



# Mental Health Parity and Addiction Equity Act (MHPAEA): Measuring and Ensuring Compliance

SAE & Associates, Behavioral Health Litigation Support DBA  
Independent Compliance Administrator (ICA)



## SAE & Associates, ICA

- Direct expertise as an Independent Compliance Administrator (ICA) for evaluation and implementation of MHPAEA
- Knowledgeable with: *Evaluating* appropriateness of, and measuring intended changes in policies and procedures; *Monitoring* the implementation of the changes; and, *Assessing* the sustainability of the change process to ensure compliance with required legal issues noted in MHPAEA.
- Equipped with a substantial data metric set to identify and evaluate service and system changes, SAE's ICA team offers an efficient and effective means to measure the change processes targeted for parity compliance goals.



## 2008 Mental Health Parity and Addiction Act (MHPAEA)

- Mental Health Parity Act (1996) – the lifetime and annual dollar limits for mental health services should be equal to other health/medical services. This ruling applied **only to commercial plans that offer mental health (MH) benefits**. Not designed to include substance use disorder (SUD) services.
- MHPAEA of 2008 – **extends benefit parity for SU services**, with restrictions similar to medical and surgical services, to individuals covered by large group plans (Employer-sponsored health insurance/ESI, local and state) and to employers with plans that offer behavioral health benefits.



The Departments of Treasury, Labor, and Health and Human Services' Final Rule (FR). November 18, 2013

- **Final Rule** effective for plan years beginning on or after July 1, 2014. With most plans starting January 1<sup>st</sup>, the effective date for the majority of plans is **January 1, 2015**.
- MHPAEA does not require plans to offer MH/SUD benefits. However, if the plan does have MH/SUD benefits, it must **offer the benefits on par with the other medical surgical benefits it covers**. Pertains to only private and public group plans with **more than 50 employees**.

For example: if a plan offers mental health inpatient services, the plan benefit design and coverage for this benefit **must be similar** to medical inpatient services benefit.

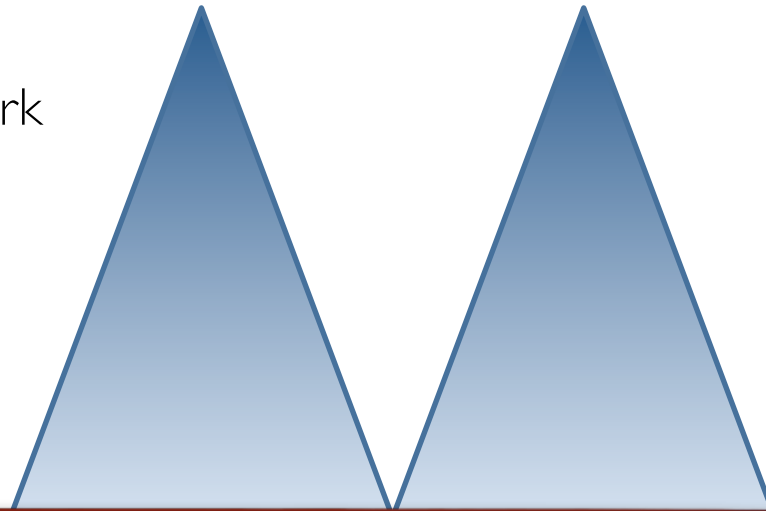


## What specific benefit services does this include?

There are **6 classifications** in the benefit scheme outlined.

It includes the following:

- Inpatient in network
- Inpatient out-of-network
- Outpatient in network
- Outpatient out-of-network
- Emergency Care
- Prescription drugs





## What intermediate levels of care are included?

The benefit scheme laid out in the Interim Final Regulations (IFR) in 2010 did not intentionally exclude intermediate levels of care such as:

- Intensive Outpatient
- Partial hospitalization
- Residential

The FR states: “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 includes **intermediate levels of care**.



## What are Non-Quantitative Treatment Limitations?

Non-Quantitative Treatment Limitations (NQTLs) are restrictions or criteria sets “which otherwise **limit the scope or duration of benefits** for treatment” and are **not expressed numerically**.

These include non-quantitative management techniques (NQMTs) such as:

- Prior authorization
- Utilization review
- Fail-first policies\*
- Prescription design

\*Fail-first policies or step therapy protocols involve the use of lower-cost treatments prior to the authorization of more expensive therapies.



