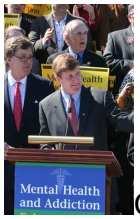
NCADD
NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.

NCADD Celebrates Final Parity Regulations



On Friday, November 8th, the Department of Treasury, Department of Labor (DOL) and the Department of Health and Human Services (HHS) issued a press release and held a webinar announcing the 206 page final regulations for implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), commonly known as "MHPAEA" or "Parity".

"Without question, the Parity Law is historically one of the most important pieces of federal legislation ever signed into law and will help reduce the stigma and discrimination that has blocked access to life-saving treatment and recovery for millions of people with alcohol and drug dependence for far too long", said Robert J. Lindsey, President/CEO of NCADD. Mr. Lindsey went on to say that, "Since the law went into effect January 1, 2011, the delay in the issuance of the final regulations has created problems for states and insurers as they work to implement the law. Most important, it has created additional problems for consumers. NCADD is very pleased that the final rules have finally been issued."

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Left to Right: Rep. Steny Hoyer (D-MD)- House Majority Leader Rep. Jim Ramstad (R-MN) Rep. Patrick Kennedy (D-RI) Former First Lady Rosalynn Carter Rep. Nancy Pelosi (D-CA) – Speaker of the House Background: Robert J. Lindsey- President/CEO NCADD John Shinholser- NCADD Richmond-McShin Foundation (sunglasses)

According to David Lewis, MD, Chair of the NCADD Medical-Scientific Committee, "Achieving parity for substance use disorders and mental health puts them where they belong-----in the mainstream of health care". Passed and signed into law by President Bush in 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) represents the culmination of almost 20 years of advocacy work by NCADD and countless other addiction and mental health organizations.

Although signed into law in 2008, Interim Final Rules (IFR) were published on February 2, 2010, effective April 5, 2010 and went into effect for all plans January 1, 2011. Parity is a critically important component of the effective implementation of the Patient Protection/Affordable Care Act (PP/ACA).

Along with the release of the Final Regulations, a set of FAQ's were released to help answer some of the most common questions:

- FAQs about Affordable Care Act Implementation (Part XVII) and Mental Health Parity Implementation- November 8, 2013
- Fact Sheet: The Mental Health Parity and Addiction Equity Act

"Substance abuse and mental disorders are just that disorders, and parity must be the way of the land - the right way", said NCADD Medical-Scientific Co-Chair, Harris B. Stratyner, PhD.

Although more time will be needed to analyze all of the provisions included in the 206 page rule, thanks to Carol McDaid, Capitol Decisions and The Parity Implementation Coalition, here are some of the key provisions in the final regulations:

- Effective Date: The final rule is effective for plan years beginning on or after July 1, 2014. In actuality, most plan years end December 31 so the effective date for most will be January 1, 2015.
- Request for Comments: The Departments requested comments on "what additional steps, consistent with the statute, should be taken to ensure compliance with MHPAEA through health plan transparency, including what other disclosure requirements would provide more transparency to participants, beneficiaries, enrollees, and providers, especially with respect to individual market insurance, non-Federal governmental plans, and church plans."
- Deadline: January 8, 2014
- Send To: E-OHPSCA-FAQ.ebsa@dol.gov

Scope of Service:

The final rule clarified the scope of service issue by stating:

1. Classification of Benefits: The 6 classification of benefits scheme (inpatient in and out-of-network, outpatient in and out-of-network, emergency care, and prescription drugs) was never intended to exclude intermediate levels of care (intensive outpatient, partial hospitalization, residential).
2. All Classifications Must Meet All Parity Tests: The final rule makes it clear that each classification and sub-classification has to meet all parity tests within each classification. And states that "the classifications and sub-classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers." This language, coupled with the new specific examples around intermediate levels of care, makes it clear that MH/SUD services have to be comparable to the range and types of treatments for medical/surgical within each class.
3. Intermediate Levels of Service: The final rule does not mandate specific services required to be offered by plans under the 6 classification scheme, but the final rule clarifies that plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assigned intermediate levels of services for medical/surgical conditions.

Non-Quantitative Treatment Limitations (NQTLs):

- The final rule strikes the provision included in the Interim Final Rule (IFR) that permitted plans to apply discriminatory limits on mental health/substance use disorder (MH/SUD) treatment if there was a "clinically recognized standard of care that permitted a difference."
- Parity requirements for NQTLs are expanded to include restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services (including access to intermediate levels of care). The net effect of this is plans will no longer be able to require a patient to go to an MH/SUD facility in their own state if the plan allows plan members to go out of state for other medical services.
- The improvement in the final rule is that plan participants or those acting on their behalf will now be able to request a copy of all relevant documents used by the health plan to determine whether a claim is paid (see disclosure section for more detail on what documents may be requested. Current or potential enrollees may request this information and plans are required to provide it within 30 days).

Disclosure and Transparency- Medical Necessity:

- MHPAEA requires that the criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request. MHPAEA also requires that the reason for the denial of coverage or reimbursement must be made available upon request. New disclosure requirements in the final rule will require plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards and other factors used to apply an NQTL were imposed on both medical/surgical and MH/SUD benefits.

MHPAEA Enforcement:

- The final rule clarifies that states have primary enforcement authority over health insurance plans. As such, states have the primary responsibility of enforcing implementation of MHPAEA. The Department of Health and Human Services (HHS), through the Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply and the Department of Labor (DOL) has primary enforcement authority over self-insured ERISA plans.

State Preemption:

- More consumer protective state laws are not preempted.

Medicaid Managed Care, CHIP and Alternative Benefit Plans:

- The final rule does not apply to Medicaid Managed Care Organizations, Children's Health Insurance Program (CHIP) or Alternative Benefit Plans (i.e. Medicaid Expansion Plans under the ACA) even though the rule states the statute applies to these entities. As stated, the January 2013 CMS State Health Official Letter will continue to govern implementation of Medicaid managed care parity. The final rule states more guidance on this will be forthcoming.

Cost Exemption for Plans and Issuers:

- The final rule provides a formula for how plans and issuers can file a cost exemption if the changes necessary to comply with the law raise costs by at least 2% in the first year.

Application to the Individual Market:

- The final rule applies to the individual market to both grandfathered and non-grandfathered plans for plan year beginning on or after July 1, 2014.

Non-Federal Governmental Plans:

- Local and state self-funded plans may continue to apply to CMS for an exemption from MHPAEA's requirements.

Multi-Tiered Prescription Drugs

- A plan may have multi-tiered prescription drug programs (applies different levels of financial requirements to different tiers to prescription drugs in accordance with the NQTL rules). A plan may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.