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Implementation of the Massachusetts Mental Health Parity Law [1]

In 2000, the legislature passed "An Act Relative to Mental Health Benefits" (hereafter, the Mental Health Parity Law or MHPL),[i] which requires private insurers, Blue Cross/Blue Shield and HMOs to cover treatment of mental health conditions on a non-discriminatory basis. The law also applies to health plans offered to state employees and retirees by the Group Insurance Commission (GIC). The Mental Health Parity Law applies to insured group plans and to non-group plans, and covers policies issued in or outside Massachusetts to state residents and policyholders with a principal place of employment in Massachusetts.[ii] This article summarizes key provisions of the law, reviews implementation efforts by regulators since the law's enactment, and considers issues open for further interpretation or enforcement.

Mandated benefits under the Mental Health Parity Law

In general

Health plans subject to the MHPL may not have annual or lifetime limits, in dollars or number of visits, for the diagnosis and treatment of certain mental disorders, which are lower than the limits on coverage for diagnosis and treatment of physical conditions. Insurers and the GIC must provide such full *parity* in coverage for mental disorders that are "biologically-based," specifically: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, and affective disorders.[iii] The Commissioners of Mental Health and Insurance may agree to expand this list to other scientifically recognized, biologically-based mental disorders listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association ("DSM"). The Commissioners plan to issue a bulletin if any disorders are added to the list.[iv]

In addition to full parity coverage of designated biologically-based disorders, carriers and the GIC must cover medically necessary treatment of any mental disorder listed in the current DSM, regardless of whether biologically-based, for a minimum of 60 days inpatient care and 24 outpatient visits per year.[v] Authorization for this benefit is subject to a determination of medically necessity by the insurer.

Finally, under the law, psychopharmacological services and neuropsychological assessment services must be treated as medical benefits, and therefore, are not subject to the 24-visit or other limitations for mental health benefits.[vi]

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Substance abuse treatment

Insurers and the GIC must cover at least 30 days per year of inpatient treatment for alcohol rehabilitation or detoxification.[vii] In addition, they must provide up to $500 per year of outpatient benefits for alcohol-related treatment. Under the Mental Health Parity Law, these limits cannot be applied when treatment for alcoholism or chemical dependency is rendered in conjunction with treatment for a mental disorder covered under the new law.

Treatment of sexual assault victim

Full parity in mental health benefits must be extended for coverage of emotional and mental disorders of victims of rape or assault with intent to commit rape, if the cost of treatment exceeds the maximum compensation given to the victim under state law.[viii]

Mandated benefits for children only

Children (under age 19) are entitled to additional protections under the Mental Health Parity Law. Insurers and the GIC must cover the diagnosis and treatment of *non-biologically based* mental, behavioral, and emotional disorders in members under 19 on an equal basis with physical conditions, if the disorder "substantially interferes with or limits" the child's functioning and social interactions. The child's primary care physician, pediatrician, or a licensed mental health professional may document that the child meets these criteria and make a referral for care. Alternatively, the child's disorder may be evidenced by conduct, including but not limited to: (a) an inability to attend school because of the disorder; (b) the need to be hospitalized because of the disorder; or (c) a pattern of conduct or behavior resulting from the disorder which poses a danger to the child or others.

In addition, an insurer must continue to provide beyond age 19, on a full parity basis, mental health benefits for a non-biologically based disorder that meets the criteria in the preceding paragraph, if the child is engaged in an ongoing course of treatment for the disorder. In such a case, the benefits must continue until the course of treatment is completed, as specified in the treatment plan. This requirement is also binding on a subsequent plan.

Range of settings required

Under the Mental Health Parity Law, insurers and the GIC must cover a range of inpatient, intermediate, and outpatient services that permit medically necessary, active and non-custodial treatment to take place in the "least restrictive clinically appropriate setting."

Inpatient services include: a general hospital licensed to provide the requested services, a facility under the direction of or licensed by the Department of Mental Health (DMH), a private psychiatric hospital, and a substance abuse facility licensed by the Department of Public Health (DPH).

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Intermediate services include Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization. Outpatient services must be provided by a licensed mental health professional in a hospital, mental health or substance abuse clinic, public community mental health center, professional office, or at home.

