Mental Health Parity

Both Massachusetts and the federal government passed mental health parity legislation in 2008. Massachusetts' law went into effect on July 1, 2009, expanding previous state parity protections. However, roughly half of Massachusetts companies are exempt from state insurance laws (generally because they are "self-insured*"). They are governed by federal regulations that historically have had less stringent requirements. The new federal law that goes into effect in January 2010 will help.

Key Points:

1. Mass. law creates a tiered system with parity only required for certain mental health diagnoses, but it does offer some protections for other conditions. Federal law does not specify applicable diagnoses.
2. Mass. law specifies certain additional rights for children**.

	State Law: Massachusetts Mental Health Parity Law, Chapter 256 of the Acts of 2008	**Federal Law:** Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
Effective Date	July 1, 2009	January 1, 2010 for most plans[†].
Who's Covered	Members of the following types of commercial plans: • Group Insurance Commission (GIC) plans for government employees and retirees • Plans issued by MA-licensed commercial health insurers • Blue Cross and Blue Shield of MA plans • Plans issued by MA-licensed HMOs • Small group plans regulated by MA insurance authorities • Non-group health plans (individual insurance) • Student plans (for higher educational institutions)	• Employees of businesses that employ 50 or more people and that offer health insurance with mental health coverage, **whether self-funded or fully-insured.** • Those in Medicaid managed care health plans
Who's Not Covered	• Employees of "self-insured"* companies (If the company employs 50 or more people, employees are covered under federal law.) • Those with out of state plans contracting with out of state employers. • Those with Medicare[‡] or Medicaid.	• Employees of small businesses (less than 50 employees) or those who don't offer health insurance with mental health coverage (most MA employers that offer coverage include MH coverage). • Those with Medicare[‡] • Those in Medicaid Fee-for-Service plans.
Protections	Prohibits standard limits (e.g., a maximum of 24 outpatient sessions and 60 days of hospitalization per year) on coverage for certain diagnoses. Insurers are still allowed to limit an individual's treatment to what is considered medically necessary- e.g., can require prior approvals and other case management review requirements. The protected diagnoses are: 1. Schizophrenia 2. schizoaffective disorder 3. major depressive disorder 4. bipolar disorder 5. obsessive-compulsive disorder	Requires that all financial requirements and treatment limitations for mental health/substance use disorder benefits are no more restrictive than those for physical disorder benefits. This includes lifetime and annual dollar limits, deductibles, copayments, coinsurance, out-of-pocket expenses, out-of-network costs (if offered) and to all treatment limitations, including frequency of treatment, number of visits, days of coverage and other similar limits.

	6. panic disorder 7. affective disorders 8. delirium and dementia 9. paranoia and other psychotic disorders 10. autism 11. eating disorders 12. substance abuse problems 13. post-traumatic-stress disorders and 14. Mental or emotional disorders in victims of rape, or assault with intent to commit rape, when the costs of diagnosis and treatment exceed the maximum covered by Mass. victim's assistance compensation. State parity rules apply to full range of services including: • General hospitals • Department of Mental Health facilities • Private psychiatric hospitals • Department of Public Health-licensed substance abuse facilities • Level III community-based detoxification • Acute residential treatment • Day treatment • Crisis stabilization • Mental health or substance abuse clinics • Professional offices of mental health professionals • Outpatient services provided in the home **For conditions/diagnoses not on the list above**, carriers are required to cover medically necessary treatment as determined by a medical professional, paying for a minimum of 60 days inpatient treatment and 24 outpatient visits. Carriers cannot impose other limitations or cost-sharing (such as copayments) on treatment for these mental disorders, unless the same requirements apply to physical conditions. **Medication visits and neuropsychological testing are not subject to these limits, and must be covered on the same terms as medical services.**	Insurers are still allowed to limit an individual's treatment to what is considered medically necessary- e.g., can require prior approvals and other case management review requirements. Requires plans to make mental health/substance use disorder medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. A plan must also make reasons for payment denials available on request.
Limits of protection	For diagnoses **not** on the list, carriers may impose annual maximum coverage limits of 60 days inpatient and 24 outpatient visits.	The federal parity law does not specify what conditions or services are covered.[1]

***Self-Insured**- Self-insured means that instead of paying an insurance company or HMO to cover the health care costs of its employees, the employer itself bears the risk and covers the cost. Self-insured companies can only be regulated under federal law.

****Special Rights for Children**

For children under the 19, Massachusetts law provides additional safeguards for "non-biologically-based" mental, behavioral, or emotional disorders, in addition to the protections for "biologically-based" disorders.

