Policy Implementation:

The Mental Health and Addiction Parity Act of 2008

Frank L. Greenagel Jr.

Rutgers University: Bloustein School of Public Policy

Spring, 2015

**Introduction**

The **Mental Health Parity Act** (MPA) of 1996 was introduced and championed by Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN). It was both a political and a personal issue for them, as Senator Domenici’s daughter lived with schizophrenia and Senator Wellstone’s brother had been hospitalized for depression for two years in college. After much debate and negotiation, a very limited bill was passed that did not mandate mental health coverage (and did not address substance abuse coverage at all). A disappointed but resolute Senator Wellstone acknowledged that it was just a “first step”[[1]](#footnote-1) toward full parity.

Over the next twelve years, the battle for parity was taken up by grass roots organizations such as the National Alliance of the Mentally Ill (NAMI), governmental research organizations like the National Institute of Mental Health (NIMH), professional organizations including the National Association of Social Workers (NASW),[[2]](#footnote-2) the American Psychological Association (APA) and the American Society of Addiction Medicine (ASAM)[[3]](#footnote-3), as well as a new generation of politicians including Representatives Patrick Kennedy (D-RI) and Jim Ramstad (R-MN), both of whom were public about being recovering alcoholics[[4]](#footnote-4).

A common refrain argued by those that opposed parity was that it would drive up costs. Those opponents included insurance companies and employer groups, and they were able to defeat a couple of lesser attempts at expanding parity with the rejection of the **Mental Health Equitable Treatment Act** (MHETA) of 2001 and again in 2002. Undaunted, parity advocates pushed for more and better research and eventually the Congressional Budget Office (CBO) published a report that took into account the effects of managed care and showed that parity did not lead to an increase in health care costs.[[5]](#footnote-5)

This (and other) research combined with the public testimony of the personal experiences of Senator Domenici, Senator Ted Kennedy (D-MA),[[6]](#footnote-6) Representatives Kennedy and Ramstad, and a collapsing economy[[7]](#footnote-7) in the fall of 2008 were able to get the **Mental Health and Addiction Parity Act** (MHPAEA) passed[[8]](#footnote-8) by the 110th Congress and signed into law by President George W. Bush as a rider on the Emergency Economic Stabilization Act of 2008.[[9]](#footnote-9) “The MHPAEA prohibited differences in treatment limits, cost sharing, and in- and out- of network coverage. It also applied to the treatment of substance disorders, which the MHPA did not address.”[[10]](#footnote-10)

It was hailed as a major victory by parity advocates. And then it got bogged down in the rule-making process. In a speech before the Senate on November 7, 2013, former Representative Patrick Kennedy[[11]](#footnote-11), now of NJ, lamented the delays of the previous five years:

MHPAEA was passed and signed into law on October 3, 2008, and its provisions became effective exactly one year later. Many insurance plans follow the calendar year; the effective date for them was January 1, 2010. The Interim Final Rule for MHPAEA was issued on February 2, 2010, effective April 5, 2010, and applicable to plans beginning on or after July 1, 2010. We have been waiting for the Final Rule ever since then – over three years.[[12]](#footnote-12)

**The Rule-Making Process**

Legislation is often written in vague terms. The Rulemaking phase helps incorporate and integrate the new law with more detailed policies. This often requires the help of industry, economic experts, scientists, researchers and the public. The Rulemaking phase includes the following steps: (1) advanced notice of rulemaking; (2) proposed rule; (3) public comment; and (4) the issuance of the final rule. The Rulemaking phase for the MHPAEA was particularly long, and was summed up by some policy analysts thusly:

After its passage, the new federal parity law entered the rule-making phase, in which those federal agencies that have jurisdiction make administrative decisions about how to interpret the legislative language. This process shapes implementation of a new law. Political scientists have long observed a tendency of interest groups to refight policy battles at the rule-making stage. In the case of the federal parity law, rulemaking created a somewhat contentious second bite at the apple for groups that had been temporarily united under an alliance to win passage of the law[[13]](#footnote-13).

The first step (advance notice of rulemaking) was a request for comments on the proposed regulations, “which was posted in the Federal Register in April 2009 by the Departments of the Treasury, Health and Human Services, and Labor, the three regulatory agencies charged with implementing the new law[[14]](#footnote-14).” They received over 400 comments.

