Federal Parity Regulations and New York's Timothy's Law: A Winning Combination

By Rachel A. Fernbach, Esq.

This is my last column as President of NYSPA. It has been an exciting and wonderful four years! Two components make NYSPA an extremely effective and outstanding professional organization—our members and our staff! Over the last several years I have met a large number of our members practicing in all sorts of settings. Our members are dedicated psychiatrists, dedicated to their patients and to our profession. I have the deepest respect for all of our members. NYSPA’s staff, many of whom have been with NYSPA for an incredible number of years (our [See President's Message on page 5]

Albany Report By Richard Gallo & Barry B. Perlman, M.D.

NYSPA Wins Reversal in Medicare/Medicaid Crossover Lawsuit; Appellate Court Orders Reimbursement to Providers

NYSPA recently received a resounding victory in its lawsuit against the NYS Department of Health seeking to enforce the provisions of a 2006 amendment to the New York State Medicaid law mandating that psychiatrists receive 100% payment of the Medicaid share of the Medicare copayment for patients who are covered by both Medicare and Medicaid. In the lawsuit brought by NYSPA and four NYSPA members, a panel of the Supreme Court of New York, Appellate Division, Second Department, unanimously declared unconstitutional a 2008 State statute that retroactively repealed the 2006 law. The Appellate Division decision, issued on March 16, 2010, reversed an order of the Supreme Court, Nassau County, which dismissed the action. The Appellate Division held that the plain language of the 2006 law clearly granted psychiatrists 100 percent reimbursement of the Medicare deductible and coinsurance fees for dual eligible individuals and that the subsequent law could not retroactively eliminate that right. Following this decision, however, the Department of Health filed an appeal on April 19, 2010, with the New York Court of Appeals, the highest court in the state. If the New York Court of Appeals decides to hear the case, it will be submitted to the Court sometime this winter with a decision shortly thereafter. If the Court finds in NYSPA’s favor, the Department of Health must reimburse psychiatrists for all crossover claims processed between August 12, 2007 and April 11, 2008.

For the purpose of applying the general parity requirement, the regulations create six different classes of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency mental health and substance use disorder prescription drugs; and (6) QTLs. If a plan provides MIH/SUD benefits in any of these six classes of benefits, the MIH/SUD benefits must be provided in each classification in which medical/surgical benefits are provided, including out-of-network classifications. It is not permissible for a health plan to create a new classification of benefits that would be outside the purview of the parity regulations. Pre-emption limitations are those that apply to more than one-half of medical/surgical benefits in a classification. A type of financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is one that applies to at least two-thirds of the medical/surgical benefits. If a type of FR or TL does not apply to at least two-thirds of the medical/surgical benefits in a classification, then that FR or TL cannot be applied to MIH/SUD benefits in that same classification. In addition, health plans may be prohibited from categorizing MIH/SUD benefits as treatment provided by a specialist, which normally results in higher copays and greater coinsurance requirements. The regulations also differentiate between quantitative treatment limita-

Albany is bad news—at least as far as NYSPA’s interests are concerned. Parity in Claims Processing for Psychiatrists

Among the upbeat items reported in this issue of the Bulletin (see Spring Area II Council Meeting by Rachel Fernbach) is NYSPA’s success in garnering a soon-to-be-issued directive from the New York State Insurance Department (SID) instructing health insurers and HMOs that they must accept and process claims submitted by psychiatrists for Evaluation and Management (E&M) services utilizing the current procedural terminology (CPT) codes. Although it has taken over two years to achieve this result, it is a significant victory for psychiatrists and their patients with respect to parity in claims processing. In February of 2008, while working with the SID on compliance issues related to “Timothy’s Law,” NYSPA advised SID staff that insurers were apparently discriminating against psychiatrists in violation of Insurance Law §3224-b, which took effect on the same day as Timothy’s Law (January 1, 2007). Specifically, §3224-b provides that an insurer or HMO, “shall accept and initiate processing of all health care claims submitted by a physician pursuant to, and consistent with, the current version of the American Medical Association’s procedural terminology (CPT) codes, reporting guidelines and conventions…” Yet, the prevailing practice of insurers and HMOs after the law went into effect was to refuse to accept and process E&M code claims submitted by psychiatrists. Instead, insurers advised psychiatrists to resubmit their claim using a 3080x psychotherapy code, despite the fact that the service provided was E&M.

