

Health Care Reform and Mental Health Parity

Prepared for the

Growing Healthy Children – 2010 Health Care Reform Summit

Charleston, West Virginia

August 30 & 31

Bill TenHoor, Senior Consultant

Advocates for Human Potential Inc. (AHP) Healthcare Solutions

Topics

1. Parity Legislation
2. Interim Final Rule (IFR)
3. Key Mental Health Provisions in the Affordable Care Act: Challenges & Opportunities
4. Questions/Discussion

Parity Legislation; Background

- The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)* was enacted on 10/3/2008
- “Equal rights in health insurance” – end discrimination
- Predecessor - the Mental Health Parity Act of 1996
 - Eliminated differential annual or lifetime limits
 - Covered large group market but not small groups or self insured plans
 - Specifically excluded substance use disorders
 - Did not include prescription drug benefits

MHPAEA Features

- Continues existing law protections (annual/lifetime limits)
- Applies to large group market and its insurers
 - Covers some 140 million employed Americans
 - 446,400 ERISA groups – 111 M
 - 20,000+ State/Local Govt. - 29 M
 - Also applies to Medicaid managed care organizations (34 M)
- Adds substance use disorders to the disorders entitled to protection
- Adds special rule for prescription drug benefits
- Does not cover everybody, however
 - Plans under 50 employees, Individual Market (& Medicare)

Other MHPAEA Features

- Does not mandate mental health benefit coverage
 - If MH is covered, however, must comply parity basis
- Note “opt out” for state & local (non Federal) government self insured employers
- Generally effective for plan years beginning after July 1, 2010 (realistically, begins Jan 1, 2011)
- However, in the interim, health plans must make a “good faith” effort to comply with the reasonable interpretation of the law.

Key MHPAEA Protections

If plan has mental health/substance use disorder benefits:

- Financial requirements (deductibles/co-pays) and treatment limits (# visits/days of coverage) can be no more restrictive than predominant requirements/limits for substantially all M/S
- No separate cost sharing or TX limits for MH/SUD only
- IF plan offers out-of-network M/S benefits, then must do same for MH/SUD
- Standards for medical necessity determinations and reasons for any denial must be disclosed upon request
- Must use “generally recognized standards” for MH and SUD
- No preemption of stronger state law coverage

The IFR

- Published by GPO on February 2, 2010
 - URL:edocket.access.gpo.gov/2010/pdf/2010-2167.pdf
- Provides a 6-component classification scheme for comparing MH and M/S benefits (discussed on next slide)
- Applies a “substantially all/predominant” test in each of the 6 classifications
- Must include both MH and M/S benefits in the cumulative financial requirements (deductibles, out-of-pocket costs)
- Defines treatment limits to include both quantitative & non-quantitative components.

Benefit Comparison Methods

- Plans must make M/S and MH/SUD benefit comparisons using six specified categories:
 1. inpatient, in-network
 2. inpatient, out-of-network
 3. outpatient in-network
 4. outpatient out-of-network
 5. emergency care
 6. prescription drugs
- Must make comparisons using coverage units (family, self)

Non-Quantitative TX Limits

Examples include:

1. Medical management standards limiting/excluding benefits based on medical necessity/appropriateness
2. Formulary design for prescription drugs – IFR has its own special rule
3. Standards for provider admission to a network, including payment rates
4. Plan methods for determining UCR charges
5. Fail-first policy or step therapy protocols triggering nonpayment for higher-cost therapies – may impact EAPs, eliminate gate keeping
6. Exclusions based on failure to complete a course of treatment

Implementation Challenges

- Three MBHOs challenge the IFR
- MBHOs' litigate based on complaints of significant administrative obstacles
 1. Requirement for a single deductible for both mental health and other medical conditions – too complex to do quickly
 2. Prohibition against “nonquantitative” treatment limitations – can’t control costs without these
- Court dismisses case on June 21 on procedural grounds
- More to come?

Health Care Reform (ACA)