The Department of Labor’s Employee Benefits Security Administration (EBSA) was charged with leading the development of the “infrastructure for MHPAEA implementation. To achieve its ultimate goal of successfully implementing MHPAEA, EBSA created a robust MHPAEA program that included four Strategies of Implementation[[15]](#footnote-15):”

 1) issuing interpretive guidance

2) conducting external outreach and compliance assistance activities

3) providing participant assistance

4) enforcing the law and regulations

According to the law, parity was to take effect on January 1, 2010 for most plans. Because of the overwhelming number of comments and the complicated nature of responding to and resolving them, the Interim Final Rules were not released until February 2, 2010.[[16]](#footnote-16) This delay in guidance from the government “posed challenges for insurers charged with restricting their benefit packages to comply with the new law…The consequence is that employers might have to alter their benefit plans three times as more information is provided regarding how to comply with the new law.[[17]](#footnote-17)”

**Interim Final Rules**

Upon the release of the MHPAEA final rules, “the Departments realized that the complexity of the law and regulations gives rise to many highly technical issues and questions[[18]](#footnote-18).” There was a great deal of confusion and anxiety regarding the implementation of the rules. It came from all sides, including “a wide-range of representatives from Congress, the Parity Implementation Coalition, Mental Health America, and American Psychiatric Association, among others.”[[19]](#footnote-19)

The Interim Final Rules stated that insurance plans are prohibited from imposing a financial requirement (like a copayment or coinsurance) or a quantitative treatment limit (QTL) restriction (such as a limit on the number of outpatient visits or inpatient days covered) that was more limiting than the "predominant[[20]](#footnote-20)" financial requirement or treatment limit restriction that applied to "substantially all[[21]](#footnote-21)" medical/surgical benefits in the same classification. The words “predominant” and “substantially all” were meticulously scrutinized and they required further clarification. “Under regulation, ‘predominant’ was defined as ‘more than half’ and ‘substantially all’ was defined as ‘two-thirds.’”[[22]](#footnote-22) Rather than add clarity, they further muddied the water.

**Access to Care and Carve-Outs**

Comments, questions and complaints poured in. Consumers were concerned about how they would increase access to care, and continually noted that mental health and (especially) addiction services were often more scarce and therefore further away than other medical services. There were questions about how to determine equivalence of services:

For example, intensive outpatient programs often used to treat substance abuse do not have an equivalent in internal medicine. Similarly, it is difficult to determine the medical/surgical equivalent for a rehab stay for an acute schizophrenic episode. Full parity demands that standards of evidence be applied consistently across mental health/substance use and medical/surgical treatments. As one health insurance executive noted, "How to provide coverage for care levels and treatment venues that are unique to behavioral health, and aligning these with medical and surgical benefits, is a continuing discussion within health plans and between plans and regulators”[[23]](#footnote-23).

The Departments did not have an answer to those questions.

**Deductibles**

Despite language in the Mental Health Parity Act of 1996 that stated that deductibles for mental health treatment must be the same as other medical treatment, the different rates of deductibles continued. This may not have been intentional, but rather the result of carve-out. Carve-outs are separate insurance plans that only deal with mental health and addiction coverage that are outsourced by the primary insurance provider[[24]](#footnote-24). Because there were two different companies providing coverage, there were two deductibles. This was an antagonizing point that Senator Domenici wanted to make sure was addressed in the MHPAEA. “Separate deductibles would force people who needed both types of services to satisfy a higher deductible than people needing only medical services and imposed a barrier to accessing benefits.”[[25]](#footnote-25) The Interim Final rules resolved this by clearly stating that plans cannot have separate deductibles[[26]](#footnote-26).

**Quantitative Treatment Limits and Non-Quantitative Treatment Limits**

Those aforementioned rules regarding financial requirements and QTLs covered six classifications: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient out-of-network; 5) emergency care; and (6) prescription drugs.[[27]](#footnote-27) They also made a distinction between parity for QTLs and Non-quantitative treatment limits (NQTLs).

QTLs are (a) visit limits and (b) co-payments. They are covered by the parity law under the Interim Final Rules. They are measurable, and it possible to detect if there have been violations. NQTLs, by their nature, are harder to gauge and measure. As a result, the Interim Finale Rules gave the appearance that they were not covered under the parity rule. The NQTLs include:

1. **Prior authorization** – Before accessing mental health or addiction care, people must be pre-authorized. Insurance companies requested this to prevent people from frivolously using services. Parity advocates have argued that this serves as another barrier to treatment, and that patients do not have to get pre-authorization to seek treatment.
2. **Standard for provider admission to network**
3. **Medical management standards**

4) **Determination of provider reimbursement rates**

5) **Requirements for step-therapy** – It has also dubbed “fail-first” by parity advocates. Mental health and addiction treatment rely on the American Society of Addiction Medicine’s (ASAM) assessment tools to determine the appropriate level of care.[[28]](#footnote-28) Before (and after) these rules were issued, insurance plans could require that a patient fail at level 1 treatment before being approved for level 2 treatment (or fail level 2 before getting approved for level 3). This is extremely problematic when a licensed professional assess a client as needing in-patient substance abuse treatment (level 3) and the insurance company only approves for intensive out-patient treatment (level 2) first. Research shows that starting at the wrong level of care worsens treatment outcomes. It is a particular cause of concern in the field of substance abuse, because the client could overdose and die if placed in the wrong level.[[29]](#footnote-29)

6) **Requirement to complete course of treatment as condition of benefit** –This means that if the patient leaves against medical advice (AMA) that the insurance companies do not have to pay for treatment.[[30]](#footnote-30)

7) **Prescription drug formulary design**

The apparent lack of application of parity to NQTLs resulted in a large number of comments, some of which were outraged. They “argued that this was another way for plans and issuers to treat coverage for mental health/substance use disorders differently than medical/surgical coverage.”[[31]](#footnote-31) In order to provide illumination, the Department of Labor provided a list of five examples of how to apply the MHPAEA’s Interim Rules to the NQTLs. That list can be found at the end of this paper as Appendix A.