[See Albany Report on page 5]
We are living in a time of many challenges, and also many opportunities. This edition of the Bulletin highlights issues on a national and statewide level which impact our patients and our profession. First, we are pleased to report a major victory in the NYSPA Medicare/Medicaid Crossover Lawsuit. We also have a report on what psychiatrists should know about the federal parity law and how it is implemented. It is every bit as important in the context of national health reform. The President's Message focuses on changes in the APA Assembly and NYSPA's response to these changes. The Area II Trustee Report provides an overview of actions taken by the APA Board. The Spring Area II Council Report highlights the issues and initiatives which were discussed at the council meeting.

The Albany Report summarizes key issues in New York State, including the Executive Budget Recommendations. We also have a response to the NYS OMA Report on Inpatient Suicide. In addition, we have an announcement for NYSPA's Third Annual Scientific Paper Contest. Finally, I am pleased and honored to introduce the April edition series Healthy Minds was nominated for two New York Emmy Awards.

 área II Trustee's Report By James Nininger, M.D.

The Board of Trustees met last in March. Major issues discussed included: fiscal concerns, the development of DSM-V, the relationship between individual psychiatrists, the APA and the pharmaceutical industry, mechanisms to consider adding or re-estimating needed contributions or committees, the APA's role in the new emerging health care structure, ongoing concerns about maintaining and enhancing Symposium 12, and scope of practice. Additionally, the Board discussed the APA national election process, changes in Psych News, appropriate minority representation on the Board, and possible changes to the APA's corporate structure, which now includes both 501(c)(3) and 501(c)(6) entities.

Regarding financial matters, after a year of sacrificing many components, large cuts requiring restructuring of the Assembly and increased work load with fewer positions for our dedicated APA staff, we were informed of a 1.4 million dollar surplus for the 2009 fiscal year. The factors that lead to this unanticipated, more positive financial status were increased revenues from the annual meeting ($200k) and publications ($400k), continuing success of DSM-IV sales (even with the expected good excess profit), improvement in the investment portfolio, and decreased expenses, including salary payments (down by $1.9 million).

James Nininger, MD
A Response to the NYS OMH Report on Inpatient Suicide

By Barry B. Perlman, M.D. and Virginia L. Susanum, M.D.

The poet A. Alvarez entitled his book about suicide, "The Savage God," to evoke its lure and horror for its victims and their families. Suicide is one of the most upsetting paths to death for all touched by it. It has been the subject of much study, aiming to understand what drives it and how to diminish it. Changes in public health and education as well as patient care are understood to have contributed to the national incidence of suicide per 100,000 population in the United States gradually but significantly decreasing from 13.2 in 1950 to 10.8 in 2003. A parallel improvement occurred in New York State where the suicide rate per 100,000 fell from 9.5 during the period from 1980 – 1985 to 6.2 in 2005, the 49th among the 50 states.

No matter the gains for the broad population, it is essential that once a person is hospitalized or even seen in an emergency room, their safety is assured. During June, 2009 the NYS Office of Mental Health released a report titled, "Incident Reports and Root Cause Analyses 2002-2008. What They Reveal About Suicides." Their overview addresses inpatient suicides, suicide attempts within 72 hours of discharge, and suicide while on pass or AWOL. During those years the average number of suicides of inpatients was 5 per year and for patients in the 72 hours post-discharge, AWOL or on pass group the rate was about 12 per year. When presented with positive data such as this, the question arises as to how to further think about it. It seems that a need for more data and drawing conclusions from it, a frame of reference is necessary. OMI's overview, draws on broad numbers about suicide and how it compares to other causes of death, to present a rather gray picture about inpatient suicide. We ask, is that perspective accurate?

