



AMERICAN COUNSELING ASSOCIATION

Frequently Asked Questions about the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) is an historic step forward for mental health advocates. The law will remove many roadblocks to treatment faced by those with mental and addictive disorders, and will help remove the stigma associated with treatment. The U.S. Department of Treasury, the U.S. Department of Labor, and the U.S. Department of Health and Human Services jointly released regulations on MHPAEA in the February 2, 2010 Federal Register. The text of the regulations can be found online at <http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf>. A three page fact sheet on the MHPAEA requirements is posted on the Department of Labor's website at <http://www.dol.gov/ebsa/pdf/fsmhpaea.pdf>.

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What does the Mental Health Parity and Addiction Equity Act (MHPAEA) say about licensed professional mental health counselors?

Absolutely nothing. The parity act does not reference *any* specific types or specialties of providers. The law attempts to establish health plan coverage for mental health and addictive disorder treatments that is at parity with coverage for medical/surgical care. It does not address issues regarding "parity" of one provider group with another.

Who does the law apply to?

The law applies to private sector health plans covering more than 50 employees. The law also applies to state and local government employee health plans, although non-federal government plans can opt out of the MHPAEA requirements if they are self-insured, and follow the notice provisions prescribed by the Centers for Medicare and Medicaid Services (CMS).

The law does *not* apply to health plans for students operated by colleges and universities. Such plans are not considered "group health plans." Health plans sponsored by state (not private) schools for school employees may or may not be covered under MHPAEA, depending on the details of the program.

When does the law take effect?

The *law* took effect for health plan years beginning after October 3, 2009. The *regulations* implementing the law take effect for health plan years beginning on or after July 1, 2010.

Although this sounds confusing, all it means is that health plans won't necessarily be considered in violation of the law between now and July 1st, 2010 if they're not quite meeting all of the *regulatory*

requirements, as long as they're making a good faith effort to abide by the law. The federal agencies involved simply needed a little more time than they were given to promulgate the regulations.

Who is enforcing the law?

MHPAEA will be enforced jointly by the Employee Benefits Security Administration (EBSA) within the U.S. Department of Labor, the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services, and the Internal Revenue Service within the U.S. Department of Treasury.

EBSA can be contacted by email through their website at <http://askebsa.dol.gov/SecInit/>, or by phone at 1-866-444-EBSA (3272). Similarly, the Department of Health and Human Services has established help line to answer questions about compliance at 1-877-267-2323, ext. 6-5511. You can also e-mail questions to phig@cms.hhs.gov.

What exactly will health plans have to change about how they operate?

Health plans will have to equalize coverage practices, including treatment limitations and financial requirements, between mental health and addictive disorder care on the one hand and medical/surgical care on the other in six classifications of benefits:

- Inpatient care provided in-network;
- Inpatient care provided out-of-network;
- Outpatient care provided in-network;
- Outpatient care provided out-of-network;
- Emergency care; and
- Prescription drug coverage.

For example, if a health plan covers outpatient services provided by out-of-network providers for medical/surgical care, it must also cover outpatient mental health services provided by out-of-network providers. Similarly, if a health plan charges a \$10 copayment for in-network medical/surgical outpatient care and a \$25 copayment for out-of-network medical/surgical outpatient care, it must charge the same \$10 and \$25 copayments for in-network and out-of-network (respectively) outpatient mental health services.

The regulations require that if a plan provides any benefits for a mental health condition or substance use disorder, benefits must be provided for that condition or disorder in each of the six classifications for which any medical/surgical benefits are provided.

The biggest change for plans will be not using quantitative visit limits. As the regulation states:

“The most common visit limits under current insurance arrangements are those for 20 visits per year. That means assuming a minimal approach to treatment of one visit per week, people with severe and persistent mental disorders will exhaust their coverage in about five months. This often results in people foregoing outpatient treatment and a higher likelihood of non-adherence to treatment regimes that produce poor outcomes and the potential for increased hospitalization costs.” (75 FR 5422)

Health plans won't be able to use quantitative (i.e., 20 visits per year) visit limits, or even nonquantitative visit limits that aren't also used for medical/surgical care. The regulations describe nonquantitative treatment limits as including “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.”