**Stakeholder Outreach and Education**

In order to help consumers, providers, insurers, employers, and other stakeholders, The Department of Labor’s Employee Benefits Security Administration (EBSA) held a series of meetings and panel discussions specifically related to MHPAEA guidance in 2010-11 with the following:

* American Law Institute-American Bar Association (ALI-ABA) Webcast
* American Benefits Council teleconference
* Office of Personnel Management/America's Health Insurance Plans Conference
* National Association of Insurance Commissioners quarterly meetings
* Multiple All-States conference calls
* Northeast Regional meeting with States, consumer groups, provider groups, and insurance industry representatives.
* Approximately 6 stakeholder meetings with organizations such as the Association for Behavioral Health and Wellness and the Parity Implementation Coalition[[32]](#footnote-32)

**Enforcement**

 In its 2012 report, the Department of Labor stated that:

 DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA. HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans. While State insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority. Therefore, if there is a complaint regarding MHPAEA, the Departments generally collaborate with one another, as appropriate, on any investigations and broad-based compliance assistance efforts[[33]](#footnote-33)”

A 2014 study found that the Interim Rules provided an extremely weak enforcement mechanism, which further encouraged insurance plans and employers to move slowly on implanting parity.[[34]](#footnote-34)

**Compliance studies and further reporting**

 The Department of Health and Human Services agreed to commission a study “to examine compliance with MHPAEA by employer-sponsored group health plans and health insurance coverage offered in connection with such group health plans.[[35]](#footnote-35)” The key points of the study were to determine if health plans and insurers were obeying the financial requirements and quantitative treatment limitations in accordance with the interim final rules. However, the study also included “an examination of the types of NQTLs that are commonly used by plans and insurers and whether and how these practices may have changed in response to MHPAEA.”[[36]](#footnote-36)

The Interim Final Rules acknowledged the complexity of these issues and that they required more studying. The 2012 Department of Labor Report that was statutorily required to report on the implementation on the law stated that the it “intends to continue collecting and analyzing compliance data (including as they relate to NQTLs) as it becomes available and will supplement the analysis of the preliminary findings of this Report, if possible, in advance of the next report to Congress due on January 1, 2014.[[37]](#footnote-37)”

**The Affordable Care Act (ACA) of 2010**

The Affordable Care Act was passed by the 111th Congress on March 21, 2010 and signed into law by President Barak H. Obama on March 23, 2010. Its goals were to (1) decrease the number of uninsured Americans; (2) reduce the costs of healthcare; and (3) increase the quality of health insurance. It also expanded and strengthened the MHPAEA in a number of significant ways. Before the ACA was passed, the MHPAEA only affected group plans. The ACA applied “the MHPAEA to issuers in the individual market and qualified health plans offered through an exchange or marketplace.”[[38]](#footnote-38)

 In a speech before the Senate three years after the passage of the ACA, Patrick Kennedy extolled that “the ACA guarantees that pre-existing conditions won’t be used to prevent us from insurance coverage, and also goes further in guaranteeing parity than our bill did.”[[39]](#footnote-39)

The ACA “defined coverage of mental health and substance use treatment as one of the ten essential health benefits (EHBs)….in this way, ACA went beyond MHPAEA by mandating coverage rather than requiring parity only if coverage is provided.”[[40]](#footnote-40)

These changes brought upon by the ACA had to be taken into account by the Department of Labor, Treasury, and Health and Human Services and were probably a major cause of the 3 ½ year delay between the issuance of the Interim Final Rules and the Final Rules. In reviewing the effects of the ACA on the MHPAEA, a 2014 White Paper out of Colorado concluded that “insurance benefits provided under an integrated ACA and MHPAEA mandate will significantly improve the current system by more adequately aligning the payment system with an evolving care delivery system.[[41]](#footnote-41)

**The Final Rule**

 Patrick Kennedy had opened that aforementioned speech before the Senate on November 7, 2013 with this introduction:

Five years ago, when my father and I sponsored the Mental Health Parity and Addiction Equity Act (MHPAEA) and shepherded it through the House and Senate, we thought its signing by President Bush was the end of a process. In fact, it was barely the beginning… Just to recap, MHPAEA was passed and signed into law on October 3, 2008, and its provisions became effective exactly one year later. Many insurance plans follow the calendar year; the effective date for them was January 1, 2010. The Interim Final Rule for MHPAEA was issued on February 2, 2010, effective April 5, 2010, and applicable to plans beginning on or after July 1, 2010. We have been waiting for the Final Rule ever since then – over three years.[[42]](#footnote-42)

