PARITY AND ACA: NEXT STEPS

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Overview of the Presentation

- **Parity & ACA: Opportunities & Challenges**
- **Parity**
  - Federal parity implementation: a chronology
  - Why is parity important to states?
  - Key provisions in final MHPAEA rule
  - Parity lawsuits
  - Tools for providers: MHPAEA implementation & enforcement
  - Parity & the Affordable Care Act
- **Affordable Care Act**
  - Medicaid expansion
  - The Exchanges

Opportunities

- Largest expansion of addiction coverage and reimbursement in a generation
- Medicalization of substance use disorders
- Stigma and discrimination reduced
- Equitable reimbursement and provider networks for addiction providers

Challenges

Like building and flying an airplane at the same time

Challenges in Detail

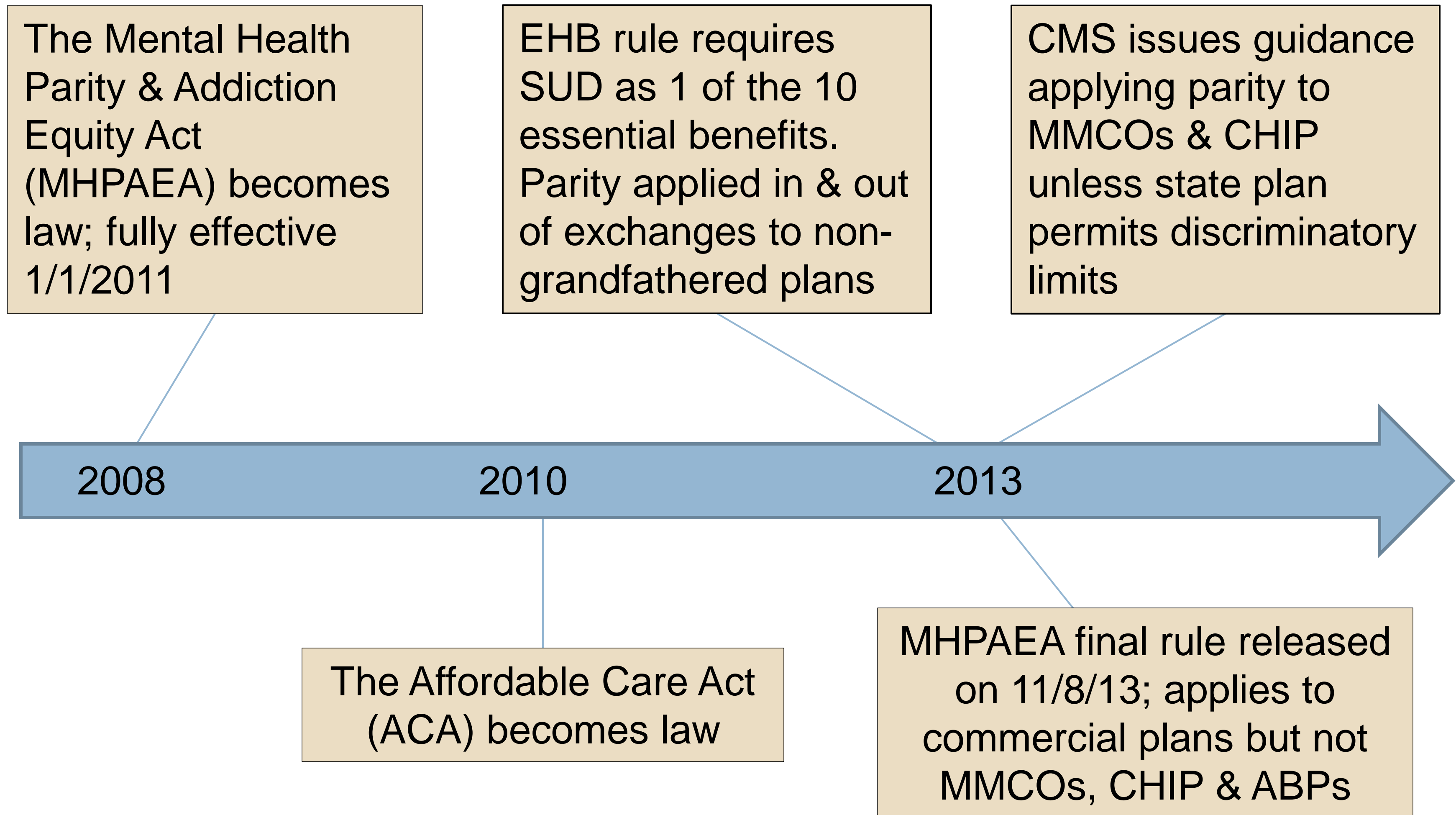
- Tech problems plaguing federally run exchanges (healthcare.gov)
- As of 11/22, 30 states expanding Medicaid (will be 31 w/VA)
- Highly politicized environment in state-federal structure
- Less than ½ of states fully implementing ACA
- Very few states have issued parity compliance guidance
- Much of the promise of parity & ACA based on state decision-making
- Landmark laws historically take decades for full implementation