The OMIH report provides a limited frame of reference. Where it says that, "...inpatient mental health treatment facilities operate approximately 3,660,000 bed days each year." The decreased numbers of suicides would be better understood if the report included data on total numbers of admissions or discharges, and on average lengths of stay. For instance, in New York State in 2004 there were 107,271 discharges from general hospital inpatient psychiatric units and the average length of stay (ALOS) was 14.81 days. By contrast, in 1990 the number of discharges was 74,563 and the ALOS was 24.77 days. Additionally, state psychiatric centers discharge approximately 7,000 persons per year. OMIH has presented data on where patients are served: in one recent year, general hospitals served 69,935, state psychiatric facilities served 11,288 and private hospitals served 10,378 individuals. These additional numbers flesh out a picture of service delivery and underscore just how infrequent suicide is amongst people served in our mental health system. Where the report agrees that every suicide is a tragedy, 17 deaths (5 inpatient and 12 post-discharge) per 100,000, a rate of 0.002%, is an achievement to be commended. Another study conducted on all discharges between 2002 and 2007 from a consortium of psychiatric providers found that every inpatient suicide was a tragedy, 17 deaths (5 inpatient and 12 post-discharge) per 100,000, a rate of 0.002%. This lower rate adds support to the conclusion that OMIH could have more vigorously emphasized suicide among inpatients has meaningfully declined. In a review of post-discharge suicides among the same cohort, the consortium has preliminarily identified 49 suicides in the first post-discharge month. We suggest that these data warrant more careful scrutiny as post-discharge period warrants more careful study and add that study of this higher-risk period is imperative to get a more accurate count of planned discharges from patients who were AWOL or on pass at the time of suicide.

The recent OMIH review might have benefited by drawing on earlier work by another interested NYS agency. In May, 1989, the NYS Commission on Quality of Care for the Mentally Disabled (CQC) released a report, "Preventing Inpatient Suicide: An Analysis of 84 Suicides by Hanging in New York State Psychiatric Facilities (1980-1985)." Their study focused on a subset of the 131 inpatient suicide deaths during those years. The suicide rate of 48 per 100,000 inpatients was 0.05%. (For purposes of perspective, the odds that a person who auditioned an American Idol will win is 1 in 103,000 or 0.001%.) Thus, over the past 25 years the inpatient suicide rate in NYS psychiatric facilities has dropped from 48 per 100,000 to 5 per 100,000. Clearly, inpatients are safer now than the decades before but still need our vigilance.

Strength of the CQC work was that it studied over 50 variables allowing for data based conclusions. Multiple providers could incorporate into practice. It recognized, as most scholars have, the unreliability of predicting which persons were likely to attempt suicide. It directed attention to the value of making the environment safer and paid detailed attention to specific matters such as actual times of higher risk and human factors such as making sure safety orders are clearly written and implemented. (We suggest that CQC consider posting their study on their web site.) The OMIH report might have been strengthened had it followed up on some important questions it raised, and presented in a fuller context. As an example, the important question of increasingly shorter lengths of stay is raised but not addressed.

The OMIH report based its recommendations on the results of root cause analyses. While this methodology is designed to identify system failures, it also is dependent on self-examination, introducing the risk of subjectivity and bias. To counter that risk OMIH requests re-investigation when they feel an institution has overlooked something. We do not dispute the value of fostering rigorous scrutiny of processes, and we feel there are important and generalizable lessons to be learned from their summary of root cause analyses.

However, it should be noted that these lessons emanate from reviews of very rare occurrences, and they are unavoidably anecdotal and subjective. The OMIH report highlights "communication" deficiencies and makes particular note of a parallel conclusion drawn in a 2005 Joint Commission report. While this certainly may be a contributory problem, the likelihood that similar communication occurred in tens of thousands of other cases where suicide was not the outcome, must not be over-

Virginia L. Susanum, M.D. looked. We must turn... to turn the approach of believing we can predict who among high risk population is most likely to attempt suicide.

Identifying faulty communication as something to eradicate stops significantly short of identifying the mental health care systems and practices based on data which, if adhered to, could further improve outcomes. Once we understood the frequency and means of suicide by hanging, including where and how it occurred within the hospital, significant environmental changes were made and the rates dropped – this was a major achievement. How to systematically lower post-discharge suicide rates is far more difficult to imagine; yet real data on frequency compels us to address this more sizeable challenge. As we attempt to meet this challenge, in an age of limited resources, it will be important to weigh the benefits of purchasing and building increasingly sophisticated environmental safety elements against the costs of enhancing the skills of staff who provide programs and aftercare.