Exclusions

Certain services are excluded from coverage under the Mental Health Parity Law. An insurer is not required to pay for services provided to a person who has third party insurance and is incarcerated or in the custody of the Department of Youth Services (DYS). Similarly, the law does not require coverage of educational services required to be provided by a school committee pursuant to Mass. Gen. Laws ch. 71B, § 5 (education for children with special needs), or services provided by DMH.

Denials of mental health benefits

Under the Mental Health Parity Law, only a "licensed mental health professional" may deny coverage for mental health services on the basis of medical necessity.[ix] Licensed mental health professionals include psychiatrists, psychologists, independent clinical social workers, mental health counselors, and mental health clinical specialist nurses.[x] This restriction does not apply, however, where the denial is for lack of insurance coverage or due to the out-of-network status of a provider.

Consent to disclosure of information

The law provides that a carrier may, as a condition of providing the mandated coverage, require an insured's consent to disclosure of information regarding services for mental disorders, but only to the same or similar extent it requires consent to disclosure of information for other medical conditions.

Implementation and enforcement of the Mental Health Parity Law

Individual right of action

The MPHL does not create an individual right of action, although a subscriber might be able to force a carrier's compliance via declaratory judgment action under a contract or third party beneficiary theory. The appeal procedures created by Chapter 141 of the Acts of 2000 (codified in Mass. Gen. Laws. ch. 1760, §§ 12-14) may be used to enforce the right in a particular case to medically necessary benefits mandated by the Mental Health Parity Law.[xi]

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Enforcement by Division of Insurance

The primary vehicle for enforcement of the MPHL is the Insurance Commissioner's licensing authority.[xii] Since the law was enacted, the Commissioner appears to have been active in ensuring that covered plans are in compliance with the law's requirements.[xiii]

Specific implementation efforts

Since passage of the Mental Health Parity law, the DOI, alone and in conjunction with DMH and DPH, has issued several bulletins to carriers interpreting the law. The state Division of Health Care Finance and Policy (DHCFP) has also issued a bulletin and amended its regulations concerning student insurance policies issued by institutions of higher education.[xiv]

Cost-sharing requirements for mental disorders not "biologically-based"

The MHPL permits specified limitations on diagnosis and treatment of mental disorders that are not biologically-based or otherwise entitled to full parity under the law (60 days inpatient and 24 visits outpatient). The Commissioner of Insurance has interpreted the law to prohibit any other limitations or cost-sharing requirements on treatment for these disorders that are different than those applied to medical services under a plan.[xv]

Sexual assault victims' rights where assault occurs outside state

The Commissioner of Insurance has declared that, in the event a rape or assault takes place outside Massachusetts, a carrier will be considered in compliance with the law if it covers services for treatment that are not compensated by a victim's compensation program in the other state.[xvi]

Right to continuation of mandated benefits after child turns 19

The MPHL requires continuation of mandated benefits after a child turns 19, when the child is receiving ongoing treatment for a mental disorder covered by the law. If the child ceases to be considered a "dependent" under the parents' health plan, the insurer must nonetheless give the child the opportunity to continue the mandated benefits if medically necessary. The DOI Commissioner has opined that an insurer may do this by offering COBRA or "mini-COBRA" continuation coverage, [xvii] if required by law. Alternatively, the child must have the opportunity to continue those benefits required by the Mental Health Parity Law. The insurer may charge a premium for continuing coverage in either case.[xviii]

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Applicability of MHPL to student health plans

The Division of Health Care Finance and Policy has interpreted the MHPL as applying, at least to a degree, to insured health plans offered to students by institutions of higher education in Massachusetts.[xix] A qualifying student health plan must offer the benefits required by the law for biologically-based mental disorders, mental and emotional disorders for sexual assault victims, and non-biologically based mental, emotional and behavioral disorders for students under 19 years old. Student plans must also cover 60 days inpatient care and 24 outpatient visits for other mental conditions. A student health plan must include: inpatient hospitalization, including room and board, hospital and physician services (at 80 percent of charges); outpatient benefits (at 80 percent of charges), up to the maximum benefit allowed for any physical condition under the policy, but not less than $1,500, for each mental illness; and maximum aggregate indemnity for all benefits for each mental illness of not less than $25,000.