Implications

- Laws are not self-implementing
- Coordinated effort between states, advocates & industry to fully implement & enforce groundbreaking laws
- Requires well coordinated networks at state & federal level with common messaging
- Sharing effective ACA & parity implementation strategies & replicating successes

Strategy: Urge providers & consumers to engage in parity education

Parity & ACA Chronology



Why is parity important to states?

- Coverage ≠ access
- MHPAEA requires parity in care management; only OR state parity law does
- Parity provides a rationale for equitable use of MAT for SUD
- Without parity, behavioral health cost shift from private to public sector continues while federal funding drops due to ACA
- Rationale for equal use levels & types of care

Strategy: Encourage DOI to do annual MHPAEA compliance audit

MHPAEA Final Rule: Who & When

- The rule does not apply to Medicaid managed care, CHIP and alternative benefit plans (more guidance is coming) but law does
- Continues to allow local & state self-funded plans to apply for an exemption from MHPAEA
- Applies to the individual market (grandfathered & non-grandfathered plans)
- Effective for plan years on or after 7/1/14 (1/1/15)

MHPAEA Does Not Apply To

- Medicare
- Traditional fee-for-service Medicaid
- FEHBP
- TRICARE
- VA

MHPAEA Final Rule: Scope of Service

- Big win for intermediate services (IOP, PHP, residential)
- Clarified scope of service issue by stating:
  - 6 classification benefits scheme was never intended to exclude intermediate levels of care
  - MH/SUD services have to be comparable to the range & types of treatments for medical/surgical within each class
  - Plans must assign intermediate services in the behavioral health area to the same classification as plans or issuers assign intermediate levels for medical/surgical

MHPAEA Final Rule: NQTLs

- Strikes provision that permitted plans to apply limits if there was a "clinically recognized standard of care that permitted a difference"
- NQTLs are expanded to include geographic location, facility type, provider specialty & other criteria (i.e can't let patients go out of state for med/surg treatment and not MH/SUD)
- Maintains "comparably & no more stringently" standard without defining the term
- Confirms provider reimbursement is a form of NQTL

MHPAEA Final Rule: Disclosure & Transparency

- Requires that criteria for medical necessity determinations be made available to any current or potential enrollee or contracting provider upon request
- Requires the reason for a denial be made available upon request
- Final rule now requires plans to provide written documentation within 30 days of how their processes, strategies, evidentiary standards & other factors were used to apply an NQTL on both med/surg & MH/SUD

MHPAEA Final Rule: Enforcement

- Final rule clarifies that, as codified in federal & state law, states have primary enforcement over health insurance issuers
- DOL has primary enforcement over self insured ERISA plans
- DOL, HHS & CMS will step in if a state cannot or will not enforce the law