In conclusion, the OMIH report makes clear that more than two decades of effort have made our inpatient units far safer. These gains are the result of concerted and collaborative efforts among governmental agencies, hospitals, and the professional teams providing direct care to our patients. While no system should "rest on its laurels," the mental health care system in NYS has done a remarkable job of driving down the number and probability of inpatient suicides. Persons admitted to our hospitals have every reason to believe they are in a safe place. All who worked to realize these goals should feel justifiably proud in what has been accomplished.

Barry B. Perlman, M.D. is Director, Dept. of Psychiatry, Saint Joseph’s Medical Center, Yonkers, N.Y. Virginia L. Susanum, M.D. is Associate Medical Director, Department of Psychiatry, New York Presbyterian Hospital, Westchester Division

The New York State Psychiatric Association is pleased to announce its

Third Annual Scientific Paper Contest

Eligibility: Any APA Member in Training (MIT) who is a Resident or a Fellow in an approved program in NYS is eligible.

Details: Contestants are invited to submit a paper, 5,000 words or less. This paper could be an original paper, a review of literature, or a critical analysis of a previously published work. Names of contestants will remain confidential, and results will not be published. Contestants are invited to submit a paper, 5,000 words or less. This paper could be an original paper, review of literature, or a critical analysis of a previously published work. Names of contestants will remain confidential, and results will not be published.

Awards: All contestants will receive a Certificate of Participation. Names of contestants and the title of their paper will be published in the Bulletin. The first place winner will be invited to the Fall NYSPPA meeting on Saturday, October 23, 2010 and receive a plaque, a cash prize of $500 and a framed certificate. The winner will be given 15 minutes to make a power point presentation of their paper. If the winner is from outside the NYS area he/she will be reimbursed for travel and hotel for one night.

Deadline: Papers should be received by close of business day on Friday, September 3, 2010.

New York State Psychiatric Association
Scientific Paper Contest
600 Garden City Plaza, Suite 202
Garden City, NY 11530
Or e-mail to centraloffice@nyspsych.com

Contact the NYSPPA Central Office
email: centraloffice@nyspsych.org
phone: 516-542-0777
for additional information or to RSVP

SAVE THE DATE!

Early Career Psychiatrists Meet and Greet
June 15, 2010
6:00 pm
Merchants East
1125 First Avenue
New York, NY 10065

Spring 2010 New York State Psychiatric Association • THE BULLETIN Page 3
The New York State Psychiatric Association held its annual Spring Area II Council Meeting on Saturday, March 20, 2010 at the New York LaGuardia Airport Marriott in East Elmhurst, New York. NYSPA President C. Deborah Cross, M.D., called the meeting to order. Richard Alesmen, M.D. introduced a Edward Harren, M.D., who will replace Maria Tsiomnon-Kassas, M.D. as Deputy Representative from the Westchester District Branch because Dr. Tsiomnon-Kassas has relocated to California.

Various NYSPA officers provided their reports. Mr. Cross noted that she will be sending her testimony to NYSPA President this Spring and that it has been a pleasure working alongside such talented and hardworking psychiatrists.

She recognized Jeffrey Borenstein, M.D., host of the Healthy Minds television program, which has been nominated for two New York Emmy Awards.

Glenn Martin, M.D., NYSPA Vice-President, provided an update on the Medicaid Preferred Drug List and the development of regional health information organizations throughout the state. He also reported on the use of electronic health record (EHR) technologies in medical offices and the related Medicare and Medicaid incentive programs. CMS recently issued proposed regulations addressing the issue of meaningful use of EHR technologies.

Finally, Mr. Martin reminded Council members that NYSPA Central Office has created new HIPAA templates to comply with the changes to the privacy and security regulations that took effect in February. The new templates and instructions for use are posted on the NYSPA website.

Barry Perlman, M.D., Chair of the NYSPA Committee on Legislation, reported that the committee has been invited to participate with a newly formed state association of medical specialty organizations. After due diligence and an expression of support from NYSMS, the Executive Committee has decided to accept the invitation to join this coalition.

Mr. Perlman also provided an update on Kendra’s Law, the New York State assisted outpatient treatment law, which will sunset on June 30 unless extended by the Legislature and Governor. There are ongoing efforts either to make Kendra’s Law permanent or extend it for another five years.