In the meantime, people with mental health and/or substance use disorders were still being denied the appropriate level of care[[43]](#footnote-43) or being kicked out of treatment when their insurance ran out[[44]](#footnote-44). An effective application of the MHPAEA would prevent these issues. Mr. Kennedy noted as much: “We are also seeing cases brought to court in several states in which individuals are claiming they were denied benefits they believe the parity law should have guaranteed them.”[[45]](#footnote-45)

The day after Mr. Kennedy’s speech before the Senate Subcommittee, the Departments of Labor, Treasury and Health and Human services jointly released the Final Rules of the MHPAEA (on November 8, 2013)[[46]](#footnote-46).

With regards to the NQTLs that had not been covered by parity in the Interim Final Rules, advocates would find that the Final Rules brought a pleasant surprise. The Final Rule

eliminated the specific exemption for different NQTLs based on "recognized clinically appropriate standards of care." Plans and issuers can still take into account clinically appropriate standards of care when determining coverage as long as they apply any NQTLs for mental health/substance use benefits comparably and no more stringently than those with respect to medical/surgical benefits. The final rule adds several examples of NQTLs such as network tier design and restrictions based on geographic location, facility type, and provider specialty, but noted that this is not an exhaustive list. The rule also clarifies that plans cannot discriminate in provider reimbursement rates as a way of discouraging mental health providers from participating in their network. Finally, in an effort to improve transparency, the regulations require plans and issuers to disclose the medical necessity criteria used, as well as any reason for a denial of a mental health or substance use claim, upon request.[[47]](#footnote-47)

**Department of Labor Report 2014**

In its bi-annual report on the state of implementation of MHPAE, the DOL highlighted two significant developments: (1) the findings of the MHPAEA compliance study and (2) the issuance of final rules:[[48]](#footnote-48)

1. **Compliance study**[[49]](#footnote-49)- It found that since 2012 that more employers and health plans had made changes in order to conform to the parity standards. “The study also found that there has been a substantial decrease in the number of plans and issuers that impose disparate quantitative treatment limitations, such as inpatient day limits or outpatient visit limits.”[[50]](#footnote-50) The study did report the alarming fact that mental health and substance abuse treatment providers were still being paid lower reimbursement rates compared to medical/surgical standards.[[51]](#footnote-51)
2. **Issuance of final rules –** The release of the Interim Final Rules, the comments and complaints about them, the NQTL/SOS study and the MHPAEA compliance study, EBSA’s outreach meetings and panel discussions all helped to guide the creation of the final rules. In addition:

experience gained through the Departments’ earlier implementation activities, specifically through enforcement efforts and through working with the regulated community to provide compliance assistance with respect to technical questions under MHPAEA, helped inform the process and identify areas where further guidance would be needed to ensure full implementation of the law.[[52]](#footnote-52)

**The Kennedy Forum**

Despite leaving public office at the end of 2010, Patrick Kennedy has continued to advocate for parity. In October of 2013, he announced a new collaboration of stakeholders, political figures and experts called the Kennedy Forum. [[53]](#footnote-53) Its primary mission is to advance the cause of mental health and addiction treatment through the implementation of parity laws. A number of luminaries were present at the inaugural meeting, including Vice-President Joe Biden, Secretary Kathleen Sebelius, the directors of the National Institute of Health (NIH), National Institute of Drug Addiction (NIDA), the president of the American Psychological Association (APA), and even “the medical director of one of the more open-minded health insurance companies.”[[54]](#footnote-54)

Mr. Kennedy continues to speak at conferences, meet with politicians, write op-ed pieces, and work with professional organizations and advocacy groups in order to advance the cause of parity. He understands that despite the legislative and cultural progress of the last 20 years, there is still a strong stigma against people with mental health and addiction disorders. As a result, he is couching this ongoing fight in more sympathetic terms:

We owe it to the men and women who have given so much for our country to guarantee they have access to the services that will enable them to flourish in our society. We need to make sure they are able to receive the best, evidence-based rehabilitation and services, just as we do for their brothers in arms with mangled limbs or other obvious wounds. When I think of the parity law, I always think of it as the best welcome home we can offer to our returning warriors.[[55]](#footnote-55)

**Conclusion**

It has been 6 ½ years since the MHPAEA was signed into law by President Bush, 5 ½ years since it became an active law, 5 years since the Interim Final Rules were released and 1 ½ since the Final Rules were published. The lag between the signing of the law and the release of the final rules led to a prolonged period of murkiness. Additionally, the passage of the Affordable Care Act in 2010, the antipathy of the post-2010-election Republican dominated House of Representatives towards the ACA, and the two year wait until the Supreme Court issued its decision upholding the ACA added to the confusion regarding parity. Employer groups and insurance companies sometimes used these lags, legislative turmoil and legal battles to delay implementation of parity[[56]](#footnote-56).