Lawsuits Alleging MHPAEA Violations

- C.M. vs. Fletcher Allen Health Care
  - U.S. District Court of VT found plans, rather than patients, have the burden of proof to provide clinically appropriate standards of care to justify treating MH/SUD claims differently than medical
- APA & CT Psychiatric Society filed suit against Anthem in CT
  - Anthem agreed to use proper CPT codes but other parity issues still pending
- Class action suit filed by NY State Psychiatric Association against UnitedHealth (dismissed based on suing wrong party)
  - Key issue: More stringent medical management (NQTL violation)

Resources

- Resources available at www.parityispersonal.org:
  - URAC parity standards
  - Massachusetts parity guidance
  - Maryland parity laws
  - Nebraska parity compliance checklist
  - Milliman employer & state guide to parity compliance
  - Toolkit for appealing denied claims

Additional Resources

- States & public plans
  - CMS Center for Consumer Insurance Information & Oversight (CCIIO)
  - 877-267-2323 ext 61565
  - E-mail: Phig@cms.hhs.gov
- Employer plans
  - DOL Employee Benefits Administration
  - 866-444-3272
  - www.askebsa.dol.gov

Affordable Care Act & Parity

- On 1/1/14*, ACA expands MHPAEA & will apply to:
  - Benefits provided in new "exchanges"
  - Benefits provided by non-grandfathered small group & individual plans
  - Benefits provided to new Medicaid population
  - **These plans will have to offer a MH/SUD benefit**

*The Administration is allowing canceled plans (that didn't meet these requirements) to continue to be offered in 2014; adherence will vary by state