NYSPA supports a five year extension or extend it for another five years. Either to make Kendra’s Law permanent or extend it for another five years.

Additionally, Lloyd Sederer, M.D., OMH Medical Director, provided an update on OMH activities, including the issuance of new clinical standards of care, new regulatory reforms and Medicaid financing reforms.

MTI Deputy Representative Election Mr. Cross announced that the winner of the election is Michael Reinhart, M.D., a resident at SUNY Downstate Medical Center.

Area II Trustee’s Report
James Ninninger, M.D., Area II Trustee, provided an update on APA finances and membership. The 2009 budget included a $1.4 million surplus, which was the result of reduced expenditures and unexpected increases in revenue from APA publishing and the annual meeting.

To date, APA membership has decreased by 600 individuals. In addition, the Board of Trustees voted to shorten the time period for national elections from 5 months to 3 months and to implement electronic voting for those members with email addresses on file.

[See Area II Council on page 5]
Albany Report continued from page 1

The 2010-2011 Executive Budget Request proposes major spending cuts to confront the State’s escalating financial problems. However, proposed funding for mental health services falls short by comparison to other state agencies. Details about the Executive Budget Request for mental health services can be found at:
http://www.omh.state.ny.us/omhweb/budget/2010/.
The Senate and the Assembly, following

Trustee’s Report continued from page 2

In the 2009 calendar year, the APA-PAC contributed $255k to 102 candidates for office. Average contribution per capita rose from $132 to $145 and the total number of contributions rose above average and represent non-presidential cycle highs. The PAC’s activity during the year has helped secure APA’s seat at the table on health reform discussions. The APA Advocacy Day this year, which had already been scaled down, was hampered by its being scheduled in the middle of a huge snow storm but the intrepid travelers who attended made it a productive and enjoyable time.

In other news, the Board voted to shorten the time period of the APA national elections from five to three months so that there will be a two month campaign period and one month ballot period. Additionally, the plan to move to an all electronic national election is being postponed by one year so that voters without a valid email address can receive a paper ballot for the 2011 election. Several candidates have expressed an interest in using social networking sites for campaigning. It was decided that these modalities will not be permitted for the 2010 and 2011 elections, but as these forms of communication are becoming more and more common, particularly by younger members, the issue will be reassessed in the future. Members frequently express an interest in more direct exchange with candidates, a wish to receive answers to particular questions, and dissatisfaction with the somewhat unequitable statements currently put forward by the candidates.

The Board discussed a report from the Ad Hoc Workgroup on Future Relationships with Industry, which is chaired by Dr. Sidney Weissman. The report recommended that relationships with an outside organization must foster and aid the APA mission, must not foster goals that are counter to those of the APA and that the APA shall not market products it does not control other than the usual and accepted member benefits, such as insurance coverage, without the approval of the Board of Trustees. The Work Group also recommended the development of a Committee on Disclosure and Potential Conflicts of Interest.

Dr. Carol Bernstein, APA President-Elect, gave a preliminary report from the Board of Trustees Ad Hoc Workgroup on Governance, Restructuring that she Co-Chairs with Dr. Ann Sullivan. The Workgroup has been charged to develop methodology for Councils requesting modifications in their structure or change, including formation or reinstatement of committees or councils, to recommend changes in the overall governance of the APA, including the BOT, Assembly, etc. and to consider changes in the relationship between the APA and the district branches. In February, the Workgroup recommended the reestablishment of the Committee on Psychiatric Dimensions of Disasters which will report to the Council on Research and Quality Care. The Workgroup recommended the formation of a Committee of Members-in-Training, details of which remain to be worked out. There were no other substantive discussions, but a promise for future feedback and guidelines to come.

I look forward to seeing many of you at the Annual Meeting in New Orleans. Please feel free to contact me (nininger@bestweb.net) with any questions, comments, or concerns.

Area II Council continued from page 4

Dr. Nininger announced that James Kazmierski, M.D., Editor of PsychNews, plans to retire and that Carolyn Robinowizt, M.D. will take over as interim Editor. Proposed changes to the DSM were posted on the internet in February and approximately 2,700 public comments have been received to date. Finally, NYSPA plans to send out an e-survey to members requesting feedback on the recommendations of the Draft Report of the APA Workgroup on Relationships between Psychiatrists and the Pharmaceutical and Medical Device Industries.

