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BULLETIN 2013-02

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts

FROM: Joseph G. Murphy, Commissioner of Insurance

DATE: April 1, 2013

RE: Changes to Mental Health Benefits

The purpose of this Bulletin is to inform commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations ("Carriers") of changes to mandated mental health benefits (including substance use disorder benefits) necessitated by the issuance of final rules for "Essential Health Benefits, Actuarial Value and Accreditation" by the federal Centers for Medicare and Medicaid Services ("CMS") as published in the Federal Register on February 25, 2013.

Massachusetts Mental Health Parity Laws

M.G.L. c. 175, §47B; M.G.L. c. 176A, §8A; M.G.L. c. 176B, §4A; and M.G.L. c. 176G, §4M require that insured health plans provide mental health benefits on a nondiscriminatory basis for the diagnosis and treatment of biologically-based mental health disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association ("DSM"), as well as for services provided for non-biologically-based disorders for rape-related incidents or for children and adolescents under the age of 19. "Nondiscriminatory basis" means that copayments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not greater for mental disorders than those required for physical conditions, and office visit copayments are not greater than those required for primary care visits.

These statutes also include provisions for medically necessary mental health services for all other mental disorders described in the most recent edition of the DSM, but not otherwise provided for as biologically-based disorders, for a minimum of 60 days of inpatient treatment and 24 outpatient visits during each 12 month period. The current requirements continue to include a range of medically necessary inpatient, intermediate and outpatient mental health services, provided in the least restrictive clinically appropriate setting.

Federal Mental Health Parity Law

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Changes Necessitated by New Federal Rules

On February 25, 2013, CMS published final rules for "Essential Health Benefits, Actuarial Value and Accreditation." Among the final rules, CMS requires that all Carriers operating in the individual and small group markets comply with federal mental health and substance use disorder parity requirements outlined in MHPAEA for coverage issued or renewed on and after January 1, 2014. With this change, all mental health benefits for biologically-based and for non-biologically-based disorders are required on a nondiscriminatory basis. This means that individual and small group health products issued or renewed on and after January 1, 2014 may not include any visit, day, or other benefit limitations on inpatient, intermediate or outpatient behavioral health services that are more restrictive than to those applied to medical/surgical benefits. Carriers may continue, however, to review the medical necessity of treatments and coordinate care in the least restrictive, clinically appropriate setting, provided that the reviews are consistent with state and federal requirements.

Form and Rate Filings

As soon as practical via SERFF, with the appropriate form filing fees attached, Carriers shall submit revised contracts, policies, certificates and evidences of coverage, or relevant riders, endorsements, or amendments that would be attached to existing documents regarding benefit changes. When submitting rate filings for coverage to be issued or renewed on and after January 1, 2014, Carriers shall include the cost of the new mental health mandate.

If you have any questions regarding this Bulletin or the filing of materials, please contact Nancy Schwartz, Director of the Bureau of Managed Care, at (617) 521-7347 or at nancy.schwartz@state.ma.us.