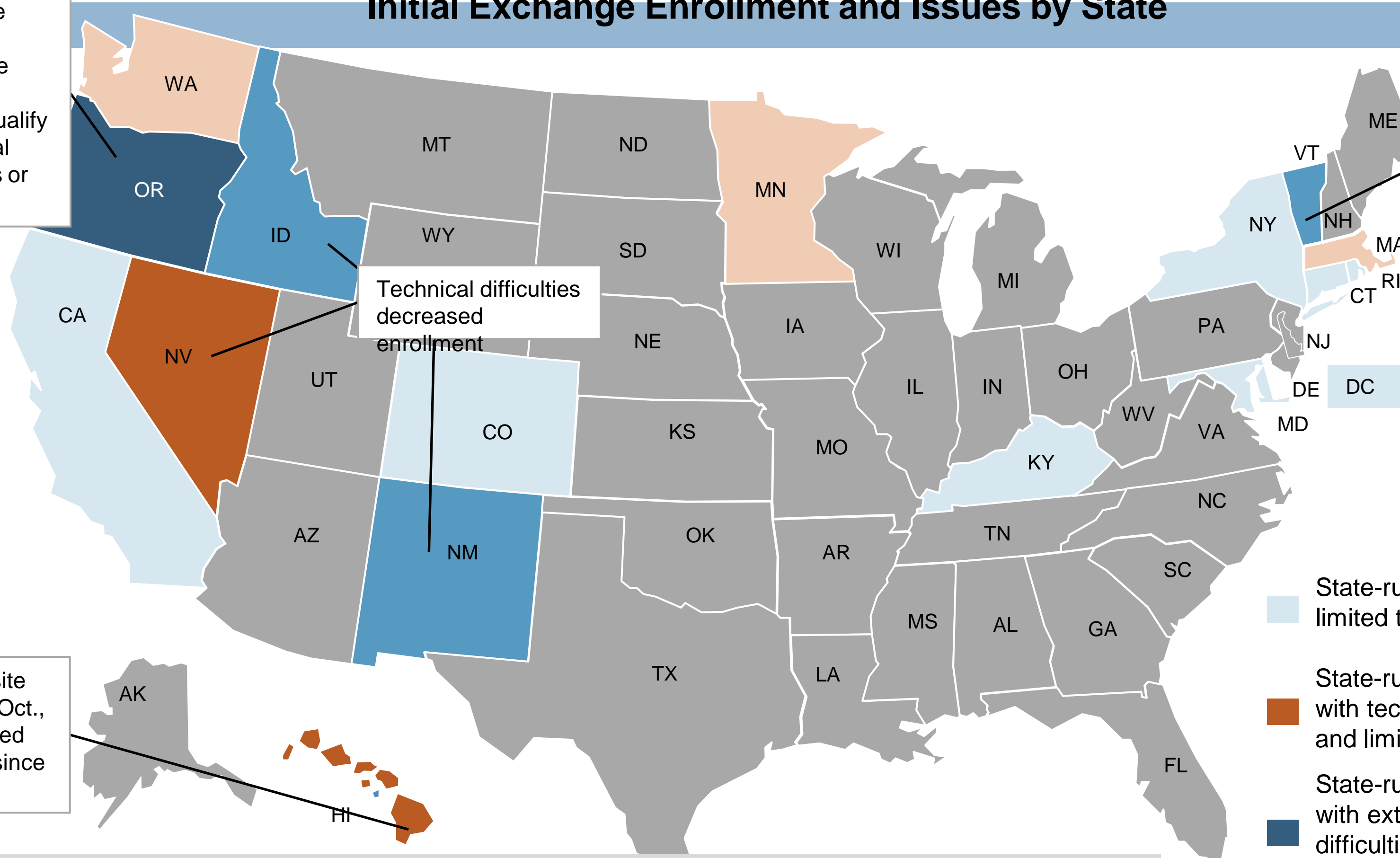
Controversial ACA Provisions

- "If you like your plan, you can keep it"
- Medical device tax
- 2.3% tax on health plans
- Individual mandate & fines
- Coverage for contraceptives

Who is expected to enroll in the exchanges?

- 65 percent previously uninsured
- More than one-third have not had a check-up for more than two years
- Lower income than those currently covered by private insurance
- More racially diverse than the those who currently have private insurance
- One in four Exchange enrollees speak a language other than English at home
- 77 percent of people enrolled through Exchanges have a high school diploma or less