The meeting was concluded with reports from the following NYSPA Committees: Public Psychiatry, Addiction Psychiatry, Children and Adolescents, Economic Affairs, ECP, MIT, and Presidents/President-Elects.

President’s Message continued from page 1

from the exposure and enjoyed the vari-
ty, I remain convinced that NYSPA rep-
resents our members in a manner which is not present elsewhere in the country. That is why I and my other officers have fought so hard to make sure that every member’s voice is heard, both at the state and the national level.

As many of you know from reading my prior columns, the national APA has been in the midst of a significant financial downturn; one which has necessi-
tated a serious cutback in the represen-
tation of NYSPA to the national APA Assembly. On Saturday March 20, your NYSPA Council advisors hope to explain how that such downsizing in NYSPA’s repre-
sentation would be achieved as fairly and equitably as possible. By now all of you have heard reports from your DB representatives as to how NYSPA will deal with the shrinkage of our national delegation to the APA Assembly. For the May 2010 Assembly NYSPA will have 14 general representatives along with your Vice President and President (Glenn Martin and me). Those 14 rep-
resentatives will represent 11 of NYSPA’s 13 DBs, and the 2 remaining DBs will each share a rep. Those DBs who will be sharing a rep are Northern NY and Central NY and West Hudson and Mid Hudson. The plan approved by the Council sought to balance the largest DBs and the smallest DBs, the down-
state DBs and the upstate DBs. New York County DB alone has almost half of NYSPA’s members (close to 2,000), while some of our DBs have fewer than 100 members.

At this time, your NYSPA officers are committed to ensuring that the APA Council continues to have broad repre-
sentation from every DB. With that in mind, each DB will continue to main-
tain the number of reps and dep reps it had prior to this downsizing for pur-
poses of the Council’s workings. As an example, Westchester and Greater Long Island each had 2 reps prior to the downsizing. Now they will each have an Assembly Rep and a State Rep, both of which are critical to the continued functioning of NYSPA and the Council. Deputy reps will also continue to be vitally important to Council functioning and our Committee representation.

As you know, the NYSPA Council meets twice a year in addition to the APA Assembly meetings. These March and October meetings have traditionally included NYSPA executive committee meetings. We have a number of highly active and well functioning committees, Economic Affairs, Legislative, Psychiatry and the Law and Public Psychiatry to name only a few. Additionally, our MITs (resi-
dents) and ECPs (Early Career Psychiatrists) are energetic and eager to continue their involvement at the state and national level. With much of the future of medicine switching to the states, NYSPA must have a strong, active and energetic Council to meet the chal-
leges of our professional future.

Glenn Martin has been an outstanding Vice President and (he is running unop-
posed for President) will be an extremely competent and dedicated President whose priority will be to ensure that NYSPA and its members are effectively represented, both nationally and state-
wide. The challenges facing NYSPA in this coming year are great, but our offi-
cers, members, and dedicated, committed, and incredibly smart. I am proud to have been your President for these four years and know that as I retire from the Presidency I leave our organization in good hands.
Parity Regulations continued from page 1

of the regulation developed an additional level of inquiry for determining whether these types of limitations are applied equitably to medical/surgical and MH/SUD benefits. Under the rule, any NQTL applied to MH/SUD benefits must be (i) comparable to (ii) applied no more stringently than those applied to medical/surgical benefits.

First, plans may not apply an NQTL to MH/SUD benefits that does not exist with respect to medical/surgical benefits. For example, plans may not require preauthorization for all inpatient MH/SUD benefits if the same preauthorization requirement is not applied to all other inpatient services. Second, even if the same NQTL is in place for both medical/surgical and MH/SUD benefits, different application of the same NQTL will violate the rule. An example of this prong of the test would be a plan that conducts concurrent review for inpatient MH/SUD benefits but conducts retrospective review for inpatient medical/surgical benefits.

The federal rules also prohibit health plans from maintaining separate deductibles for MH/SUD benefits and medical/surgical benefits, even if the amount of the deductible is the same. Finally, there have been some questions raised regarding whether the federal law and regulations apply to Medicaid managed care organizations and mental health advocates are awaiting official guidance on this issue.