The regulation explicitly addresses this last example, stating that

[R]equiring participants to exhaust the EAP [employee assistance program] benefits—making the EAP a gatekeeper—before an individual is eligible for the major medical program’s mental health or substance use disorder benefits is a nonquantitative treatment limitation subject to the parity requirements. Consequently, if similar gatekeeping processes with a similar exhaustion requirement (whether or not through the EAP) are not applied to medical/surgical benefits, the requirement to exhaust mental health or substance use disorder benefits available under the EAP would violate the rule that nonquantitative treatment limitations be applied comparably and not more stringently to mental health and substance use disorder benefits. (75 FR 5416)

With respect to nonquantitative treatment limits, ACA will encourage the Departments to amend the regulation to prohibit health plans from discriminating against providers on the basis of their type of license. Refusing to cover fully licensed providers—such as counselors—is an all-to-easy method for health plans to limit access to care. ACA encourages counselors to submit comments on the regulation asking for this change.

The MHPAEA regulations also stipulate that health plans must use a single, unified deductible for all covered services, including medical/surgical care, mental health care, and addictive disorder services.

Will MHPAEA end managed care plan utilization review and case management for outpatient psychotherapy?

No. MHPAEA was not written to address the broader issue of managed care plan practices and general patient (and provider) protections. It assumes that health plans will continue to take steps to make sure they are only paying for medically necessary care. The restraint on costs associated with the use of managed care plan practices was one of the biggest arguments *for* the parity legislation as it was moving through Congress. As the regulation states, “the Departments [of Treasury, Labor, and Health and Human Services] expect medical management and managed care techniques will help control any major cost impact resulting from MHPAEA and these regulations.”

However, the regulations *do* require that health plans make available, upon request to any current or potential participant, beneficiary, or contracting provider, the criteria used for making medical necessity determinations with respect to mental health or substance use disorder benefits. In addition, MHPAEA requires that health plans provide the reason for any denial for services with respect to mental health or substance use disorder benefits.

How does the MHPAEA law interact with parity laws in my state?

MHPAEA was carefully written to provide a floor, not a ceiling, of benefit protections, and thus does not supersede or preempt state laws. Health plans must meet the requirements of both existing state laws and of MHPAEA.

Will MHPAEA require health plans to cover specific diagnoses?

Unfortunately, no. This was one of the biggest battles in the fight to enact the law, one which the mental health advocacy community wasn’t able to win. MHPAEA does not require coverage of any specific diagnoses. If a health plan currently excludes coverage of services for eating disorders, for example, they can continue to do so under MHPAEA, and can even exclude other specific disorders if they so choose.

However, MHPAEA does *not* override state laws in this area, so if a health plan is required by state law to cover certain disorders or services, that requirement still applies.

Will health plans have to cover specific treatments for mental and addictive disorders?

No. This is a thorny issue. The array of mental health and substance use therapies used today isn't completely analogous to that used in medical/surgical care. No bill requiring coverage of specific types of mental health care could have made it through Congress, and MHPAEA did not attempt to do so. The law instead focuses on eliminating disparities between mental health and substance use care and medical/surgical care in the broader design and implementation of health insurance coverage.

To quote the agencies, "These regulations do not address the scope of services issue." The Departments are particularly interested in comments on "whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage."

Can health plans opt out of the MHPAEA requirements, or stop covering mental health care altogether?

Plans can decide to drop coverage for mental health and substance abuse disorder benefits (if they are allowed to do so under state laws). However, this is not considered likely. As the regulation states, "Research on the introduction of state parity laws suggests few plans or individuals will drop insurance coverage due to parity." The Congressional Budget Office (CBO) estimates that MHPAEA requirements will lead to average health insurance premium increases of only 0.4 percent. Given the effect of untreated mental and addictive disorders on physical health—and the potentially high cost of treatment—health plans would be penny wise but pound foolish to drop coverage for mental health care.

In limited circumstances, plans can apply for an exemption from the MHPAEA requirements if they incur an annual cost increase of two percent for the first year the plan is subject of MHPAEA (or one percent thereafter) as a result of the application of the parity requirements. The cost increase must be certified by a qualified and licensed actuary, and if approved, the plan must provide notice that it is exempting itself from the parity requirements.

Importantly, an exemption from the MHPAEA lasts only one year. The following year the plan must again come into compliance. Thus, the increased cost exemption may only be claimed for alternating plan years.

Can I comment on the regulations?

Definitely! Comments on the parity regulations are due on or before May 3, 2010. To submit comments, go to <http://www.regulations.gov>, and enter "MHPAEA CMS" in the search box labeled "Enter keyword or ID", and then click on "submit a comment" for one of the agencies' postings entitled "Interim final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act."

Please note that all comments will be made available to the public, so do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments will be posted on the internet exactly as received, and can be retrieved by most search engines. Comments may be submitted anonymously. Comments can also be mailed to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-4140-IFC, P.O. Box 8016, Baltimore, MD 21244-1850.