Hey, Whatever Happened to Mental Health Parity?

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Status. Actually, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act became effective January of this year. That is right, 2010. The dramatic struggles, partisan clamor and sheer scope of the recent healthcare reform law eclipsed our consciousness of the new federal parity law. Parity Act is revolutionary in its own right: it immediately affects you as well as current and prospective patients, health insurance companies, managed-care organizations and self-insured employers.

The law required that the US Department of Health and Human Services (HHS) devise implementation procedures and guidelines, which were expected to be released before the first of the year to give insurers sufficient time to prepare. Sensibly, HHS requested input from stakeholder groups, including APA. The resulting complex set of rules – "Interim Final Rules"--released over 3 months late on January 29, 2010, leaves many substantive concerns unresolved. Many of these issues are discussed below. So, please read on so you can understand what is happening to you, learn more about the operational and policy challenges in mental health care, and express yourself knowledgeably in preparation for the "rule comment" period beginning July 2010.

Background. After a decade and half of advocacy by the APAs of psychologists and psychiatrists, substance abuse treatment and consumer interest groups, President George Bush signed the bill on October 3, 2008. In contrast to the recent fierce polarization, the Parity Act enjoyed broad bipartisan congressional support. It also represented a significant leap over the 1996 federal Mental Health Parity Act that required equity only for annual and lifetime dollar limits. While he roamed the White House, Bill Clinton mandated parity in the various insurance policies in the Federal Employee Health Plans. Another great step.

Basics. In broad outline, the federal Parity Act does *not* require health plans to include mental health and substance abuse (MHSA) coverage. Further, its provisions only apply to plans that cover 50 or more employees. Nor does it immediately cover Medicare, which has a multi-year phase-in parity schedule. Thankfully, it does cover 82 million individuals in self-funded (ERISA) plans that were exempted from current state parity regulations.

The law addresses equity mainly regarding financial (e.g., deductibles, out-of-pocket expenses) and treatment limitations (e.g., frequency and number of visits). Also on the positive side is the requirement that if the plan has out-of-network benefits, it must provide similar MHSA coverage. Whenever state parity laws are stronger than the federal Parity Act, then the state regulations over-ride (the so-called "preemption standard").

Some advocates on the provider side were hoping that the federal government might establish medical necessity guidelines to replace those established by the insurers. This does not seem likely any time soon. The new parity law does require an insurance plan, upon request, to make MHSA medical necessity criteria available to current or potential participants, beneficiaries or providers. A plan must also explain the basis for payment denials.

Results of Parity So Far. The outcomes of those states that have been mandating parity for a while as well as that of the Federal Employee Health Plans have yielded some significant out-of-pocket savings for consumers, some marginal increase costs to insurers (e.g., about .004%), some reduction in services ("more efficient utilization", in insurer parlance), and some improvements in health indicators.

Opt-Out. There is, however, an opt-out provision for health plans if a certified actuary can substantiate that their expenses attributable to parity have increased by 2% after six months during the first year or 1% thereafter. The Departments of Labor or HHS must be notified of this;

these two federal agencies as well as the states may then audit the plan to evaluate compliance. The plan exemption, however, lasts for only one year and still requires that MHSA be covered in the meantime. The US Treasury also has the authority to impose an excise tax on noncompliant insurance companies.

At this juncture, the New Jersey state government plans to opt-out. I do not know about you but I pledge not to drive and hence pay the toll for the New Jersey Turnpike until that state relents. Take that!

Circumvention. Because the Parity Act does not require MHSA coverage, a few companies have dropped that type of coverage. An executive from a large grocery chain complained "We can't have an open checkbook. If an employee went to a psychiatrist and ran up a million dollars, it would come out of our pockets." When the executive was questioned about expensive cancer treatment, he replied, "Cancer is different. That's an identifiable phsyical situation" (*Washington Post*, March 2, 2010, E4). Leaving aside the enviable income of the hypothetical psychiatrist in the example, see *Perspective* section below.

Many Cooks. The law specifies that aside from HHS, the Departments of Treasury and Labor share responsibility for enforcing the regulations. The realworld roles of these three agencies and the enforcement process are not entirely clear. A law without enforcement muscle is hardly a functioning law. We'll see.