## Why are NQTLs important to monitor?

Both the IFR and FR established that NQTLs on MH/SUD benefits **may not be more stringent** than those on medical/surgical benefits.

Includes **processes and evidenced based standards** of care used to apply NQTLs for MH/SUD be no more stringent than those for medical/surgical benefits.

The “processes, strategies, evidentiary standards and other factors used by the plan or issuer to determine whether and to what extent a benefit is subject to an NQTL **be comparable and applied no more stringently** for MH/SUD than for medical surgical.”





## What are types of NQTLs?

- Geographic location
- Facility type
- Provider specialty
- Provider reimbursement rates

All of which may not limit the scope or duration of benefits for services, **including access to intermediate levels of care**

Example: Plans may not require patients to go only in-state if they allow out-of-state medical services for the same level of care.



## What are Quantitative Treatment Limitations?

- Quantitative Treatment Limitations (QTLs) are defined as any restrictions on the scope or duration of treatment including the **frequency of treatment, number of visits, the days of coverage.** These are expressed numerically across benefit services.
- QTLs must also be **equivalent** between behavioral health and the most common medical/surgical treatments.
- For example: the benefit must cover the same number of medical/surgical admissions as they would for MH/SUD admission.



## How does MHPAEA impact benefit design for provider networks and medication treatment?

- Plans and issuers allowed to **use multiple provider network tiers**, but only if these tiered networks are not imposed more stringently on MH/SUD than they would be on medical surgical services.
- Plans may have **multi-tiered prescription drug/medication treatment** but may not apply these tiered prescription drug programs more stringently on MH/SUD prescription drugs.



## What about plan documents and disclosure requirements?

- MHPAEA requires **criteria for medical necessity determinations be made available** to any current or potential enrollee or contracting provider upon request.
- The **reason for denial of coverage or reimbursement must be made available** upon request.
- For employer health plans, **disclosure requirements include written documentation within 30 days** of how their processes, strategies, evidentiary standards and other NQTLs imposed on MH/SUD are similar to those imposed on medical/surgical benefits.



## What are the financial requirements of Parity?

- IFR defined financial requirements for behavioral health services to be **equivalent** with the **predominant or most common** medical/surgical treatments.
- The **same calculations** used to determine copays, deductibles, coinsurance and out-of-pocket limitations/maximums be the same as behavioral health services as the medical/surgical services.
- Also **prohibit plans and issuers from having cumulative requirements** (such as deductibles or out-of-pocket maximums) or cumulative QTLs on MH/SUD that accumulate separately from the medical/surgical in the same classification.



## MPHAEA Enforcement

- States have primary enforcement authority over health insurance issuers. The DOL is the primary enforcer for all self-insured employer plans. HHS through CMS has enforcement authority over issuers in a state that does not comply. DOL has primary enforcement authority over self-funded employer plans.
- CMS, as of January 16, 2013, made it clear that sections of the IFR and FR do apply to **Medicaid managed care organizations** (MCOs) and that **NQTLs** also apply to **Medicaid MCOs**.

