New Mandate for Covering Mental Health And Substance Abuse May Force Employers To Reduce Hospital and Drug Benefits

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In the wake of the highly publicized health care reform bill, hospitals and pharmacies that are worried about changes in their relationship with insurance companies and employers might want to refocus on the near term and the potential for marketplace disarray resulting from the implementation of an unheralded law. Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) in October 2008, but it just went into effect for company health plans beginning July 1, 2010.

The law affects companies that currently provide mental health and substance abuse benefits to more than 50 employees. Starting in the upcoming plan year, those companies must now equalize financial requirements and treatment limitations for depression, schizophrenia, drug addiction, and similar conditions with those offered for medical and surgical care. An earlier law dictated “parity” for annual and lifetime limits.

The Departments of Health and Human Services, Treasury, and Labor issued an interim final rule on February 2, 2010, specifying exactly how companies must meet the expanded mandate. The rule established six categories of care and stated that medical and mental health and substance abuse coverage had to be equalized within each of these categories: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs. Any limitations on mental health benefits within any of the six groupings cannot be more restrictive than the predominant limitation applied to substantially all the medical/surgical benefits.

This requirement applies to both quantitative limits, such as copays and number of physician visits, and non-quantitative treatment limits, which, in the argot of this rule-making, has come to mean the variety of medical management tools used by managed care organizations (MCOs), including formulary development.

The requirements were a little foggy for the hospital industry, which asked for clarification, worrying that some of the services it provides might be disadvantaged by the new law. Others argued that the agencies’ determination that employers must also equalize drug coverage went beyond what Congress intended in the 2008 law.

Rick Pollack, Executive Vice President of the American Hospital Association (AHA), says that it is unclear which mental health benefits are being referred to in equalizing coverage for certain hospital services (e.g., skilled nursing). For example, should skilled nursing be compared with residential treatment on the mental health side?

The AHA, responding to decisions concerning the interim final rule, urged the agencies to consider including a category for post-acute care or, as an alternative, to clarify the category that would apply to this type of care.

Mr. Pollack said, “At the present time, it is unclear into which category, if any, certain post-acute benefits, such as skilled-nursing facility benefits, fall. More detail would help ensure that parity is provided appropriately as well as offer protections for providers and patients alike.”

 Typically, large companies in particular, whose health insurance may be self-funded, contract with a mainline insurance company to administer a medical/surgical benefit and a behavioral health care “carve-out” company to administer the mental health/substance abuse benefit. Examples of the carve-out companies include Magellan Health Services, Inc.; Beacon Health Strategies, Inc.; and Value Options.

Among the interim final rule dictates that Magellan has protested is its application of parity to prescription drugs. Tony Kotin, MD, Chief Medical Officer at Magellan, says that including prescription drugs as one of the six mandated classifications was completely unanticipated and goes well beyond the focus and intent of the MHPAEA. He argues that the creation of a prescription drugs classification as a subset of both medical/surgical and behavioral health benefits unnecessarily distorts the benefit plan design. He stated:

Magellan Health Services strongly supports parity, and we believe that every patient, regardless of type of illness, should have access to health benefits without discrimination. That’s why we are seeking greater clarity on the vague language in the regulations. Our hope is to avoid the creation of unnecessary complexity that adds administrative and financial burdens to providers and patients and inhibits access to care.

The pharmacy benefit category has stirred other concerns too. Laurence L. Greenhill, MD, President of the American Academy of Child and Adolescent Psychiatry (AACAP), worries that it will become an avenue for denying appropriate care. He explained:

In order to treat children with severe mental illnesses, child and adolescent psychiatrists sometimes prescribe medications that are not FDA-approved for the age, diagnosis, or indication [for which] they are intended. Any requirement for documentation for off-label use and fail-first policies can be applied only if they are also required in medical/surgical treatment.

According to Steve Wojcik, Vice President of Public Policy at the National...
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Business Group on Health, his members estimate health insurance costs will increase by 1%. Companies are legally able to drop mental health coverage as a result of the MHPAEA, although that seems unlikely. They can also apply for an exemption in their second year of compliance if health insurance costs in the first year increase by 2% as a result of the expanded mental health/substance abuse coverage.

If companies avail themselves of either option, the result would have a huge impact on the demand for hospital and pharmacy services. More likely, according to the Society of Actuaries, is that instead of improving mental health coverage as a result of the MHPAEA mandate, employers will erode medical/surgical and drug coverage to bring it down to the level of mental health care. That is not what Congress intended, of course—but the MHPAEA wouldn’t be the first law to have unintended consequences.