And in fact, rules keep being updated and released. On April 6, 2015, the Departments of Treasury, Labor, and Health and Human Services released “a long-awaited rule proposing how the parity law should also protect low-income Americans insured through the government’s Medicaid managed care and the Children’s Health Insurance Program (CHIP) plans. The proposed regulation is similar to one released in November 2013 for private insurers**.”**[[57]](#footnote-57)

In order to help providers and consumers understand this complex law and its constant updates, insurance companies like Aetna[[58]](#footnote-58) and advocacy organizations such as NAMI[[59]](#footnote-59) have posted instructions and frequently asked question pages.

The future of parity can probably be best summed up by an exchange that took place at a panel discussion[[60]](#footnote-60) at the 2014 annual conference of the New Jersey Association of Mental Health and Addiction Agencies (NJAMHAA).[[61]](#footnote-61) The panel was on the Governor’s Task Force on Heroin and Opiate’s report, but a number of questions were asked about parity. The following conversation[[62]](#footnote-62) took place between an Executive Director of a hospital based in-patient mental health program and Dr. Louis Baxter[[63]](#footnote-63), the past-president of the American Society of Addiction Medicine (ASAM):

**ED:** Will the Affordable Care Act actually ensure that insurance companies pay for the treatment of my patients?

**Dr. Baxter:** Yes.

**ED:** Multiple insurance companies are continuing to deny coverage, despite the fact that I have a number of well-regarded licensed professionals that have fully documented why our patients need treatment.

**Dr. Baxter:** I know. It is unfortunate. The delays and lack of instruction from the feds encouraged the insurance companies to drag their feet. But the law is there and they must obey.

**ED:** They are not...

**Dr. Baxter:** (interrupting) I know. I know what you are going to say. They are still not paying. They are denying claims. They are clearly violating the Parity Act and the Affordable Care Act. The answer is a combination of litigation and enforcement. A number of consumers and providers will have to sue insurance companies in order to get them to follow the laws.

**ED:** (interrupting) That could take years.

**Dr. Baxter:** Yes, probably five or so. But the insurance companies will lose and the government will do a better job of enforcing it. It’s a process. A long one. I know that this is discouraging folks, but parity will happen. It will just require the great American tradition of litigation.

As in the cases of other rule making, implementation will depend upon litigation (that happens to be the case with most rule-making; it's true of stream pollution and other environmental and ecological violations, although in many of those cases the suit is brought by state and federal agencies). In the matter of health care it's the individual who has been slighted that is going to have to sue. That places an unfair burden on the individual, but that has been the case before, during and after the parity law movement.

**Bibliography**

Barry, C. L., Huskamp, H. A., & Goldman, H. H. (2010). A Political History of Federal Mental Health and Addiction Insurance Parity. Milbank Quarterly, 88(3), 404-433. doi:10.1111/j.1468-0009.2010.00605.x

Beronio, K., Glied, S., & Frank, R. (2014). How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care. *The Journal Of Behavioral Health Services & Research*, doi:10.1007/s11414-014-9412-0

CBO (Congressional Budget Office). 2002. CBO’s Estimate of S.543, The Mental Health Equitable Treatment Act of 2001.

Dahline, S. L. (2014). Mental Health Parity: Closing the Gaps*. Journal Of Pension Benefits: Issues In Administration*, 21(4), 38-41.

DeLoss, G. J., Ashpole, L. L., & Whelan, K. K. (2014). Mental Health Parity and Addiction Equity Act Final Rules: Limited Enforcement Options Don't Overcome Unequal Treatment. *Journal Of Health & Life Sciences Law*, 7(3), 73-105.

Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (November 8, 2013)

# Gold, J. Kaiser Health News: “Rule Proposed On Providing Mental Health ‘Parity’ In Medicaid Program.” N.p., n.d Web 6 May 2015.

Golplerud, Eric. (2013) *Consistency of Large Employer and Group Health Plan Benefits with Requirements of the Paul Wellstone and Pete Domenici Mental Health and Addiction Equity Act of 2008.*U.S. Department of Health and Human Services

Goodell, Sarah. (2014) Health Affairs: “Mental Health Parity.” N.p., n.d. Web 3 May 2015.

Government Accountability Office. (2011). *Employers’ Insurance Coverage Maintained or Enhanced Since Parity Act, but Effect of Coverage on Enrollees Varied*

Government Accountability Office. (2012). *Treatment Exclusions in Employers’ Health Insurance Coverage*

Hebert, A. M. (2009). Mental Health Parity: Moving Closer to an Effective National Policy*. Journal Of Financial Service Professionals*, 63(2), 28-31.

Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010)

Keller, M., et al (2014). Mental Health Parity and Addiction Equity Act: A Watershed Moment for the Future of Behavioral Health Care.