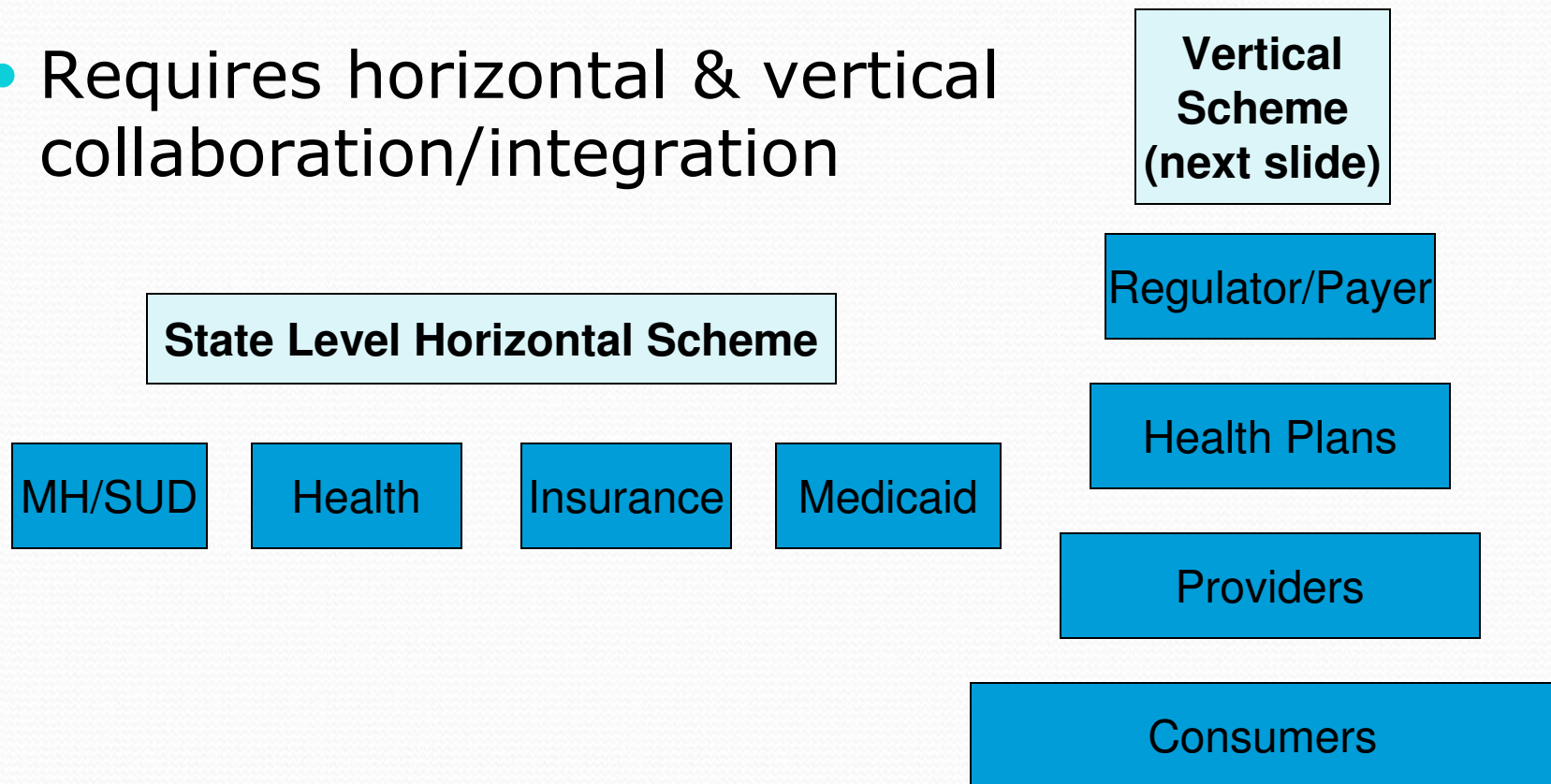
- Integrates MH into reforming health system
- Increases access – *require/subsidize/simplify* coverage to benchmark/essential benefit
 - 15+ M through Medicaid (<133% poverty)
 - 15+ M get affordable private coverage thru HI Exchanges (<400%)
 - Adds coverage through age 26 for dependents
 - Eliminates pre-existing conditions clauses (right away for children)
 - Requires guaranteed issue and renewal
- Adds preventive services (no cost sharing)
- More universal health system, controlling costs, improving quality, focusing on value/outcomes, experimenting
- Integrating Acute Care & Wrap-Around Recovery Support

Health Care Reform (ACA)

- H & MH Integration under Medicaid
 - Health care homes for those w. co-morbidities
 - Primary care services integrated w. specialty care
 - Service co-location opportunities (\$50M for demos)
- Medicaid-Medicare integration/improvements
 - Health promotion (e.g., tobacco cessation) programs – reducing risk for preventable diseases
 - Prescription drugs (Part D and the “doughnut hole”)
 - Accountable Care Organization pilots

Health Reform (ACA)

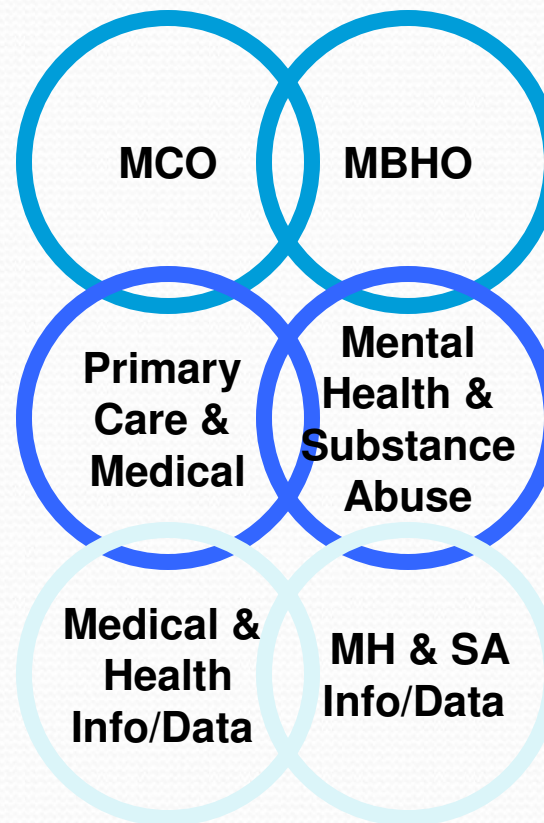
- Requires horizontal & vertical collaboration/integration



Integration in Operation

Integration Issues:

1. Business Rules
2. Business Process and Workflow
3. Interoperable EMR Systems
4. Training
5. Communications Infrastructure



Domains:

- Utilization Mgmt, Case Mgmt and Disease Mgmt
- Population Mgmt
- Integrated/Shared Treatment Plans
- Data revealing encounters, costs, clinical outcomes, satisfaction, etc.

Thank You

Follow-up Questions and Contact

Bill TenHoor, Senior Consultant

781-934-9676

bill@tenhoor.com

www.ahpnet.com and www.behavioralhealthtoday.com