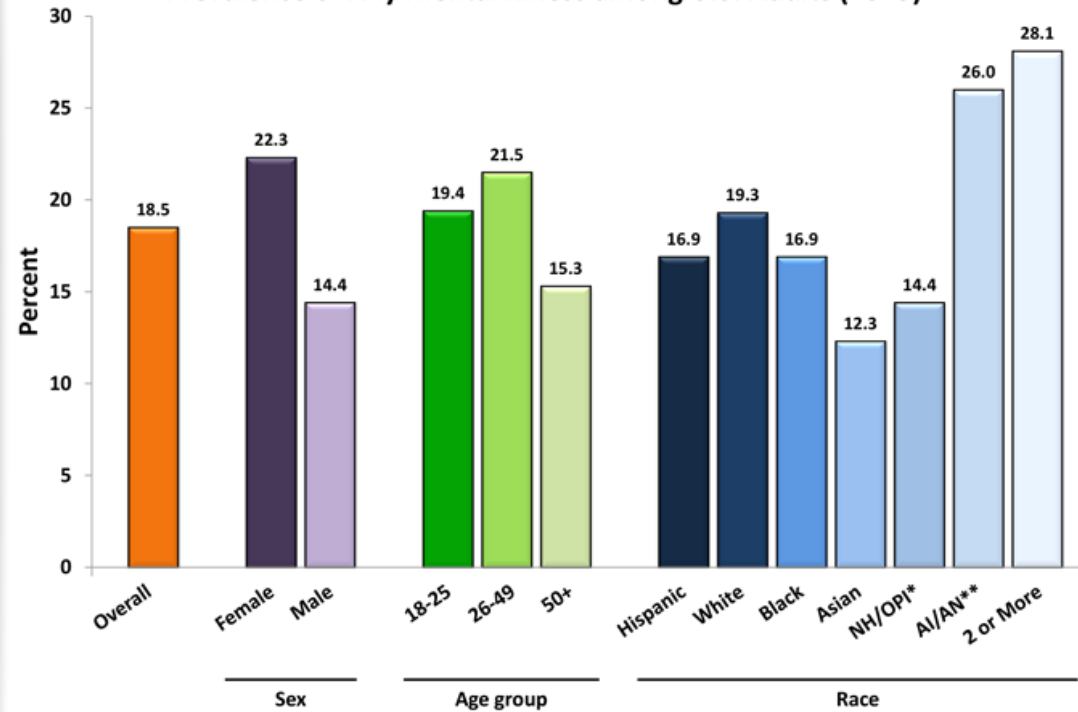


## Mental Health Prevalence Rate

Why is mental health treatment parity important?

<http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>

Prevalence of Any Mental Illness among U.S. Adults (2013)



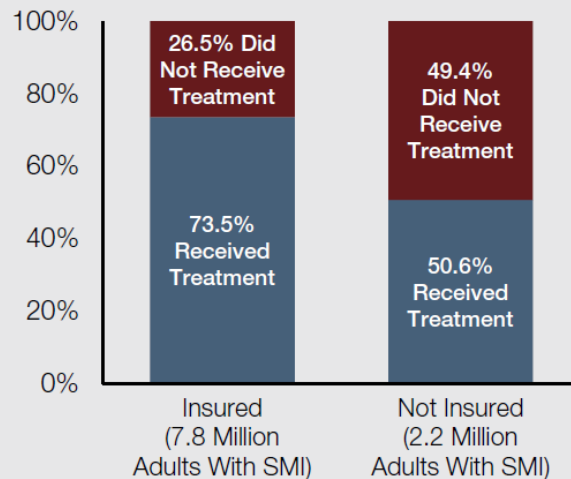
Data courtesy of SAMHSA

\*NH/OPI = Native Hawaiian/Other Pacific Islander  
\*\*AI/AN = American Indian/Alaska Native



## Treatment Utilization for Mental Illness

Past-Year Mental Health Treatment/Counseling Among Adults Aged 18 or Older With SMI, by Health Insurance Status (2013)<sup>12,14</sup>



*In the U.S., adults with SMI were less likely to receive mental health treatment if they did not have health insurance.*

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013.

How many people who need treatment actually receive services?

[http://www.samhsa.gov/data/sites/default/files/National\\_BHBarometer\\_2014/National\\_BHBarometer\\_2014.pdf](http://www.samhsa.gov/data/sites/default/files/National_BHBarometer_2014/National_BHBarometer_2014.pdf)