Kennedy, Patrick. "Opening Statement of Patrick J Kennedy, Founder, The Kennedy Forum, Brigantine, NJ." Committee on Senate Judiciary: Subcommittee on Oversight, Federal Rights and Agency Actions. Washington, D.C. 7 Nov. 2013. Speech.

Mental Health Parity and Addiction Equity Act, Pub. L. 111-148 (2007)

NAMI: National Alliance on Mental Illness: “The Mental Health Equity Treatment Act of 2001.” N.p., n.d. Web 3 April 2015.

New Jersey. Governor’s Council on Alcoholism and Drug Addiction (GCADA). Task Force on Heroin and Other Opiate Use by New Jersey’s Youth and Young Adults. *Confronting New Jersey’s New Drug Problem: A Strategic Action Plan to Address a Burgeoning Heroin/Opiate Epidemic Among Adolescents and Young Adult, 2014.*

http://greenagel.com/wp-content/uploads/2014/03/2014-Final-Report.pdf

Rische, C. (2011). Mental Health Parity and Our Inability to Make Forward Progress*. Journal Of Pension Benefits: Issues In Administration*, 18(3), 29-36.

US Congress. Senate. Committee on Senate Judiciary. Subcommittee on Oversight, Federal Rights and Agency Actions. (2013) *Auto Safety and Mental Health Rules*. 113th Congress. 1st session.

US Department of Labor. 2012 Report to Congress: Compliance With the Mental Health Parity and Addiction Equity Act of 2008.

US Department of Labor. 2014 Report to Congress: Compliance With the Mental Health Parity and Addiction Equity Act of 2008.

**Appendix A**

(guidance from the Department of Labor’s 2012 Report to Congress)

Examples in the interim final rules illustrate how to apply the MHPAEA rules for NQTLs. The following summarizes those examples:

* A group health plan limits benefits to treatment that is medically necessary, requires concurrent review for inpatient, in-network mental health and substance use disorder benefits but does not require concurrent review for any inpatient, in-network medical/surgical benefits, and instead conducts retrospective review for inpatient, in-network medical/surgical benefits. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 1, 29 CFR § 2590.712(c)(4)(iii), at Example 1, and 45 CFR § 146.136(c)(4)(iii), at Example 1.
* A plan requires prior approval that a course of treatment is medically necessary for outpatient, in-network medical/surgical, mental health, and substance use disorder benefits, however, the plan denies payment for mental health and substance use disorder treatments that do not have prior approval, and only reduces by 25 percent payment for medical/surgical treatments that do not have prior approval. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 2, 29 CFR § 2590.712(c)(4)(iii), at Example 2, and 45 CFR § 146.136(c)(4)(iii), at Example 2.
* A plan generally covers medically appropriate treatments, and for all benefits, the evidentiary standards the plan uses in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved and are applied in a manner that may differ based on clinically appropriate standards of care for a condition. The plan complies with MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 3, 29 CFR § 2590.712(c)(4)(iii), at Example 3, and 45 CFR § 146.136(c)(4)(iii), at Example 3.
* A plan generally covers medically appropriate treatments and in determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration, but for other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 4, 29 CFR § 2590.712(c)(4)(iii), at Example 4, and 45 CFR § 146.136(c)(4)(iii), at Example 4.
* An employer maintains both a major medical program and an employee assistance program (EAP). The EAP provides, among other benefits, a limited number of mental health or substance use disorder counseling sessions. Participants are eligible for mental health or substance use disorder benefits under the major medical program only after exhausting the counseling sessions provided by the EAP, but no similar exhaustion requirement applies with respect to medical/surgical benefits provided under the major medical program. The plan violates MHPAEA's rules for NQTLs. 26 CFR § 54.9812(c)(4)(iii), at Example 5, 29 CFR § 2590.712(c)(4)(iii), at Example 5, and 45 CFR § 146.136(c)(4)(iii), at Example 5.

**Appendix B**

Another grieving mother, Patti, related to us the story of her son, Sal. Sal was born two months premature. His loved ones would later note that he came into this world early, and left early. Patti explained that Sal was an absolutely beautiful person with a heart of gold. He was a

fiercely loyal, loving, sensitive young man who touched so many people during his life. Sal gave his family one of the most precious gifts that anyone could give - his beautiful son.

Sal was addicted to heroin. He also had no health insurance. One day, he reached out to his family for help. They took him to a hospital emergency room. The hospital turned him away and provided his parents with a list of treatment centers. They called every treatment center on the list and were turned away by all of them when told that Sal was using heroin. They were told that no beds were available, and that the situation was not life threatening. His parents came to learn that if they were to say that he was abusing alcohol, rather than heroin, he would have a better chance of getting into a treatment program. They proceeded to call one of the facilities that had previously turned them down. This time, they said that he was abusing alcohol.

The treatment facility told them to call back first thing in the morning, explaining that there would be a bed available, along with funding. Sal called back at 8:00 in the morning and said that he was drinking alcohol and needed help. He was told to come right to the facility and that there was a bed available for him. His parents drove him to the treatment center, but only after making him drink vodka so that alcohol would be in his system.

