The Mental Health Parity and Addiction Equity Act of 2008: Improving Access to Mental Health and Substance Use Treatment and Services

Introduction

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) dramatically changes the obligations of insurance plans to provide equitable coverage for mental health and substance use conditions. Mental Health America (MHA) affiliates can play an important role in ensuring widespread implementation of the new parity law, from educating individuals and employers to collecting information about problems to share with the state and federal entities charged with overseeing the law's implementation.

Background

Under the new law, group health insurance plans cannot have more restrictive financial requirements (like higher co-payments) or treatment limitations (like a limited number of outpatient visits per year) for mental health and substance use conditions than they do for other health conditions, such as diabetes or asthma. The new law is much more expansive than the 1996 federal parity law, the Wellstone Mental Health Parity Act, which made it unlawful for health insurance plans to set stricter annual and lifetime dollar limits on mental health care than on other medical care.

MHPAEA will affect about 113 million Americans who have health insurance through their employers, including 82 million who are not currently covered by state parity laws. The law also applies to adults and children who receive health coverage through Medicaid managed care plans and the Children's Health Insurance Program (CHIP) (see further discussion below).

MHPAEA became law on October 3, 2008. For most employers and insurance companies, the law's requirements take effect on January 1, 2010. In situations that involve labor unions, where there are Collective Bargaining Agreements (CBA) in place, the effective date could be later, depending on the expiration date of the CBA in

question. Unlike the 1996 parity law, the new law is permanent, meaning that it does not expire or require Congressional reauthorization in the future.

Basics

Who is affected?

- People who have health coverage under group health insurance plans established or purchased by employers with 51 or more employees.
- People who need mental health and/or substance use services and treatment. Unlike many parity laws, the MHPAEA includes substance use conditions in the definition of mental health, greatly expanding access for people who struggle with addiction or chemical dependency.

What does the law require?

- Financial Requirements (including deductibles, co-payments, co-insurance, out-of-pocket expenses)
    - Insurance plans must ensure
        - (1) that financial requirements for mental health and substance use benefits are not more restrictive than those for most medical/surgical benefits and
        - (2) there are no separate cost-sharing requirements for mental health and substance use benefits
    - EXAMPLE: Under the new parity law, if an insurance plan has a $10 co-pay for most office visits related to health problems, then the co-pay for office visits related to mental health and substance use conditions cannot be higher than $10.
- Treatment Limitations (including frequency of treatment, number of visits, days of coverage, other similar limits on scope or duration of treatment)
    - Insurance plans must ensure that
        - (1) treatment limitations for mental health and substance use benefits are not more restrictive than those for medical/surgical benefits and
        - (2) there are no separate treatment limitations for mental health and substance use benefits
    - EXAMPLE: Under the new parity law, insurance plans may no longer place restrictions on the number of times per week a person can receive psychotherapy unless the plan places the same restrictions on treatment for other health conditions.
- Out-of-Network Providers
    - If an insurance plan covers medical/surgical benefits provided by out-of-network providers, it must also cover mental health and substance use benefits provided by out-of-network providers with the same financial

requirements and treatment limitations as are applied to other out-of-network providers by the plan.

- EXAMPLE: Under the new parity law, insurance plans can no longer require that beneficiaries use in-network providers for all their substance use treatment unless the same restriction is placed on treatment for physical health conditions.

Are there any health plans that don't have to comply with the new parity law?

- Small businesses—defined as companies that employ 50 or fewer employees—are exempt from the law.
- There is a one-year exemption if plan costs exceed a certain amount because of the mental health and substance use benefits. The law exempts specific insurers from the parity requirements if their total costs increase by more than 2 percent in their first year or 1 percent each subsequent plan year. Because the Congressional Budget Office (CBO) estimates that costs will increase by about 0.4 percent as a result of the parity bill, there is little expectation that insurers will need to request this exemption. The CBO estimate is based on the federal government's experience with parity in the insurance it provides its own employees.

Does the law require plans to provide mental health and substance use benefits?

- The law does <u>not</u> require health plans to provide mental health benefits. It simply requires that IF a plan does provide mental health and substance-use benefits they must be no more restrictive than the coverage for other medical conditions.
- Although there is no requirement that health plans continue to provide mental health or substance use benefits, it is likely that most employers would not take the extreme step of dropping all such coverage. Treating mental health and substance use conditions helps keep employees on the job and productive, and studies have shown that providing parity does not substantially increase insurance costs.

Does the law require coverage of particular mental health and substance use conditions?

