MHPAEA violations are corrected.

Q10: What are the Departments doing to promote compliance?

The Departments are working with plans, issuers, and their service providers to help them understand and come into compliance with MHPAEA and to ensure that participants and beneficiaries receive the benefits they are entitled to under the law. The Departments also coordinate with State regulators to ensure compliance and issue guidance to address frequently asked questions from stakeholders. Compliance assistance is a high priority for the Departments and our approach to implementation is marked by an emphasis on assisting plans and issuers that are working diligently and in good faith to comply with the requirements of the law. The Departments receive complaints from participants, beneficiaries, providers, and other stakeholders and work with these individuals and the regulated community to correct violations.

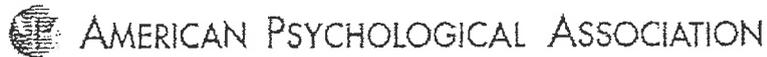
⁵ For more information on the small employer exception, see Q8 of the FAQs available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

⁶ For more information on MHPAEA's increased cost exemption, see Q11 of the FAQs available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

⁷ If you are an employee of a State or local government and would like to know if your employment-based plan has opted out, contact HHS at 877-267-2323, ext. 61565 or at phig@cms.hhs.gov.

⁸ See 75 FR 34538 at 34539 (June 17, 2010) for more information on special rules for retiree-only plans.

The Departments also engage in extensive outreach and compliance assistance activities throughout the year on MHPAEA. For a copy of MHPAEA outreach publications, and to get information on upcoming events, see <http://www.dol.gov/ebsa/mentalhealthparity/>.



Mental Health Parity and Addiction Equity Act

How does the new mental health parity law affect my insurance coverage?

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act taking a great step forward in the decade-plus fight to end insurance discrimination against those seeking treatment for mental health and substance use disorders. This law requires health insurance to cover both mental and physical health equally. Under this law, insurance companies can no longer arbitrarily limit the number of hospital days or outpatient treatment sessions, or assign higher co-payments or deductibles for those in need of psychological services.

The 2008 act closes several of the loopholes left by the 1996 Mental Health Parity Act and extends equal coverage to all aspects of health insurance plans, including day and visit limits, dollar limits, coinsurance, co-payments, deductibles and out-of-pocket maximums. It preserves existing state parity and consumer protection laws while extending protection of mental health services to 82 million Americans not protected by state laws. The bill also ensures mental health coverage for both in network and out-of-network services.

Research shows that physical health is directly connected to mental health and millions of Americans know that suffering from a mental health disorder can be as frightening and debilitating as any major physical health disorder. Passage of this law will lead the health care system in the United States to start treating the whole person, both mind and body.

Frequently asked questions

The frequently asked questions, or FAQs listed below contain questions and answers relating directly to the new mental health parity law.

What is mental health and substance use parity?

Parity means equal coverage for mental health and physical health conditions covered under health plans. The 2008 Mental Health Parity and Addiction Equity Act provides the following:

Equal benefits: Means that benefits coverage for mental health and substance use treatments must be at least equal to that coverage provided for physical health services.

Equal limits: All of the financial requirements and treatment limitations applied to mental health and substance use benefits may be no more restrictive than for physical health benefits.

Equal cost-sharing: The new law prohibits the use of higher patient cost-sharing (deductibles, co-payments, maximum-out-of-pocket costs) for mental health and substance use benefits than for physical benefits. For example, your co-payment for psychotherapy will be the same amount as your co-pay for an office visit with your family physician.

What does the Mental Health Parity and Addiction Equity Act do?

Applies to groups of more than 50 employees: The act, effective January 1, 2010, ends inequities in health insurance benefits between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees.

Creates equity: Applies to all financial requirements in health insurance plans, including:

- lifetime and annual dollar limits,
- deductibles, copayments, coinsurance,
- out-of-pocket expenses, and
- to all treatment limitations including frequency of treatment, number of visits, days of coverage and other similar limits.

Insurance plans will no longer be able to apply a different deductible for mental health services than they do for physical health services, or more restrictive limits to the number of treatment sessions or days of hospital stays.

When does the new law take effect?

The Mental Health Parity and Addiction Equity Act will apply to most health plans beginning January 1, 2010. The current 1996 parity law will remain in effect through December 31, 2009.

Will my health plan have to comply with the new law?

The act applies to all group health plans with more than 50 employees, whether they are self-funded (regulated under ERISA) or fully insured (regulated under state law), that provide mental health or substance use benefits. Those health plans with 50 or fewer employees will remain subject to current state mental health parity requirements. The new law does not apply to the individual insurance market.

What diagnoses are included under parity?

The parity act covers all diagnoses for mental disorders. It goes beyond the 1996 act and some state parity and mandated benefit laws by also requiring parity for substance use disorders. There are no exclusions. In effect, whatever a plan covers must be at parity with (equal to) what is covered for physical health problems. As in the current system, a health plan may deny coverage based on medical necessity or under the terms of its coverage contract with an employer.

Can benefits for a particular diagnosis be excluded from coverage under the new parity law?

Yes, employers are not prohibited from dropping coverage for a diagnosis. The act broadly defines mental health and substance use disorder benefits to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.

Does the new act have any impact on benefits management and medical necessity criteria?

A health plan may manage the benefits under the terms and conditions of the plan. The act requires insurance plans to make medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. A health plan must also make reasons for payment denials available to participants or beneficiaries on request or as otherwise required.

Does the new parity law apply to out-of-network services?

Yes. Under the new law, if a health plan provides both out-of-network physical and mental health/substance use disorder benefits, these services must be provided at parity.

If a plan currently provides only out-of-network physical health benefits, this new law will require it to add out-of-network mental health and substance use disorder benefits, at parity.

Can health plans drop mental health and substance use benefits completely?

Yes. The act does not require health plans to provide mental health and substance use benefits, but if the plan does provide such coverage, it must be at parity with physical health coverage.

Elimination of these benefits would likely be very expensive to health plans. A Kaiser Family Foundation Annual Survey of Benefits showed that 97 percent of plans already provide mental health and substance use benefits. It is now well accepted these benefits are an integral part of treating most health conditions. Effective treatment of most illnesses like diabetes, asthma and congestive heart conditions requires a full recognition and treatment of comorbid mental health and substance use disorders.

My state already has a parity law. How will this new federal law impact state law?

State laws only apply to fully insured groups. They do not apply to "self-insured" ERISA groups. Forty three states have enacted parity laws. While some of these laws provide for strong parity protections, many are not as comprehensive as the new federal law. For those states with strong existing parity laws, the Mental Health Parity and Addiction Equity Act is protective of state law. If a provision in a state parity law provides for less protection than the federal law, it is the federal law that prevails. Conversely, if the state law provides for more protection than the federal law, state law prevails.

Does the new law apply to Medicare and Medicaid patients?

The act does not apply to Medicare patients. In July 2008, Congress provided for Medicare coinsurance parity for Medicare patients by 2014 when it enacted "phase-in parity" under the Medicare Improvements for Patients and Providers Act (MIPPA). The 2008 act, however, does apply to Medicaid managed care health plans.

Are you an employer looking for information about Mental Health Parity? See the Employer's Guide

(<http://www.phwa.org/resources/goodcompany/newsletter/article/112>).

August 2009

Find this article at:

<http://www.apa.org/helpcenter/parity-law.aspx#>