He was admitted for treatment and was told that the county would pay for his therapy. Eleven days later, the facility called Sal’s family to say that his funding had run out and that they had to come get him. Sal told them that he was afraid to leave because he needed more help. Sal’s sister came to the treatment center to pick him up. She was told to take him directly to another facility. His release papers had a box checked that indicated a “high risk of relapse.”

Sal’s sister drove him directly to the other facility, but when they arrived, they were told that no beds were available. Sal and his family spent the day calling treatment centers. Despite his need for residential treatment, the only facility willing to take him provided only intensive outpatient therapy. This IOP program met only three days a week from 6:00-9:00 p.m. While in that program, Sal relapsed and suffered an overdose.

Sal was not alone at the time, but no one called 9-1-1 to seek medical assistance. Perhaps they were afraid of being arrested. As a result, Sal was left alone to die.

**Appendix C**

At another one of our hearings, Dominick, a broken-hearted father, conveyed his thoughts about his son, Chris. Chris could always be counted on for his acts of kindness. He was an above average student, had countless friends, was active in his church community, and was an integral part of his close-knit family. He was loved by his coworkers and the children at the camp where he worked. Chris enjoyed and excelled at athletics and although he was not a natural at any sport, his hard work afforded him the opportunity to play at competitive levels in several sports. Chris was noted for his sportsmanship, win or lose. He earned solid grades, from elementary school through college. He enjoyed learning. Chris was enthusiastic about life.

At some point during his later teen years, Chris and a group of friends experimented with drugs and he became addicted. As the disease progressed, Chris turned to heroin, which was less expensive than other opiates. When he was 19 years old, Chris summoned the courage to tell his parents that he was abusing heroin. The news shook them as they had no idea that he was using drugs, much less that illicit drug. They had simply attributed small changes in his personality to the stress of school and the typical concerns of an adolescent.

Chris readily agreed to go to rehab. He spent a few days in inpatient care before being moved to an intensive outpatient program (IOP) at the same facility. The director of the IOP recommended that Chris “graduate” from the program after only eight weeks so that he would not “over leverage the insurance” in the event of a future relapse. Chris’ parents objected and explained that cost was not an issue and that they were prepared to pay the expense of needed treatment out-of-pocket. The IOP director ignored them and without the courtesy of further discussion, Chris was discharged.

For several months, Chris seemed to be alright. He re-enrolled in a college degree program and was doing well. He began to play sports again and proudly stood as godfather to his niece. Once again, he happily joined his family in activities, outings and celebrations. But having been denied the long-term inpatient treatment that he apparently needed, and before anyone in the family could notice, Chris returned to illicit drug use and very soon thereafter died of a heroin overdose at the age of 20.