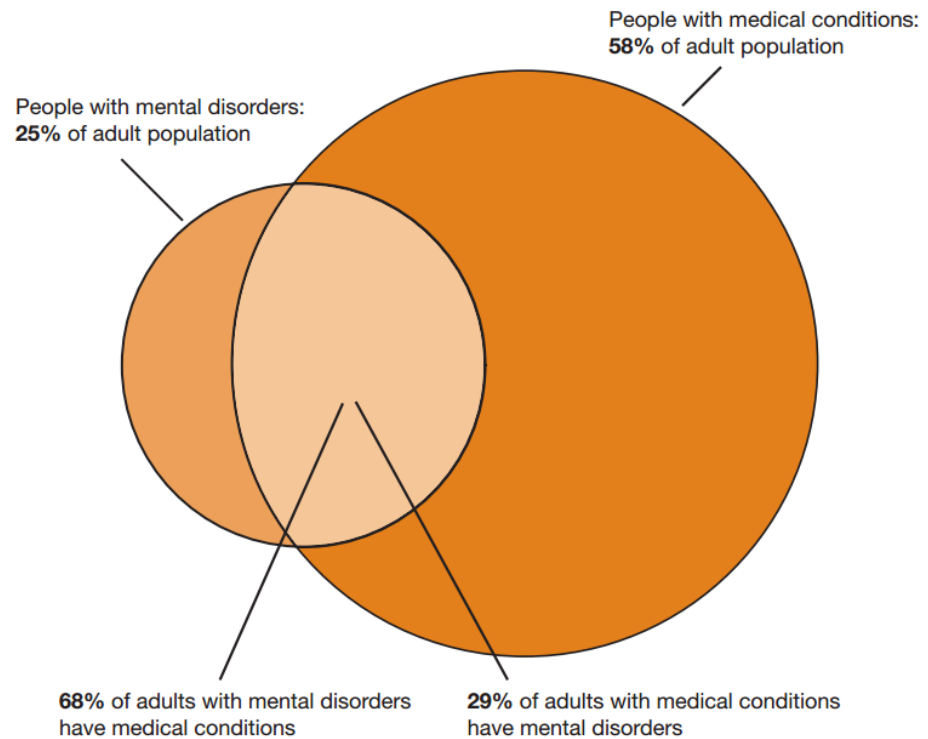


## Co-occurring Prevalence with a Medical Illness

How relevant is mental health to overall health?

[http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf69438/subassets/rwjf69438\\_1](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438/subassets/rwjf69438_1)

*Percentages of people with mental disorders and/or medical conditions, 2001–2003*



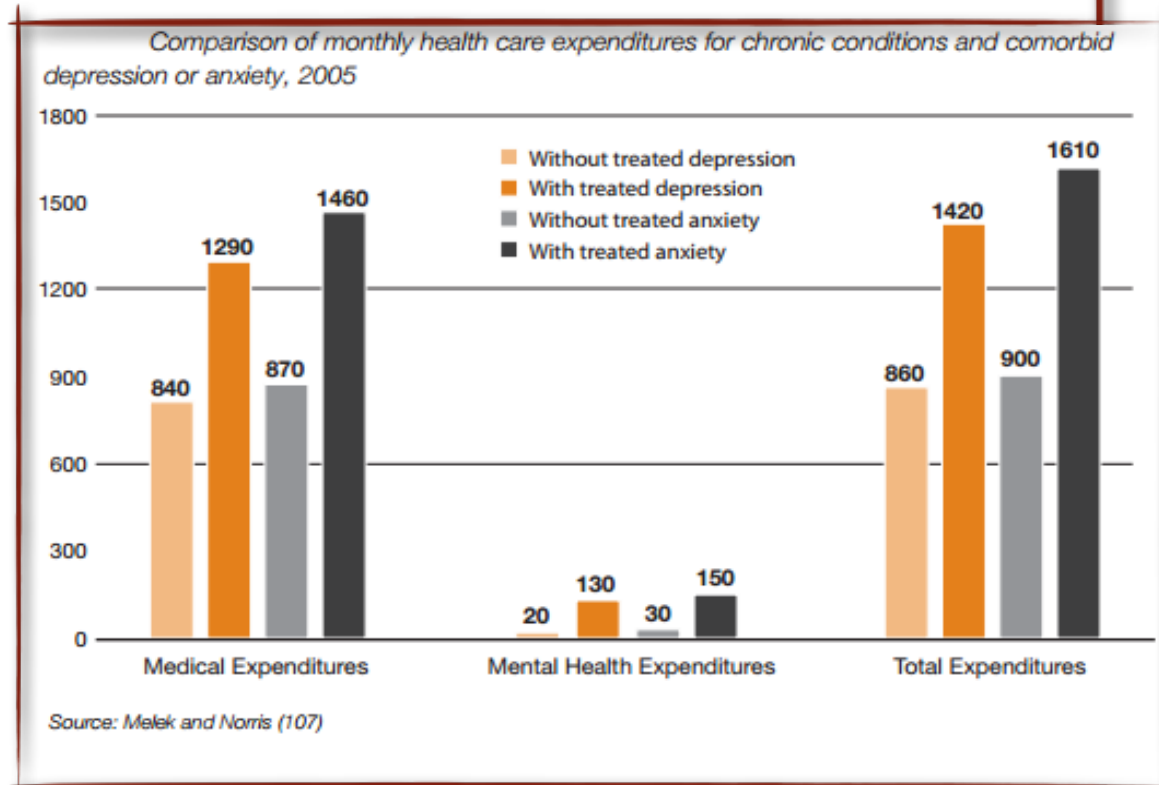
*Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)*



## Cost of Co-Occurring Medical and MH Conditions

How relevant is mental health to overall cost of care?