Specifically, the law requires health plans to provide coverage to children for non-biologically-based mental, behavioral, or emotional disorders that substantially interfere with or substantially limit functioning and social interactions, where

1. The child's primary care physician, pediatrician, or a licensed mental health professional has made the referral for diagnosis and treatment of the disorder, and has documented the substantial interference or limitation,

OR

2. The substantial interference or limitation is evidenced by conduct, including, but not limited to (1) an inability to attend school, (2) the need for hospitalization, or (3) a pattern of conduct or behavior that poses a serious danger to self or others.

If a child turns 19 while undergoing treatment, the health plan must continue to provide this coverage until the course of treatment is completed and while the benefits contract covering the adolescent remains in effect. The plan is allowed to charge a premium for these extended benefits, if the child's eligibility for coverage would otherwise end at 19.

† **Effective Date for Federal Law** is January 1, 2010, **except** for plans maintained under collective bargaining agreements (i.e., union contracts) ratified before the enactment date; they are not subject to the Act until the next contract period.

‡ **Medicare-** The new laws do not apply to Medicare patients. In July 2009, however, Congress provided for Medicare coinsurance parity for Medicare patients when it enacted the Medicare Improvements for Patients and Providers Act (MIPPA). Currently, Medicare beneficiaries are responsible for paying 50 percent of the approved amount for outpatient mental health services, but only 20 percent for other services. Under MIPPA, mental health services will enjoy the same 80-20 percent split in coinsurance by 2014. This phase-in to coinsurance parity for outpatient mental health services begins in January 2010, when beneficiaries will pay 45 percent coinsurance; the figure drops to 40 percent in 2012, 35 percent in 2013 and 20 percent in 2014.

[1] *Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: Explained in Brief*, By Jared Moré, December 16th 2008, http://www.treatmentsolutionsnetwork.com/blog/index.php/2008/12/16/wellstone-pete-domenici-mental-health-parity-and-addiction-equity-act-of-2008-explained-in-brief/ retrieved 12/8/09.

-Adapted from: Mass Legal Help http://www.masslegalhelp.org/mental-health/mental-health-parity, National Alliance for the Mentally Ill (MA chapter) http://www.namimass.org/policy/NAMI%20Mass%20Fed.parity.Q&A..doc, and http://www.namimass.org/policy/state%20mental%20health%20parity%20fact%20sheet.doc, all retrieved 12/1/09. "Medicaid and most out-of state plans contracting with out-of-state employers are not considered to fall under the state law on parity" from http://www.mass.gov/mhlac/dys_04.pdf.

Mental Health Parity – Which Law Applies? (Table)

Employer and insurance characteristics	Which Law Applies
Employees of **fully insured** employers who are enrolled in the following types of commercial plans (**less than 50 employees**): • Group Insurance Commission (GIC) plans for government employees and retirees • Plans issued by MA-licensed commercial health insurers • Blue Cross and Blue Shield of MA plans • Plans issued by MA-licensed HMOs • Small group plans regulated by MA insurance authorities	MA
Employees of **fully insured** employers who are enrolled in the following types of commercial plans (**50 or more employees**): • Group Insurance Commission (GIC) plans for government employees and retirees • Plans issued by MA-licensed commercial health insurers • Blue Cross and Blue Shield of MA plans • Plans issued by MA-licensed HMOs • Small group plans regulated by MA insurance authorities	Both
Employees of **fully-insured** out-of-state companies using out of state carriers – 50 or more employees	Federal
Employees of **fully-insured** out-of-state companies using out of state carriers – less than 50 employees	Neither. Covered by other state laws?
Employees of **self-insured** companies with less than 50 employees	Not covered
Employees of **self-insured** companies with 50 or more employees	Federal
Those with Non-group health plans (individual insurance)	MA

Those with Student plans (for higher educational institutions)	MA
Those with Medicare	Neither*
Those with Medicaid HMOs	Federal
Those with Medicaid Fee-for-Service plans	Neither*

* **Medicare and regular Fee-for-Service Medicaid** are not covered by either law, they have their own regulations. In July 2009 Congress provided for Medicare coinsurance parity for Medicare patients when it enacted the Medicare Improvements for Patients and Providers Act (MIPPA). Currently, Medicare beneficiaries are responsible for paying 50 percent of the approved amount for outpatient mental health services, but only 20 percent for other services. Under MIPPA, mental health services will enjoy the same 80-20 percent split in coinsurance by 2014. This phase-in to coinsurance parity for outpatient mental health services begins in January 2010, when beneficiaries will pay 45 percent coinsurance; the figure drops to 40 percent in 2012, 35 percent in 2013 and 20 percent in 2014.

Mental Health Parity – Which Law Applies (Flow-Chart)