1. Senate Hearing 1994, 104-2. [↑](#footnote-ref-1)
2. I have been a member of NASW since 2006. [↑](#footnote-ref-2)
3. I have also been a member of ASAM since 2014. [↑](#footnote-ref-3)
4. Representative Kennedy also publicly spoke of living with bi-polar disorder and how he would park his car far away from his therapist’s office in Washington so no one would know he was getting treatment. [↑](#footnote-ref-4)
5. CBO, 2002. [↑](#footnote-ref-5)
6. He spoke about feeling powerless and terrified for his son’s substance abuse and mental health disorders. [↑](#footnote-ref-6)
7. More on this in a moment [↑](#footnote-ref-7)
8. *The Mental Health and Addiction Parity Act of 2008,* Public Law 110-342, 122 U.S. Statutes at Large (2008). [↑](#footnote-ref-8)
9. Actually, it helped get the Emergency Economic Stabilization Act (EEAS) passed, as it was attached to it after a few failed votes in the House of Representatives in order to change nay votes to yeas. House members who supported parity but voted against the EESA were lobbied and a number of them flipped because of the fact that MHPAEA was added as a rider. [↑](#footnote-ref-9)
10. Goodell, S, 2014. [↑](#footnote-ref-10)
11. He declined to run for reelection in the fall of 2010. A few years later, he often repeated that “he had to leave Congress in order to stay sober.” [↑](#footnote-ref-11)
12. Kennedy, P, 2013. [↑](#footnote-ref-12)
13. Barry, Huskamp, and Goldman, 2010. [↑](#footnote-ref-13)
14. Barry, Huskamp, and Goldman, 2010. [↑](#footnote-ref-14)
15. Department of Labor, 2012. [↑](#footnote-ref-15)
16. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010) [↑](#footnote-ref-16)
17. Barry, Huskamp, and Goldman, 2010. [↑](#footnote-ref-17)
18. Department of Labor, 2012 [↑](#footnote-ref-18)
19. Department of Labor, 2012. [↑](#footnote-ref-19)
20. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010) [↑](#footnote-ref-20)
21. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010) [↑](#footnote-ref-21)
22. Goodell, S, 2014. [↑](#footnote-ref-22)
23. Goodell, S, 2014. [↑](#footnote-ref-23)
24. For example, Rutgers employees with Horizon Blue Cross Blue Shield had a carve out for mental health and addiction treatment which was handled by Magellan for a number of years. [↑](#footnote-ref-24)
25. Goodell, S, 2014. [↑](#footnote-ref-25)
26. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010) [↑](#footnote-ref-26)
27. Department of Labor, 2012. [↑](#footnote-ref-27)
28. There are three main levels of care. Level 3 is residential treatment. Level 2 is intensive outpatient and partial hospitalization treatment, which involves 9 to 25 hours a week of treatment – patients are not provided with housing. Level 1 care is outpatient treatment, which is 8.5 hours or less per week. [↑](#footnote-ref-28)
29. As a multi-licensed treatment professional since 2006 who has worked in in-patient, out-patient and university settings, I’ve directly seen this problem easily 100 times. I have threatened insurance companies that I will testify on behalf of the client or their families if anything happens and that I would put my eight licenses and certifications up against whoever denied the claims. That threat works about 50% of the time. But it shouldn’t have to come to that. [↑](#footnote-ref-29)
30. This incensed parity advocates as well. I’ve actually found this quite useful, as the threat of a looming $3K to $35K bill will keep clients in treatment and compliant when they otherwise might have dropped out. Substance abuse clients are unlike almost any other patient-type, as they frequently do not want and reject treatment. [↑](#footnote-ref-30)
31. Goodell, S, 2014. [↑](#footnote-ref-31)
32. Department of Labor, 2012 [↑](#footnote-ref-32)
33. Department of Labor, 2012 [↑](#footnote-ref-33)
34. DeLoss, G. J., Ashpole, L. L., & Whelan, K. K. (2014). [↑](#footnote-ref-34)
35. Interim Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, (February 2, 2010) [↑](#footnote-ref-35)
36. Department of Labor, 2012 [↑](#footnote-ref-36)
37. Department of Labor, 2012. [↑](#footnote-ref-37)
38. Goodell, S, 2014. [↑](#footnote-ref-38)
39. Kennedy, P, 2013. [↑](#footnote-ref-39)
40. Goodell, S, 2014. [↑](#footnote-ref-40)
41. Keller, M, et al, 2014. [↑](#footnote-ref-41)
42. Kennedy, P, 2013. [↑](#footnote-ref-42)
43. Sal Marchese was not able to access the correct level of care. He died while in the wrong level of treatment. His story is taken from NJ Task Force Report on Heroin and Other Opiates and can be found at the end of this paper as Appendix B. [↑](#footnote-ref-43)
44. Chris Coppola is a tragic example of this. I have entered his story from the NJ Task Force Report on Heroin and Other Opiates as Appendix C. [↑](#footnote-ref-44)
45. Kennedy, P, 2013. [↑](#footnote-ref-45)
46. Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240 (November 8, 2013) [↑](#footnote-ref-46)
47. Goodell, S, 2014. [↑](#footnote-ref-47)
48. Department of Labor, 2014. [↑](#footnote-ref-48)
49. The 150+ page report can be found here: http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf [↑](#footnote-ref-49)
50. Department of Labor, 2014. [↑](#footnote-ref-50)
51. This has been (and still is) certainly due to the fact that people with substance abuse and or mental health disorders are less able and less likely to advocate for themselves. There are less powerful and less vocal advocates for these disorders than say, heart disease or breast cancer. Hence the need for the MHPAEA. [↑](#footnote-ref-51)
52. Department of Labor, 2014. [↑](#footnote-ref-52)
53. https://www.thekennedyforum.org/ [↑](#footnote-ref-53)
54. Kennedy, 2013. [↑](#footnote-ref-54)
55. Kennedy, P, 2013 [↑](#footnote-ref-55)
56. These lags and ongoing changes to the parity laws gave, unfortunately in this writer’s opinion, insurance companies a legitimate reason to delay implementation. [↑](#footnote-ref-56)
57. Gold, J, 2015. [↑](#footnote-ref-57)
58. https://www.aetna.com/faqs-health-insurance/employers-mental-health-parity-final-regulations-faqs.html [↑](#footnote-ref-58)
59. http://www2.nami.org/Template.cfm?Section=Issue\_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=15944 [↑](#footnote-ref-59)
60. I was on that panel. [↑](#footnote-ref-60)
61. http://www.njamhaa.org/ [↑](#footnote-ref-61)
62. It was not recorded. I have reconstructed this exchange from memory to the best of my ability. The words may not be exactly accurate, but the spirit of the discussion is. [↑](#footnote-ref-62)
63. Dr. Baxter and I have known each other for several years. He served on the Task Force with me, is the Consulting Medical Director of the treatment program that I run in New Brunswick and is also a friend. [↑](#footnote-ref-63)