| Q&A from Assurex Global Webinar "New Mental Health Parity and Addiction Equity Act (MHPAEA) Rules" | September 27, 2018 |
|---|---|
| **Question** | **Answer** |
| What distinguishes a provider, say a psychologist, as an "office visit" or a "MH office visit"? | For a group health plan which provides mental health benefits, it may not be necessary to distinguish between a medical/surgical office visit and a mental health office visit. If it is considered an "office visit", the plan would be required to offer the same or more generous cost-sharing for mental health or substance abuse disorder office visits as it does for medical/surgical office visits. If there is a desire to carve out such coverage completely, or to provide more generous cost-sharing terms for mental or substance abuse disorder benefits, it will be necessary to more carefully define such benefits. The reality is that there are not currently clear definitions, and therefore the definitions and classifications may vary between plans. |
| We cover MH Office visits at a copayment equal to our PCP Office visit (not specialist). How would a patient know when to press back if they're charged a Specialist Office Visit instead? | As with any benefit coverage under the plan, education about the benefits available and familiarity with the plan design will hopefully help. Patients are expected to review charges and ask questions if charges don't match expectations. |
| WE have struggled a bit with the non-quantitative limits regarding pre-authorization for IOP and partial day hospitalization as there are no direct comparisons with medical/surgical stays. We have made decisions re: classification internally but would be interested in any input. Thank you. | Clarity on exactly how to handle non-quantitative treatment limitations, including pre-authorization requirements, is still a work in progress. The FAQs issued by the agencies in April 2018 are evidence of efforts to begin to try and provide further clarification, but the reality is that there is still lots of room for interpretation, and "parity" will look different from plan to plan depending upon a plan's specific design.<br>To attempt to follow mental health parity rules, first benefits or services should be assigned to a particular classification (e.g. in-patient (in-network) or out-patient (in-network)). Then consider whether or not there are non-quantitative treatment limitations in place within that particular classification, and if so, how they are being applied to medical/surgical benefits. For example...If intensive outpatient (IOP) is determined to fall within the out-patient, in-network classification, it could be further subclassified as either an office visit or "other". If there are pre-authorization requirements in place for medical/surgical benefits in that particular classification, it would be okay to impose similar pre-authorization requirements for IOP. |

| | |
|---|---|
| What if mental health benefits are more generous than medical/surgical benefits? | If a group health plan is providing mental health or substance abuse disorder benefits, mental health parity rules require that any requirements or limitations not be more restrictive for mental health or substance abuse disorder benefits, but there is nothing currently prohibiting plans from applying more generous terms for such benefits. |
| Is it okay to exclude or include limits on applied behavior analysis (ABA) for autism? | Mental health parity rules do not require that particular benefits be covered. A plan could choose not to provide any mental health or substance abuse disorder benefits, subject to ACA and state coverage requirements. However, if coverage is provided for any mental health or substance abuse disorder benefits, the benefits (including ABA) would have to be provided "in parity" with medical/surgical benefits.<br>Under ACA rules, small, fully-insured plans are required to provide coverage for all essential health benefits, and most group health plans (regardless of size) are prohibited from placing annual or lifetime dollar limits on essential health benefits. The benchmark plans defining essential health benefits vary from state to state, so it would be necessary to consider the applicable state's benchmark plan to understand whether or not ABA would be considered an essential health benefit and require coverage. In addition, more and more states are mandating specific coverage for the treatment of autism, which may include ABA.<br>If the plan is required under the ACA or state coverage requirements to provide ABA coverage, or chooses to do so, any limits must be considered under the mental health parity rules framework and cannot be any more restrictive than those placed on medical/surgical benefits. |
| As an employer with less than 50 employees, does our medical plan have to comply with these rules? | Most group health plans offering mental health benefits or substance abuse disorder benefits beyond what is considered preventive coverage have to comply with the mental health parity rules. While there is a small employer exception (for employers with less than 50 employees), the exception really only applies to small group health plans that are self-funded.<br>Small, fully-insured plans are required under the ACA to offer coverage for all essential health benefits, including mental health and substance disorder benefits, and the rules further require that these benefits be provided in parity; so while not required under mental health parity rules, small, fully-insured plans are required to provide such benefits in parity under the ACA rules. |
| | |
| | |