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Final Regulations Strengthen Parity For Mental Health and Substance Use Disorders

Summary

New federal regulations provide stronger tools for ensuring health insurers don't discriminate against people with substance use disorders and mental illness. The regulations apply the federal law requiring parity between health insurance coverage for physical ailments and for mental illness and substance use disorders. This should help improve access to comprehensive care for consumers.

The key provisions of the new regulations include:

- Requiring parity across a broader range of services, particularly intermediate services including residential treatment, partial hospitalization and intensive outpatient programs
- Barring discriminatory limitations on locations of care, types of facilities or specialists
- Requiring insurers to share more information about how they make coverage decisions
- Clarifying that states are the primary enforcers of parity.

Background

The federal parity law requires health plans, including certain Medicaid plans, to cover mental health and substance use disorders treatment to the same extent the plans cover other medical or surgical treatment. The Affordable Care Act (ACA) extends federal parity protections to more health plans, including those for new Medicaid enrollees and people purchasing health insurance through the new insurance Marketplaces.

Congress passed the original law in 2008, and federal officials issued interim regulations in 2010. The government's delay in issuing final parity regulations meant that the government agencies charged with enforcing the parity laws were unsure how to effectively implement the law's requirements. As a result, parity enforcement has been relatively weak over the past five years. The new final regulations provide more clarity and clout to the state and federal enforcement agencies, which will ultimately improve consumer access to mental health and substance use disorders treatment.

For most health plans, the new rules will take effect January 1, 2015. The new rules do not apply to plans in Medicaid managed care, the Children's Health Insurance Program or Medicaid expansion plans, which will be covered by guidance expected to come next year.

Highlights

Community Catalyst is a national non-profit advocacy organization building consumer and community leadership to transform the American health care system.

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Parity across a broader range of services

The 2008 parity law was not explicit about the range of services covered. The final rule clarifies that intermediate services are subject to federal parity requirements. Intermediate services are more intensive than most office-based care but less intensive than a hospital stay; they include residential treatment, partial hospitalization and intensive outpatient programs. Under the final rule, if a health plan provides a full scope of services for medical and surgical conditions, it must offer a comparable scope of services for mental health and substance use disorders. However, the final rule does not require that health plans offer specific intermediate services.

For example, if a health plan covers residential nursing home services for medical conditions, the plan must cover residential care for substance use disorders, according to the new regulations.

Fewer limitations allowed on services

The law and interim regulations barred charging higher copays for treatment of substance use disorders and mental illness than for other diseases and also barred greater limits on the number of office visits. The law also prohibits other limits, called non-quantitative treatment limitations (NQTLs), that cannot be measured by a number or dollar amount. These include prior authorization procedures and prescription drug “step therapy” policies, where patients are required to try one medicine – often a less-expensive one – before their doctor may prescribe another. Under the law, a health plan may not impose an NQTL on mental health or substance use disorder benefits unless a comparable NQTL is imposed on medical or surgical benefits.

The interim regulations included a partial list of NQTL practices and policies covered by parity. The list included medical necessity guidelines, prescription drug formularies, and standards used to develop networks of health care providers, among others. The final rule adds two examples of NQTLs: the design of network “tiers” and coverage limits based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of coverage.

The final rule also confirms several provisions in the interim regulations, including that the list of NQTLs is illustrative, not exhaustive. The final rule also discusses provider reimbursement rates as a form of NQTL that is subject to parity requirements, and explains that any factors a plan uses in setting provider reimbursement rates (e.g. geographic market, supply and demand, training and licensure of providers) must not be used more stringently for mental health or substance use disorder services.

The requirement that NQTLs be applied comparably across mental health/substance use disorders and medical/surgical benefits does not bar all variation in the application of NQTLs. The final rule recognizes that health plans may take into account “clinically appropriate standards of care”, but eliminates that standard as a guaranteed exception to the parity law.

Increased transparency and disclosure

The final rule also requires increased health plan transparency and greater access to information about how health plans make decisions about what they cover, as a means for enabling parity enforcement. According to the law, health plans must disclose the medical necessity criteria applied to a particular service or treatment, and the reasons for any denial of coverage. The final

rule clarifies that these requirements are in addition to disclosure requirements under other federal laws, such as the Employee Retirement Income and Security Act (ERISA) and the ACA.

For example, ERISA requires large group health plans (typically work-based coverage) to provide consumers with the medical necessity criteria and NQTLs for both medical/surgical and mental health/substance use disorder benefits. For plans not subject to ERISA, the ACA gives consumers denied coverage the right to receive copies of documents relevant to a benefits claim.

Access to more complete plan information will make it easier to identify parity violations.

Applying the new regulations

The final rule is clear: state agencies have primary enforcement authority when it comes to parity. Some states have already embraced this authority by issuing their own regulations and guidance on parity and bringing enforcement actions against health plans that violate parity. Other states have been slower to accept their enforcement role; advocates in these states should use the final regulations to [urge state insurance agencies to better implement and enforce parity.](#)

Advocates should also take advantage of the ability to obtain important health plan information from health insurance carriers. The final regulations highlight transparency, and allow health plan members to request information that will help identify whether a plan is discriminating in its coverage of treatment for mental illness and substance use disorders. With this information, consumers and advocates are in a better position to challenge health plan policies that delay and deny treatment.

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