- Unlike some state parity laws, which do require coverage of certain conditions, the new federal law sets no such requirement. Just as under the 1996 parity law, health plans are able to decide which conditions they cover. Whatever the plan covers must be at parity with medical/surgical coverage.
- While employers are not prohibited from dropping coverage of particular diagnoses, experience suggests that they would not respond to the law by excluding from coverage conditions they have previously covered. The new parity law does establish an oversight mechanism that will lay the foundation for congressional action in the event that health plans do exclude specific

conditions. (See Oversight and Enforcement section below regarding a General Accountability Office study.)

Will plans still be able to deny services based on "medical necessity"?

- Insurance plans will still have the authority to deny claims for services or treatment that they find are not "medically necessary." However, the new law attempts to make medical necessity decisions more transparent.
- Under the new law, current or potential participants, beneficiaries, and contracting providers may request information about what criteria are used to determine if a particular service or treatment is medically necessary. Upon such a request, plan administrators must provide the medical necessity criteria for mental health and substance use benefits.
- Upon request or when required, plan administrators must also provide the reasons for denials of reimbursement or payment to participants and beneficiaries.

State Parity Laws

- MHPAEA does not change state parity laws that are already in effect in most states. If your state's parity law has stronger provisions than the new federal law, those provisions stay in place. If your state parity law is weaker than the new federal law, however, then the stricter requirements of the federal law must be followed. In this way, MHPAEA creates a floor, a minimum set of requirements that group health plans must follow. States can choose to put in place additional requirements that go beyond the federal law, such as requiring that smaller employers also provide parity in insurance coverage, but they can't require less than MHPAEA requires.
- One of the great limitations of state parity laws is that they cannot regulate employers who self-insure rather than purchase health insurance, generally large employers. Companies that self-insure are covered by federal law, the Employee Retirement Income Security Act (ERISA). Most Americans—82 million—have health insurance through these self-insured plans, so even the most comprehensive state parity laws reach just a fraction of their state residents.
- Companies that self-insure do not have to comply with state parity laws, but they must provide the "floor" benefits outlined in MHPAEA.

Medicaid Managed Care and SCHIP

- Under MHPAEA, managed care organizations that have Medicaid contracts to provide mental health and substance use disorder benefits are treated like health insurers who are offering group plans, meaning that they must provide parity with other medical benefits. However, these managed care organizations

are not eligible for the exemption based on cost that is available to other insurers. Fee-for-service Medicaid is not covered by MHPAEA because the State Medicaid Agency is not considered a group health plan under federal law.

- In February 2009, President Barack Obama signed legislation that requires most state Child Health Insurance Program (CHIP) plans to comply with MHPAEA. The CHIP program allows states to provide health insurance to low-income children who would otherwise not qualify for Medicaid. States can choose to open their Medicaid plans to these children or to offer "benchmark equivalent" plans through private insurers. The original CHIP legislation allowed states to cover only 75 percent of the cost of mental health care included in these benchmark plans. Under the CHIP renewal legislation, these private CHIP plans must follow MHPAEA requirements to provide children with equal coverage for mental health and substance use disorder services and treatment.

Oversight and Enforcement

- Three different federal agencies are responsible for overseeing implementation of and compliance with the MHPAEA:
    - U.S. Department of Labor (DOL) because DOL is responsible for oversight of insurance plans that are subject to the Employee Retirement Income Security Act (ERISA)
    - U.S Department of Health and Human Services (HHS) because HHS is responsible for oversight of all health insurance plans not covered by ERISA
    - U.S. Department of the Treasury (Treasury) because of changes to the Internal Revenue Code that allow Treasury to impose tax penalties for non-compliance with the law
- The new law directs all three federal agencies to issue regulations by October 9, 2009, and to coordinate the administration of regulations, rulings, interpretations, and enforcement of MHPAEA. The regulations are intended to help clear up any parts of the law that are confusing and to provide more detailed procedures or requirements than what's outlined in the statute. Even if the agencies fail to meet the deadline for issuing regulations, the law will still go into effect as planned.
- In addition to working on regulations, DOL (with the cooperation of HHS and Treasury) will publish and disseminate guidance/information for, and provide assistance to, group health plans, participants/beneficiaries, state/local regulatory bodies, and the National Association of Insurance Commissioners regarding the law's requirements. The law also requires DOL to submit reports to Congress on compliance of group health plans with the law. The first compliance report is due January 1, 2012; then DOL must submit reports every two years after that.
- The law also requires a report from the Comptroller General (General Accountability Office (GAO)). The GAO must provide Congress with a report in

October 2011 that analyzes (1) specific coverage rates for all mental health and substance use conditions; (2) diagnoses most commonly covered or excluded; (3) effect of law on coverage trends; and (4) the impact of covering or excluding specific diagnoses on participant/enrollee health, health care coverage, and costs of delivering health care.

- Many states may conduct their own oversight and report problems or concerns to Congress or one of the federal agencies. State oversight could include the Attorney General, Insurance Commissioner, and state legislators.