Health Care Law Update from Clark Hill PLC

By Peter J. Domas / May 29, 2014

Final Mental Health Parity Regulations Expands Coverage for Individuals In Need of Behavioral Health Care

By: Peter J. Domas

On Friday, November 8, Kathleen Sibelius, the Secretary of Health and Human Services, announced final regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). These final regulations, along with the requirements of the Affordable Care Act, greatly increase access to behavioral health services by requiring that such services be covered to the same extent as coverage for medical and surgical health conditions.

In 2008, the MHPAEA required that most insurance plans offering behavioral health services, including mental health and substance abuse treatment services, must provide such benefits on par with the covered services for physical medicine. However, while the law prohibited payors from imposing annual or lifetime dollar limitations on mental health benefits on terms less favorable than such limits imposed on physical medical benefits, there were several significant exceptions that limited the effectiveness of expanding behavioral health coverage.

The largest of these exceptions is that the law only applies to insurance plans that offered behavioral health coverage. As a result, most plans eliminated behavioral health coverage to avoid the increased cost of providing additional services. However, under the Affordable Care Act, behavioral health services is now required as an essential health benefit, and thus must be included in all plans offered on the health insurance exchange and any non-grandfathered individual and small group policies. Medicare and traditional Medicaid are currently not subject to the new regulations, but guidance has already been published for Medicaid managed-care plans and further guidance is being implemented which will likely incorporate additional behavioral health coverage under these programs as well. Therefore, the vast majority of policies will now require behavioral health services, and under the MHPAEA, these must be on par with other covered services.

The final regulations further limited the loopholes for payors covering behavioral health services by removing the ability of payors to impose "non-quantitative treatment limitations to the extent that recognized clinically appropriate standards of care may permit a difference." These non-quantitative standards include those relating to medical necessity, network design, standards for provider admission, reimbursement rates, and methods for determining usual customary and reasonable charges. The final regulations realized that this exception was likely to be abused by the payors to justify significant restrictions on the availability of covered services. The final rule now requires that a plan may not impose restrictions unless such limitations are comparable and are applied no more stringently that the limitations imposed on medical and surgical benefits in the same benefits classification.

For limitations on services that are quantifiable, such as frequency of treatment, number of visits, days of coverage, days in a waiting period, there may be no difference between behavioral health and physical medical coverage. Furthermore, the final regulations identify six classifications that must have "substantially all" the same restrictions. These six classifications are in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency care, and prescription drugs. A plan will possess "substantially all" the same restrictions between behavioral and physical medicine if restrictions on behavioral health services also apply to at least two-thirds of the medical/surgical benefits in a classification. Plans are also required to perform the parity analysis annually in years when a change in benefit design, cost-sharing structure, or utilization affects the analysis within a classification

Finally, the regulations specifically address that "intermediate services" must be provided. These services include residential treatment, partial hospitalization, and intensive outpatient care. As a result, behavioral health providers will now be able to provide consumers with treatment options on an equal basis as those provided by physical medicine providers.

While the MHPAEA and the provisions of the Affordable Care Act will greatly increase the accessibility to behavioral health services, there are some important limitations that may allow a plan to exclude such coverage. Some plans may apply for exemptions from the laws if an employer-based plan can demonstrate that the Final Rule increases its healthcare costs by 2% in the first year that the new rule applies to the plan, or by at least 1% in subsequent years. However, such exception will not excuse the plan from being required offering behavioral health services as part of the essential health benefits under the Affordable Care Act.

The increase in the coverage for behavioral health services presents an excellent opportunity for behavioral health providers to provide services to an increasing number of consumers, and plans covering these consumers will be required to pay for such services at a rate on par with those paid to physical medicine. This increase in coverage by third-party payors will change the landscape of the behavioral healthcare delivery system. Managed care networks will need to grow to include behavioral health delivery options; contacts with third party payors will become increasingly important; and the delivery of integrated health services will be critical. Our Behavioral Healthcare Attorneys work on these issued daily and can assist your organization in taking advantage of the new opportunities presented by the Affordable Care Act and the MHPAEA.

For more information or for assistance on what the Final Rule means for your organization and what growth opportunities may exist for your behavioral healthcare business, please contact

Greg Moore , Neda Ryan , or Peter Domas .