State Exchanges Faced Technical Difficulties on Debut

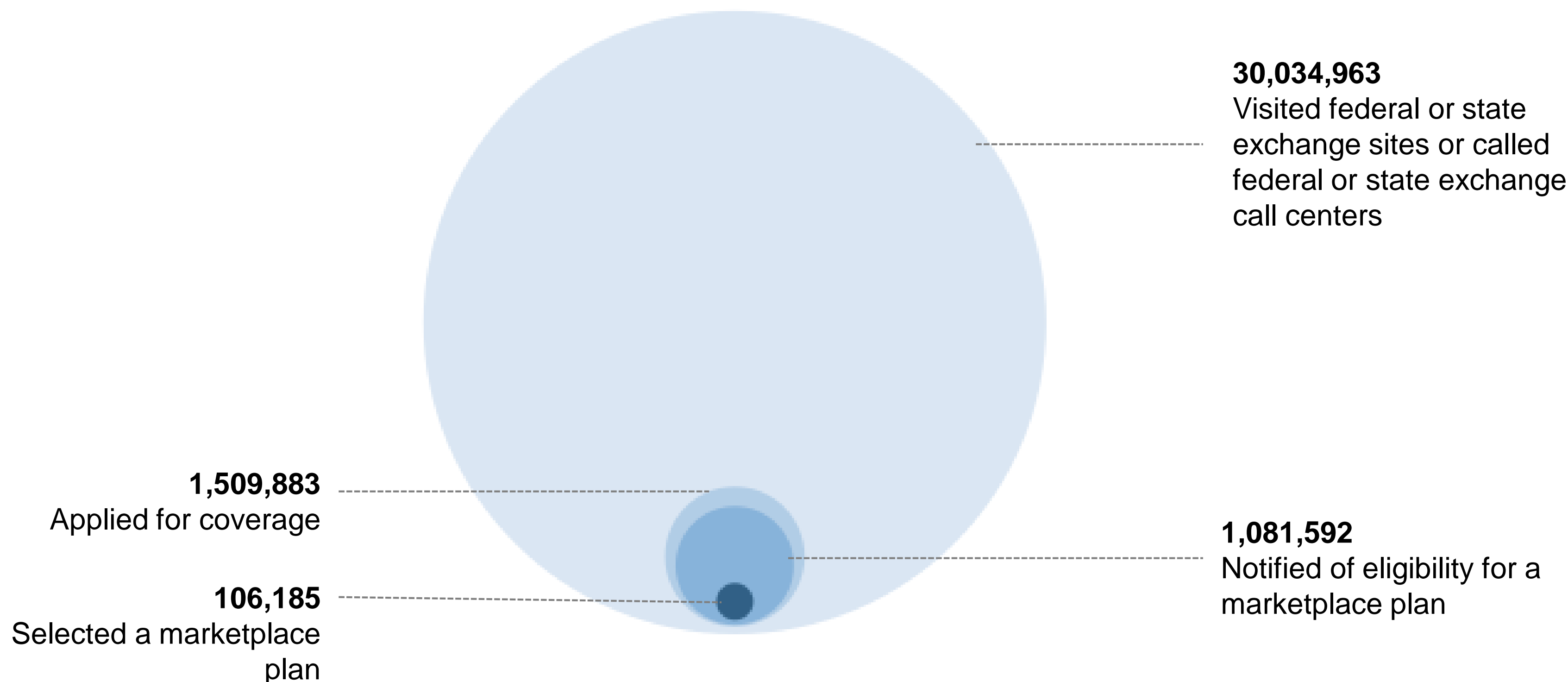


Analysis

- Federal exchanges weren't the only ones hampered by technical difficulties; as of Nov. 13 Oregon, for example, has not enrolled a single person
- Enrollment in state exchanges may increase as technical issues are resolved, but these difficulties killed critical momentum during the exchanges' debut.

Sources: Abby Goodnough and Reed Abelson, "Some state insurance exchanges continue to battle technical problems," The New York Times, November 13, 2013; Arit John and Philip Bump, "California Enrolled More People Than the Entire Federal Exchange," The Atlantic Wire, November 13, 2013; Gosia Wozniacka, "Cover Oregon plans 400 new hires," Statesman Journal, November 12, 2013.

Less Than 1% of Site Visitors, Callers Enrolled in Exchanges



Analysis

- The administration reported unexpectedly low enrollment in the new health insurance exchange marketplaces in the first month of the exchanges' debut, with only 106,185 Americans enrolling in a marketplace plan
- Technical problems with the exchange website were expected to contribute to low enrollment, but the Nov. 13 report—indicating enrollment was only at 20% of goal for October—has lawmakers on both sides of the aisle considering amendments to the Affordable Care Act (Administration set goal of enrolling 7 million by March 2014)

What can you "buy" on the exchanges?

- "Qualified Health Plans" (QHPs)
  - Private insurance plans
  - Must cover "**essential health benefits**"
  - Must offer certain levels of value ("metal levels")
  - Must include "**essential community providers,**" where available, in their networks
  - Must have provider network sufficient to ensure access to MH/SUD services without "unreasonable delay"
  - Must comply with ACA insurance reforms

Strategy: Get copies of QHP benefit packages & verify packages are ACA & MHPAEA compliant

How MHPAEA Applies to Exchanges

- Plans offered in the exchanges will be required to offer a mental health & addiction benefit at parity
- "New" individual & small group plans (plans not in existence on 3/23/10) will also have to offer mental health and addiction at parity
- ACA data regs require plans to report on quantitative treatment limitations
- MHPAEA guidance requires reporting of NQTLs

Strategy: Make sure exchange requires QHP reporting of BH financial & other treatment limits

Parity & Medicaid Expansion

- January 2013 Medicaid parity guidance
  - Medicaid MCO plans must comply w/parity unless state plan allows discriminatory limits
  - Benefits for the "newly eligible" Medicaid population must include MH/SUD at parity
  - Parity final rule does not apply to MMCOs, CHIP & ABPs
- PIC asking for new guidance on application of final rule within 6 months or by 7/1/14
- CMS guidance available at: http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html

Strategy: Advocate for CMS parity guidance applying final rule by 7/1/14

Questions?

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