Requirement of "adequate access" to behavioral health services

In the first year of its operation, DPH's Office of Patient Protection, which administers the external review process under chapter 176O, received a large number of appeals involving mental health benefits, in particular, denials of out-of-network care.[xx] Partly in response to this evidence of inadequacies in mental health provider networks, the Commissioners of Insurance, Mental Health and Public Health jointly issued a bulletin to carriers in early 2002. The bulletin reminds carriers covered by the Mental Health Parity and managed care laws, which offer mental health benefits through a network, that they must ensure "adequate access" to behavioral health services.[xxi] Many health plans in Massachusetts subcontract, or “carve out,” the administration of mental health and substance abuse services to a third party.[xxii] For insured group and non-group plans, state law requires that the primary insurer oversee the contractor’s compliance with state insurance mandates, including adequacy of networks.[xxiii] The Commissioners interpret adequate access to mean that:

1) Networks must have all mandated provider types;
2) Network providers must offer the full range of mandated services, including specific treatment modalities appropriate for all ages and types of covered mental conditions;
3) Networks must have enough providers so that no patient has to wait a medically inappropriate amount of time for care of an acute condition; and
4) Care must be delivered promptly and appropriately.

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In addition, carriers should also have procedures in place to:

1) Assist members with timely scheduling of necessary behavioral health care when a member is having difficulty finding appropriate care;
2) Monitor the provider network (and any carve-out's network) to ensure that a sufficient number of behavioral health providers are accepting new patients and that a full range of mental health services is being authorized; and
3) Provide out-of-network treatment when no in-network provider can render acute, medically necessary covered treatment.

Issues open for further interpretation or enforcement

Thus far, the regulatory agencies charged with interpreting and enforcing the MHPL have done so by means of bulletins and correspondence with carriers. While the law does not require DOI or DMH to issue regulations, there are a number of areas that could benefit from clarification. The following list identifies several areas that could benefit from further guidance, either by regulation or other formal regulatory issuance.

1) The law permits the Commissioners of Mental Health and Insurance to add "biologically-based" mental disorders to the list of conditions entitled to full parity. DOI has stated that it will issue a bulletin if such a change is effected. Yet it is unclear what the process will be for deciding whether a mental disorder should be designated as "biologically-based." For example, can a person affected by exclusion of a mental disorder petition for its addition or otherwise have input into the decision-making process? This issue is ripe for clarification.

2) The law is ambiguous as to how a diagnosis is determined for purposes of outpatient psychotherapy coverage. It is not uncommon for a person to have both a biologically-based illness, such as bipolar disorder, and one or more non-biologically based conditions (e.g., post-traumatic stress disorder). When the patient receives psychopharmacological treatment for the biologically-based disorder, the carrier may treat psychotherapy as medically necessary only for the non-biological condition and inappropriately limit coverage.

3) Thus far, regulators have not formally interpreted the law's applicability to out-of-network providers in Point-of-Service (POS) and Preferred Provider Organization (PPO) plans. While some insurers have applied the law's requirements to both in and out-of-network benefits, others have not. This is a potentially significant issue, as mental health provider networks are often overly restrictive or lack sufficient specialists.

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4) The MHPL's application of parity to treatment of individuals with a "dual diagnosis" (chemical dependency and a major psychiatric disorder) is laudable. However, like the problem with psychotherapy coverage for patients who have both biological and non-biological illnesses, the law is ambiguous as to how a carrier determines when treatment for chemical dependency is "in conjunction with" other mental health treatment. Also, it is unclear whether this enhanced coverage for dually-diagnosed individuals applies to all mental disorders in the DSM or only to those entitled to full parity under the new law.

5) Advocates who fought to enact the MHPL were very concerned about the limitation in care settings permitted under prior law, especially for children. Further interpretation and enforcement may be necessary to ensure that the law adequately regulates insurers' coverage of a full range of care settings and treatment modalities.

6) The MHPL exempts from covered services for children those required to be provided by a school committee under Mass. Gen. Laws ch. 71B, § 5 (special education for children with special needs). Yet chapter 71B excuses school committees from paying for "health care goods or services to the extent that such goods or services constitute medically necessary treatment for disease, illness, injury or bodily dysfunction which would be covered by a third party payor [other than Medicaid] but for a school-aged child's eligibility for such goods and services under [ch. 71B]." In light of this circular language, advocates for children are understandably concerned that the familiar payor merry-go-round (between schools and insurers) for children's behavioral health needs will continue.

Conclusion

The Mental Health Parity Law is a significant step toward bringing insurance coverage of mental disorders onto the same plane as treatment of so-called "physical" conditions. Where implementation of this important law is in its early stages, it remains to be seen whether further steps will be necessary to fully effect parity in mental health benefits.

