A Consumer's Guide to the Mental Health Parity and Addiction Equity Act

What Is the Mental Health Parity and Addiction Equity Act?

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that prohibits certain discriminatory practices that limit the coverage for behavioral health treatment and services that is provided by a health plan or insurance policy. "Coverage" for a treatment or service means that the health plan or insurer will pay for part or all of the cost of providing it.

How does MHPAEA work?

If insurance providers and health plans offer coverage for mental and substance use disorders (M/SUD), MHPAEA requires this coverage to be comparable to the coverage they provide for physical health conditions. The coverage offered for behavioral health services must be no more restrictive than the coverage provided for medical and surgical services.

MHPAEA protects Americans by limiting restrictions on coverage for M/SUD in three ways:

- Financial requirements, such as copays, coinsurance, or out-of-pocket maximums, cannot be more restrictive for M/SUD than they are for medical/surgical services
- Limitations on the use of services, such as limits on the number of inpatient days or outpatient visits that are covered, cannot be more restrictive for M/SUD than they are for medical/surgical services
- Other kinds of treatment limitations, such as requirements for medical necessity determinations or prior authorization, must be applied in comparable ways to both M/SUD and medical/surgical services

It is important to note that MHPAEA does not require plans to offer coverage for mental and substance use disorders. MHPAEA also does not require plans to offer coverage for specific behavioral health diagnoses (such as depression or eating disorders), or to offer coverage for specific treatments (such as methadone) or services (such as supported employment). However, if a plan does offer M/SUD coverage, then it must be provided in parity with (equivalent to) coverage for physical health conditions.

What plans have to offer coverage for behavioral health conditions?

The Affordable Care Act requires health insurance and health plans sold in either the individual market[1] or the small group market[2] to offer coverage for M/SUD as part of a comprehensive package of

[1] An individual market insurance policy is one that you purchase for yourself directly from an insurance company, and is not employment-based.

[2] A small group health plan is a health plan that you obtain from your employer. In most cases, most or all employees in the company will participate in the plan, and the employer will pay part of the cost of the premiums. Under the ACA, a small group plan is generally defined as an employment-based plan that includes no more than 100 employees.

treatments and services known as essential health benefits. This mandatory coverage for M/SUD must comply with the federal parity requirements set forth in MHPAEA.[3]

What plans are governed by MHPAEA?

Most health insurance and plans are subject to MHPAEA. Federal parity laws govern:

- Large group plans[4]
- Most small group plans[5]
- Individual market plans
- Most governmental plans[6],[7]
- Medicaid managed-care programs
- Medicaid Alternative Benefit Plans[8]
- CHIP (Children's Health Insurance Program)

How can I tell if a specific financial requirement or quantitative treatment limitation on an M/SUD benefit is allowed?

The first question to ask is what "classification" of benefits the treatment or service you are examining falls under. Each M/SUD benefit must be compared to the medical/surgical benefits in the same classification. MHPAEA creates six classifications of benefits:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

If a plan provides M/SUD coverage in any of these categories, it must provide M/SUD coverage in all of them.

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[3] There is an exception for older plans that are "grandfathered" under the ACA. "Grandfathered" generally means that coverage for those plans was already in effect on March 23, 2010, and that this coverage that has not made certain changes to cost-sharing or benefits since then. These "grandfathered" plans are exempt from certain requirements of the ACA, including EHB and parity.

[4] Under MHPAEA, a large group plan is a private-sector employer-sponsored plan with 51 or more employees.

[5] Fully-insured non-grandfathered employer-sponsored plans with 50 or fewer employees will be subject to MHPAEA. Grandfathered self-insured small group plans will not be subject to MHPAEA.

[6] The requirements of MHPAEA were extended to Federal Employee Health Benefit Plans through official guidance from the Office of Personnel Management in an FEHB Program Carrier Letter on November 10, 2008: http://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf

[7] Self-funded non-Federal government plans are allowed to opt out of the Federal parity law.

[8] Medicaid Alternative Benefit Plans and benchmark equivalent plans will be available in states that expand Medicaid to people who were not previously eligible for coverage under Medicaid and who become eligible due to the new eligibility criteria.

