Federal Mental Health Parity regulations released

On February 2, 2010, the federal government issued regulations that interpret the Federal Mental Health Parity Act. This act requires both fully-insured and self-funded group health plans with more than 50 employees to offer the same level of coverage for mental health and substance use disorder services as is offered for medical and surgical services through the plan. The act became effective last fall, and ConnectiCare previously took all necessary steps to comply with the act. The regulations add complex new calculations to determine parity of benefits. ConnectiCare is identifying impacts created by these regulations which will be effective for new and renewing groups as of July 1, 2010.

Regulation provisions

Very briefly, if a group health plan provides both medical/surgical benefits and mental health or substance use disorder benefits, the plan may not apply any financial requirements (such as copayments, coinsurance, deductibles and out-of-pocket expenses) or treatment limitations (such as a certain number of visits) to mental health or substance use disorder benefits in any of the following benefit classifications, that are more restrictive than those applied to medical/surgical benefits.

- Inpatient, In-Network;
- Inpatient, Out-of-Network;
- Outpatient, In-Network;
- Outpatient, Out-of-Network;
- Emergency Care; and
- Prescription Drugs.

Additionally, there are other treatment limitations (non-quantitative) that can affect benefits under the plan. Any processes, strategies, evidentiary standards or other factors used in applying these limitations to mental health or substance use disorder benefits must be comparable to and no more restrictive than those used with medical/surgical benefits in the same classification. These limitations include, but are not limited to, the following:

- Medical management standards limiting benefits based on medical necessity or an exclusion for experimental/investigational treatments;
- Prescription drug formulary design;
- Standards for determining provider admission in a network, including reimbursement rates;
- Determinations of usual and customary charges;
- Refusal to pay for higher-cost therapies until lower-cost therapies are used (fail-first policies or step therapy protocols); and
- Conditioning benefits on completion of a course of treatment.

The requirements for assuring parity in each of the designated areas are complicated, and we are reviewing the regulations and our benefit plans to determine any steps we will need to take. We are also working closely with our vendors on an implementation plan. As we move forward, we will provide updates as necessary.