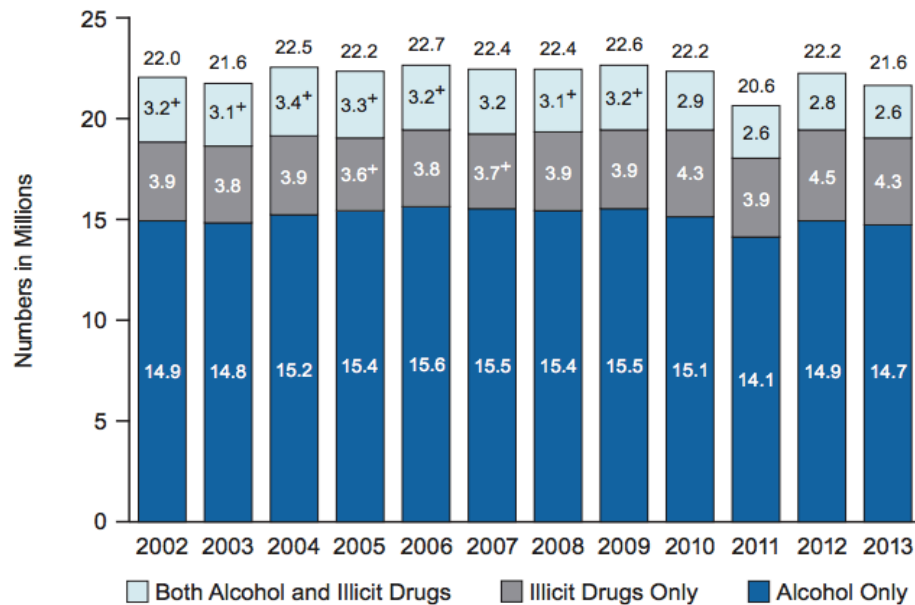
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## Substance Dependence or Abuse Prevalence Rate

**Substance Dependence or Abuse in the Past Year among Persons Aged 12 or Older: 2002-2013**



<sup>+</sup> Difference between this estimate and the 2013 estimate is statistically significant at the .05 level.

Note: Due to rounding, the stacked bar totals may not add to the overall total.

How prevalent is substance use or abuse issues?

<http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>

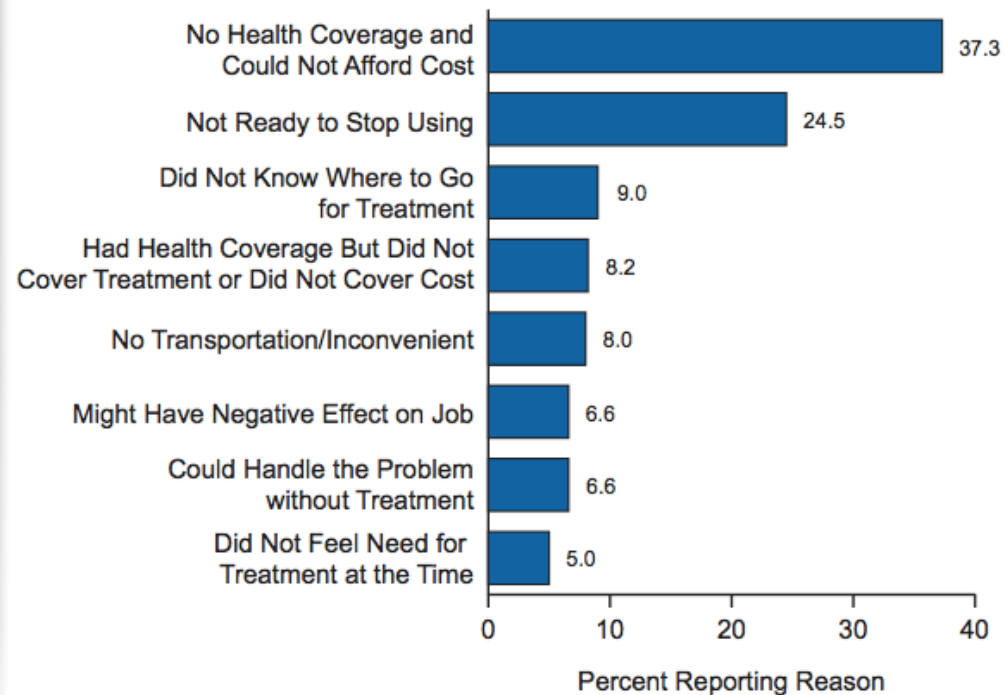


## Treatment Utilization

What are the access barriers to treatment for substance use?