Care Management Inequity. The law does *not* require equity regarding the *management* of MHSA benefits such as pre- and ongoing authorization procedures. In anticipation of the Parity Law, Blue Cross and Blue Shield, CIGNA as well as Aetna have implemented additional case management and pre-authorization procedures for MHSA services. It is likely that other insurers will increase the care management of MHSA coverage relative to so-called "medical" coverage, adding to the MHSA clinicians' non-billable burden and related expenses for clinicians.

Fail First Requirements. Another potential worry was…Will insurers push for "fail first" trails to control costs, possibly at the expense of timely treatment, instead of appropriately stepping up the levels of care and the weighing of the safety risk to the patient. An example is the stipulation that bariatric surgery is not authorized by insurers until a patient first fails to reduce significant weight under a physican-monitored weight loss program. In the MHSA realm, will less expensive treatments such as telemed interventions or medication-only be required before weekly psychotherapy is authorized. Probably not.

Access to Care, Standards and Levels of Care, and Types of Providers. Many were surprised that the Interim Final Rules did not set minimum parameters for scope of services, levels of care (e.g., partial hospitalization resources or step-down intensive outpatient substance abuse services), covered diagnoses and types of treatment providers that must be covered by MHSA benefits. The existing regional and state gaps in these areas and problems with access to appropriate care will not be fixed by current federal Parity Act. It will be left to the state legislatures to address these issues, though the former may be reluctant to impose costs on insurance companies. We are fortunate in Virginia because – thanks to the lobbying of VACP – insurance companies are mandated to include clinical psychologists. Add VACP and our NVACP Legislative Advocacy Committee to your daily gratitude list!

"Medical" vs. "Mental" Disorders. Managed care and insurance companies do have leeway in defining what is a so-called "medical" vs. a MHSA disorder. Will insurers be allowed to categorize major mental illnesses, such as autism or other developmental disorders as biologically based "medical" with their own coverage limitations? Likely a great many professionals in the medical and MHSA fields do not believe in such a dichotomy but this divide is a current fulcrum for levers of health economics.

Combined Deductible. Prior to the release of the HHS Parity rules, there was a fear that the law

could have been interpreted by insurance companies to replace a single deductible with "separate but equal deductibles" for medical and MHSA. Such an additional MHSA deductible would be, of course, a financial barrier. Fortunately, the rules prohibit this practice. The insurance industry, in anticipation of Parity and possible healthcare overhaul, has spiked their premium rates, straining affordability for employers and consumers.

To track a "unified" deductible, "parent" insurance companies will have to interface claim databases with their subcontracted behavioral health managed-care companies that processes the MHSA claims. This transition will likely be "buggy" and somewhat aggravating to providers and patients. The combined deductible will also mean that patients will "satisfy" their deductibles sooner, triggering greater costs to the insurer. Good for patients, bad for insurers.

EAP and Gatekeeping. The new rules prohibit EAPs (Employee Assistance Programs) from gatekeeping patients' insurance benefits, as some EAPs have being doing. EAPs can still be a positive get-around to the Parity law because as a free service to employees and their dependents, it bypasses the copay and deductible hurdle, access to MHSA services easier.

Perspective and R-E-S-P-E-C-T. The health care system contains inherently conflicting stakeholders, *ergo* parity is likely to be a solution that causes problems.

Providers who participate in insurance plans may have more demands placed on them to justify, account and assess progress (e.g., outcome assessments). Non-participating providers will not entirely escape increased care-management either when their patients file a claim for out-of-network benefits.

Do you think care management and accountability by the insurance company, when done competently and not too intrusively, is good, justified, or fair? Do you object to insurance utilization management, find it annoying, or an infringe on your sense of professional autonomy? Will you be willing to accept more of it as a fair trade off?

As I noted before, the Interim Final Rules do not require equality in the care-management of MHSA vs. "medical" benefits. At best, this reflects the prevailing Cartesian dualism; at worse, it expresses the continuing stigma and lower societal standing of MHSA treatment , disorders and our patients. For that matter, many of us, refuse to see "patients" and will only help "clients." Compared to "physical medicine", we are considered by many to be the less scientific, inferior, applied science. True, psychology is earning more respect. And "behavioral medicine" and "integrated health care" are gaining acceptance. Psychologists who support empirically-based treatment and research also advance the cause.

Yeah, it is complicated but not hopeless. Meantime, we will all see how the Parity momentum fairs. We are not yet in the post-Descartes era. [Hungry for more, check out: www.apapractice.org and www.behavioral.net/MPAEA.]

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