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Endnotes

[i] Chapter 80 of the Acts of 2000, codified at Mass. Gen. Laws ch. 32A, § 22; ch. 175, §47B; ch. 176A, §8A; ch. 176B, §4A, ch. 176G, §4M.
[ii] The law became effective January 1, 2001 with respect to the Group Insurance Commission and large group insured plans, and to small group insured plans (fewer than 50 employees) and non-group plans on January 1, 2002.
[iii] One commentator has noted that insurers are unlikely to view dysthymia as an "affective disorder" entitled to parity under the law. Parity Bill Explained, Richard Sherman, LICSW, Director of Public Policy, National Association of Social Workers, Mass. Chapter (Focus Newsletter, December 2000), http://www.naswma.org.
[iv] Division of Insurance (DOI) Bulletin No. 2000-06 (July 20, 2000).
[v] This replaces the previous standard of $500 annually for outpatient mental health services. This portion of the law has been referred to as "extended benefits" (rather than parity). Parity Bill Explained, *supra* note 3.
[vi] Due to an apparent drafting error, this provision was not included in the part of the law that applies to the GIC (Chapter 80 of the Acts of 2000, section 1, codified at Mass. Gen. Laws. ch. 32A, §22).
[vii] *See* Mass. Gen. L. ch. 175, § 110(H); ch. 176A, § 10; ch. 176B, § 4A 1/2; ch. 176G, § 4; ch. 32A, §22(f).
[viii] *See* Mass. Gen. L. ch. 258C, § 3 (current maximum compensation is $25,000).
[ix] The MPHL incorporates the definition of "medical necessity" in Mass. Gen. Laws ch. 176O: "health care services consistent with generally accepted principles of professional medical practice." This definition is further refined in DPH and DOI regulations at 105 CMR 128.020 and 211 CMR 52.03.
[x] In addition, under Mass. Gen. Laws ch. 176O, §12(a), the reviewer must be licensed in the appropriate specialty for the health service requested and, in some cases, be in the same license category as the requesting provider.
[xi] For convenience, a digested version of the appeal rights provided by ch. 176O follows: a) a provider may seek reconsideration of the initial denial; b) the patient has the right to internal review within set time frames; c) ongoing treatment may continue pending completion of internal review; d) the plan's denial must explain the basis for the decision and notify an insured of the right to external review; e) an insured has the right to external review by qualified clinical decision-makers within set time frames; f) an insured may request continued coverage pending external review; g) the decision of the review panel is binding and enforceable in state superior court. Until recently, there was some doubt whether the binding nature of state external review law was valid. The U.S. Supreme Court appears to have settled this question in the affirmative in *Rush Prudential HMO, Inc. v. Moran*, 2002 U.S. LEXIS 4644, 122 S. Ct. 2151 (2002), in upholding a similar law in Illinois.
[xii] *See* ch. 80 of the Acts of 2000, § 11.
[xiii] Based on a selective review of carrier filings at DOI offices on July 15, 2002.
[xiv] DOI Bulletins Nos. 2000-06, 2000-10, and 2002-07; DHCFP Admin. Bulletin No. 01-02.
[xv] *See* DOI Bulletin No. 2000-10 (September 8, 2000).
[xvi] See DOI Bulletin No. 2000-06 (July 20, 2000).
[xvii] COBRA (Consolidated Omnibus Reconciliation Act of 1985), 29 U.S.C. § 1161 *et seq.*; "mini-COBRA" refers to Mass. Gen. Laws ch. 176J, § 9 (applicable to insured plans for employers with 2 to 19 employees).
[xviii] See DOI Bulletin No. 2000-10.
[xix] Div. of Health Care Finance and Policy Admin. Bulletin 01-02 (January 26, 2001); *see also* 114.6 CMR 3.00.
[xx] *See* Liz Kowalczyk, Mental Coverage Has Most Complaints, Boston Globe (February 14, 2002).
[xxi] *Id.*
[xxii] For example, Harvard Pilgrim Health Care contracts with Value Options and certain Blue Cross/Blue Shield of Massachusetts' plans contract with Magellan for MH/SA services.
[xxiii] DOI Bulletin No. 2002-07 (Feb. 15, 2002) (jointly issued by Commissioners of DOI, DMH and DPH).

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