<http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>

### Reasons for Not Receiving Substance Use Treatment among Persons Aged 12 or Older Who Needed and Made an Effort to Get Treatment But Did Not Receive Treatment and Felt They Needed Treatment: 2010-2013 Combined



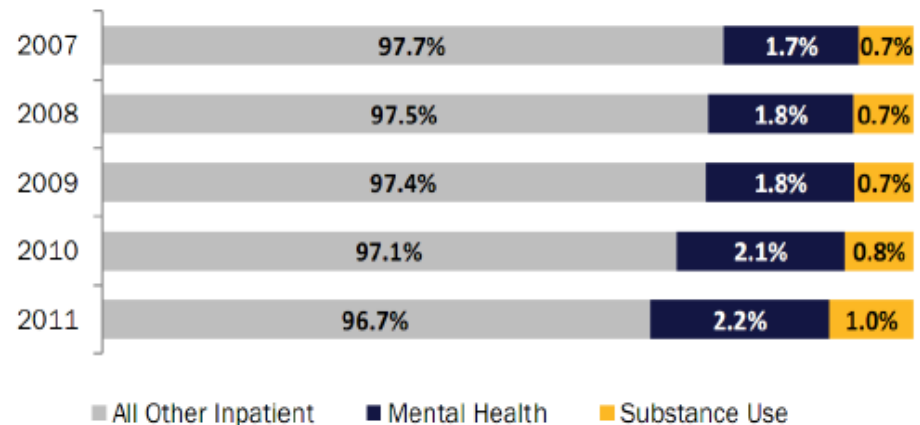


## What is the per capita cost across INPT services?

In examining 3 years prior to the IFR, the year IFR was issued and 1 year after the IFR, Health Care Cost Institute (HCCI) found that relatively small amounts are spent on MH and SUD covered by employer-sponsored health insurance (ESI)

[https://www.hcup-us.ahrq.gov/reports/ED\\_Multivar\\_Rpt\\_Revision\\_Final072010.pdf](https://www.hcup-us.ahrq.gov/reports/ED_Multivar_Rpt_Revision_Final072010.pdf)

### Share of Inpatient Per Capita Spending (2007-2011)



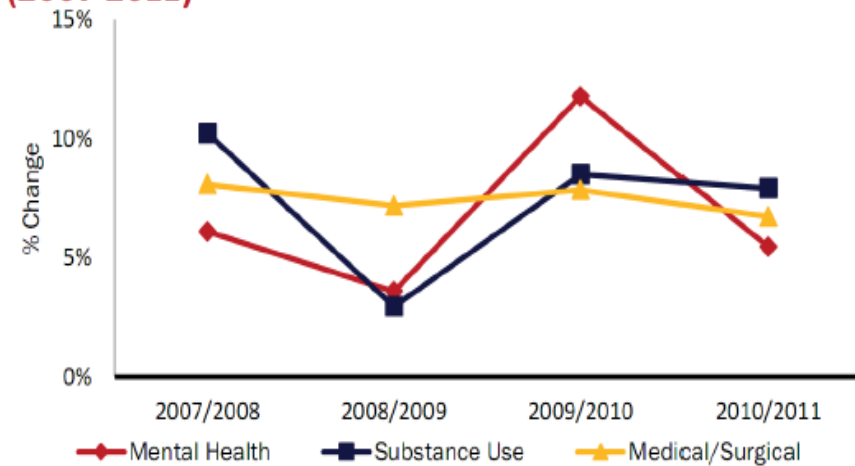
Note: Not to scale. Source: HCCI, 2013



## Service Utilization for MH and SA after MHPAEA

- Prices rose faster for MH and SUD admissions than for medical/surgical admissions.
- In the ESI health care market, cost/price *rather* than utilization rates have been the major driver of spending for the commercially insured.
- Analysis of MH/SUD Parity and its enforcement needed to ensure access and implementation.

**Changes in Price Paid per Inpatient Admission (2007-2011)**



Source: HCCI, 2013



Thank you for viewing our presentation on  
MHPHAEA!

*For more information about SAE's ICA team and their expertise across care environments and functions, email us at [info@saeassociates.com](mailto:info@saeassociates.com), or call us at (212)-684-4480.*