Once you have selected a classification for comparison, a two-part test is used. Let's use a copay as an example:

(1) Do at least two-thirds of all medical/surgical benefits in the same classification also have a copay? If yes,

(2) What is the level of the M/SUD copay? Is it no higher than the copay that is required for more than one-half of the medical/surgical benefits in that classification that are subject to a copay?

If the answer to the first question is "no," then the copay is not allowed under MHPAEA. If the answer to the second question is "no," then the copay must be lowered to the level of most copays in that classification. If the answer to both questions is "yes," then the M/SUD copay is considered to be in parity with the medical/surgical copay, and therefore is allowed by MHPAEA.

This same two-step analysis is used for all types of financial requirements and quantitative treatment limitations under MHPAEA. The most common types of financial requirements include deductibles, copays, coinsurance, and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. "Levels" of financial requirements and quantitative treatment limitations refers to the magnitude of the requirement or limitation. For example, different levels of coinsurance include 20% and 30%, different levels of copays include $15 and $20, or different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode. These are just examples, so you could find a type or level of financial requirement and quantitative treatment limitations that is not specifically listed here.

How does MHPAEA apply to managed care?

Many insurers use care management tools to decide whether a specific treatment or service is covered, such as asking whether that service is "medically necessary" for the patient, or requiring "step therapy" or "prior authorization" for a treatment or service. Other care management tools include restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of coverage for treatments and services. For example, a plan might only cover a specific treatment if it is delivered in certain clinics, or by certain preferred providers.

MHPAEA requires that the processes, strategies, evidentiary standards, and other factors that a plan uses to manage an M/SUD benefit be comparable to, and no more restrictive than, those used to manage medical/surgical benefits in the same classification.

What information about my plan is available under MHPAEA?

You have the right to request information about the criteria for medical necessity determinations for M/SUD benefits for any plan that is governed by MHPAEA. Similarly, if you are enrolled in a plan and reimbursement or payment for a treatment or service you receive is denied, then you can request free copies of all documents, records, and other information relevant to your claim.

This information may help you to understand the processes, strategies, evidentiary standards, and other factors that your plan uses to manage or restrict the care that is covered under the plan. The

information should also help you to find out whether the care management tool is being used for M/SUD benefits in a way that is comparable to how it is being used for medical/surgical benefits.

Who is responsible for enforcing MHPAEA?

A number of state and federal agencies share oversight and enforcement of parity. Enforcement varies based on the type of insurance plan.

If you have questions or complaints about your plan's compliance with MHPAEA, it may be useful to contact your plan first to request further information about your plan or to file an appeal. You can also contact any of the organizations listed below. The Departments will work together and with the states, as appropriate, to ensure MHPAEA violations are corrected.

- For individual and small group plans in most states, the state insurance commissioner enforces MHPAEA. In a few states that do not have the authority to enforce MHPAEA, the U.S. Department of Health and Human Services (HHS) is enforcing it. Contact information for your state's insurance commissioner's office can be found at http://www.naic.org/state_web_map.htm.
- For most employer-sponsored plans in the private sector, the U.S. Department of Labor (DOL) and the Internal Revenue Service (IRS) have enforcement authority. You can contact a benefit advisor in one of DOL's regional offices by calling toll free at 1-866-444-3272 or by sending an e-mail to www.askebsa.dol.gov.
- For most employer-sponsored plans in the public sector, the U.S. Department of Health and Human Services (HHS) has enforcement authority. You can contact HHS by calling 1-877-267-2323, extension 6-1565, or by emailing phig@cms.hhs.gov.

What other laws require M/SUD coverage?

States also have an important role in regulating health plans sold to groups and individuals. Some states have parity laws that require that individual or group plans being sold within that state to provide more comprehensive coverage for M/SUD than that required under federal law.[9]

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[9] See *State Laws Mandating or Regulating Mental Health Benefits*, http://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx; *State Mental Health Parity Laws,* http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=94867; *CAHI Identifies 2,271 State Health Insurance Mandates*, http://www.cahi.org/article.asp?id=1115