Intersection with New York State Law

Timothy’s Law, New York’s mental health mandate that became permanent in 2009, requires all group health plans to provide coverage for at least 30 inpatient days of treatment and 20 outpatient days of treatment for all mental health diagnoses that are covered by the health plan provided to New York State employees and their families, which covers essentially all mental illnesses. In addition, among other things, Timothy’s Law requires employers with 100 or more employees to maintain separate New York State carve-out companies for combined medical/surgical and MH/SUD benefits, even if the amount of the deductible is the same. Finally, a separate New York law requires health plans to provide at least 60 days of outpatient treatment for alcoholism and substance use disorders.

A significant limitation of the federal law is that it fails to require health plans to provide coverage for all or even certain MH/SUD diagnoses. Therefore, under the federal law, plans could potentially provide coverage for certain mental illnesses but not others, as long as the benefits provided are at parity with non-MH/SUD benefits offered under the plan. However, when combined with the powerful mental health mandates included in Timothy’s Law, this limitation not only loses its teeth, but is altogether eliminated.

Under the federal guidelines, the Timothy’s Law 30/20 minimum that applies to essentially all mental illnesses will be expanded to provide complete parity for those same diagnoses. Pre-existing limits on inpatient hospital stays and outpatient mental health visits will disappear. In fact, benefits, coverage limitations, deductibles and co-payments (for both in-network and out-of-network services) for mental health will become the same as for all other medical conditions. Further, New York’s minimum 60-day outpatient alcoholism treatment benefit will be expanded into a parity benefit for outpatient and inpatient treatment of alcoholism and substance use disorders.

There is an exception under ERISA, the federal law regulating employee benefit plans, for health plans provided by employers who are self-insured, large plan multi-state employers and labor unions. ERISA-exempt health plans are not subject to state insurance mandates such as Timothy’s Law and, therefore, are not required to cover any specific mental health diagnoses. ERISA-exempt, however, will be subject to the new federal parity law and will be required to provide parity in benefits with respect to any mental health or substance use disorder benefits offered under their plan.

In sum, all group health plans that are subject to MHPAEA and Timothy’s Law (and that are not ERISA-exempt) will be required to provide full parity in connection with financial requirements and treatment limitations imposed on essentially all MH/SUD diagnoses. This powerful combination of state and federal law more than enhances mental health and substance use disorder benefits (in New York State) – it creates a multiplier effect, whereby the whole is far greater than any of the individual parts.

The Future

It remains to be seen how true parity will play out in the insurance marketplace. The insurance industry has repeatedly argued that the requirement for combined deductibles will be difficult to implement as well as cost-prohibitive. Carve-out companies expect difficulties in reworking their infrastructures to accommodate the new rules for management of mental health benefits.

parity in prescription drug benefits and reimbursement rates. In fact, a group of managed behavioral healthcare organizations has brought an action in federal court seeking to enjoin the federal government from implementing and enforcing the federal parity regulations. Regardless of the ultimate outcome of the litigation, the new parity requirements are likely to have an adverse impact on the financial health of the mental health carve-out industry, which is likely to affect mental health providers and their patients.

Nowwithstanding the challenges ahead, Timothy’s Law, MHPAEA and the final interim regulations represent major victories in the longstanding fight for parity in mental health.

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Nowwithstanding the challenges ahead, Timothy’s Law, MHPAEA and the final interim regulations represent major victories in the longstanding fight for mental health parity. For new plans commencing on or after July 1, 2010, individuals seeking MH/SUD benefits, particularly in New York, should expect an unprecedented level of parity between MH/SUD benefits and other benefits. In addition, the Patient Protection and Affordable Care Act (P.L. 111-148), the health care reform bill recently passed by Congress, includes provisions confirming that the parity protections of the MHPAEA will extend to mental health carve-outs. The Patient Protection and Affordable Care Act (P.L. 111-148), the health care reform bill recently passed by Congress, includes provisions confirming that the parity protections of the MHPAEA will extend to mental health carve-outs. The Patient Protection and Affordable Care Act (P.L. 111-148), the health care reform bill recently passed by Congress, includes provisions confirming that the parity protections of the MHPAEA will extend to mental health carve-outs.

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