SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

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Mental Health Parity and Addiction Equity Act (MHPAEA)

- A federal law that generally prevents group health plans and health insurance issuers **that** provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/ surgical benefits.
- MHPAEA originally applied to group health plans and group health insurance coverage and was amended by the Affordable Care Act to also apply to individual health insurance coverage.
- HHS has jurisdiction over public sector group health plans, while the Departments of Labor and the Treasury have jurisdiction over private group health plans.

Mental Health Parity and Addiction Equity Act (MHPAEA)

- The Mental Health Parity and Addiction Equity Act (MHPAEA) requires group health plans to ensure that the financial requirements and treatment limitations that are applicable to mental health or substance use benefits are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan.

General Parity Requirements

- MHPAEA defines financial requirements as including deductibles, copayments, coinsurance and out of pocket expenses
- MHPAEA defines treatment limitations as including "limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment"
- Prior to MHPAEA, limits were often imposed on BH health benefits that did not exist for medical/ surgical benefits.

General Parity Requirements

- Plans may not impose a non-quantitative treatment limit (NQTL) on MH/SUD benefits unless
  - any processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, **or**
  - other factors used in applying the limitation to medical/surgical benefits in the same classification.

General Parity Requirements

- MH/SUD coverage is NOT mandated under MHPAEA
- However, if a plan provides coverage for MH/SUD benefits in any classification, coverage for MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided
- This final rule for Medicaid and CHIP includes four benefit classifications: inpatient, outpatient, professional (including emergency care), and prescription drugs

Application of Parity to Medicaid and CHIP

- Parity applies to all individuals enrolled in a Managed Care Organization (MCO) as defined by §438.2, regardless of whether that plan provides MH/SUD services
- Once an individual is enrolled in an MCO, their entire benefit package is subject to parity, including any services delivered through another type of managed care plan or FFS
- Parity does not apply to beneficiaries who receive FFS Medicaid state plan services only

Application to MCOs

- States have two options if they find that the benefit package afforded to enrollees of MCOs does not meet the requirements of this final rule:
  - Change their state plan so that the service package complies with these proposed rules; or
  - Add benefits or remove any relevant treatment limitations from the benefit package provided by the MCO, PIHP or PAHP without making any change to the service in the state plan

"Federal Parity and Access to Behavioral Health Care in Private Health Plans"

- Hodgkin, D., et. al. (2018)
- In 2010, "…a nationally representative survey of commercial health plans was conducted in 60 market areas across the continental United States, achieving response rates of 89% in 2010 (weighted N=8,431) and 80% in 2014 (weighted N=6,974)."
- "In 2014, **68% of insurance products reported having expanded behavioral health coverage** since 2010…Most plans reported no change to prior-authorization requirements between 2010 and 2014."
- Coverage for eating disorders and autism did not improve.

"Impact of MHPAEA" *(Milliman, 2017)*

- Conducted an analysis of healthcare utilization and cost patterns from 2008 – 2013
  - Commercial claim & membership data
  - Paid-to-Allowed Ratios
  - Per Member Per Month (PMPM) Costs
  - Annual utilization rates per 1000 members for inpatient, outpatient, professional, and prescription drug services.
  - 60 million HMO member months; 325 million PPO member months
    - (Note: SC Medicaid typically experiences 14 million member months/year with typical point-in-time enrollment of 1,050,000 beneficiaries)

Milliman's Findings for 2008-2013

- Paid-to-allowed ratio = benefit richness (the % of total allowed cost paid for by the insurer)
  - Greater increases in paid-to-allowed ratios for behavioral health vs. non-behavioral health
  - Greatest gains early on following parity implementation
  - Biggest changes to services previously more restrictive
- Per Member Per Month Costs
  - Cost trends for behavioral health services were up to 2-3 times over that of non-behavioral health services trends
  - Inpatient, outpatient, and professional categories all outpaced same categories for non-behavioral health
- Utilization – trends consistent with paid-to-allowed ratio and PMPM

"Impact of MHPAEA" *(Milliman, 2017)*

Conclusion – "…MHPAEA has driven increases in access to, and benefit richness for, mental health and substance use disorder benefits."

What MHPAEA Doesn't Do…

- MHPAEA does not guarantee provider reimbursement parity
- Behavioral Health provider groups must compete at the RVS (resource-based Relative Value Scale) Update Committee (RUC) level to address reimbursement and coverage issues driven by Common Procedural Terminology (CPT) development
- This is seen as a "zero-sum game"


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