

UNDERSTANDING IMPLEMENTATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

May 9, 2012

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires employment-based group health plans and health insurance issuers that provide group health coverage for mental health/substance use disorders to maintain parity between such benefits and their medical/surgical benefits. Specifically, MHPAEA and its implementing regulations generally:

- Provide that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits can generally be no more restrictive than the requirements or limitations applied to medical/surgical benefits.
- Include requirements to provide for parity for nonquantitative treatment limitations (such as medical management standards).
- Expand the parity requirements of an earlier law, the Mental Health Parity Act of 1996, such that **plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.**

The Departments of Labor, the Treasury, and Health and Human Services (HHS) (collectively, the Departments), administer MHPAEA together with the States. This document provides basic information about the Departments' MHPAEA implementation efforts.

More detailed information on MHPAEA's requirements is available at <http://www.dol.gov/ebsa/mentalhealthparity/>.

COMMON MHPAEA IMPLEMENTATION QUESTIONS

Q1: Who oversees MHPAEA implementation?

The Departments, as well as the States, all have important roles with respect to MHPAEA implementation to ensure that there are coordinated interpretive guidance and enforcement efforts.

The Departments share responsibility for interpretations under MHPAEA, including regulations and other guidance, which is generally developed and issued jointly to ensure consistency.¹

¹ See 64 FR 70164 (December 15, 1999) for a Memorandum of Understanding between the Departments regarding provisions of shared jurisdiction, which includes MHPAEA.

The Departments of Labor and the Treasury generally enforce these requirements for private, employment-based group health plans. States have primary enforcement responsibility with respect to health insurance issuers. If a State does not act in the areas of its responsibility, HHS may make a finding that the State has failed “to substantially enforce” the law and enforce directly. HHS also has direct enforcement authority over non-Federal governmental plans (those sponsored by State and local government employers).

Employees with questions about MHPAEA, including complaints about compliance by their employment based group health plans, can contact any of the Departments. The Departments will work together and, to the extent an issuer is involved, will work with the States, as appropriate, to ensure MHPAEA violations are corrected.

Q2: Have the Departments issued regulations implementing MHPAEA?

Yes. The Departments jointly issued interim final regulations on February 2, 2010.² These rules generally became applicable for plan years beginning on or after July 1, 2010.

Q3: What does it mean to issue an interim final regulation?

The Departments’ interim final MHPAEA regulations apply to group health plans and health insurance issuers for plan years beginning on or after July 1, 2010. The regulations are “interim” in the sense that public comments were invited, which is used to inform the Departments’ work. Comments received on the MHPAEA regulations have informed the issuance of guidance, including frequently asked questions (FAQs) addressing common questions regarding MHPAEA.³ Plans and issuers are required to comply with interim final regulations.

Q4: It is permissible for a health plan to define mental health coverage as consisting solely of inpatient care benefits?

No. The Departments regulations set forth six classifications of benefits: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.⁴ If a plan covers mental health or substance use disorder benefits in one of the six classifications, the plan must provide coverage in all of the classifications in which medical/surgical benefits are available. Therefore, a plan that provides medical/surgical benefits on an outpatient basis may not limit mental health or substance use disorder benefits to inpatient care only.

² 75 FR 5410 (February 2, 2010).

³ FAQs regarding MHPAEA were issued on June 30, 2010 (<http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>), December 22, 2010 (<http://www.dol.gov/ebsa/faqs/faq-aca5.html>), and November 17, 2011 (<http://www.dol.gov/ebsa/faqs/faq-aca7.html>).

⁴ In June 2011, the Departments released an FAQ that established an enforcement safe harbor for a plan or issuer that divides its benefits furnished on an outpatient basis into two sub-classifications for purposes of applying the financial requirement and treatment limitation rules under MHPAEA: (1) office visits, and (2) all other outpatient items and services. See <http://www.dol.gov/ebsa/faqs/faq-mhpaea.html>.

Q5: Does my health plan violate MHPAEA because it uses a separate managed behavioral health organization to provide utilization review and other services with respect to mental health and/or substance abuse benefits (sometimes called a carve-out arrangement)?

No, MHPAEA does not require that insurance arrangements be organized in any particular way. Instead, MHPAEA requires that mental health and substance use disorder benefits be covered and managed in a manner that is no more stringent than medical/surgical benefits. Managed behavioral health organizations may have specialized expertise in the treatment of mental health and substance use disorders and in organizing networks of specialty providers.

To comply with MHPAEA, group health plans, their health insurance issuers, and other service providers should work together to ensure that standards for financial requirements, treatment limitations and non-quantitative treatment limitations are being met. In particular, standards used in applying nonquantitative treatment limitations to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than the standards used in applying the limitations with respect to medical/surgical benefits, except to the extent that recognized clinically-appropriate standards of care permit a difference.

Q6: MHPAEA and its implementing regulations impose mathematical tests for determining whether a financial requirement or quantitative treatment limitation (such as a copay or visit limit) on mental health/substance use disorder benefits is permitted. Are nonquantitative treatment limitations, or NQTLs, (such as medical management standards) analyzed the same way?

No. While the Departments' regulations set forth mathematical rules for analyzing plan limitations that are expressed numerically, nonquantitative limitations are analyzed differently.

With respect to nonquantitative treatment limitations, the Departments' regulations provide that under the terms of the plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used by a plan or issuer in applying an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits, unless recognized clinically appropriate standards of care may permit a difference.

For more information and guidance regarding NQTLs, see the interim final regulations, as well as the FAQs available at: <http://www.dol.gov/ebsa/pdf/faq-aca7.pdf>.

Q7: How does MHPAEA interact with State mandates?

States generally may impose stricter requirements on health insurance issuers. For example, while MHPAEA does not require that plans provide benefits for any particular mental health condition or substance use disorder, a State law may mandate that an issuer offer coverage for a particular condition. To the extent a State law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition must be in parity with medical/surgical benefits under MHPAEA.

If health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State's insurance laws.

Q 8: Are there plans that are exempt from MHPAEA?

Yes. While MHPAEA applies to most employment-based health coverage, there are a few important exceptions. Specifically, MHPAEA does not apply to small employers who have fewer than 51 employees.⁵ There is also an increased cost exemption available to plans whose costs increase by more than a specified amount and who follow guidance issued by the Departments.⁶ Additionally, plans for State and local government employees that are self-insured may opt-out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees).⁷ Finally, MHPAEA does not apply to retiree-only plans.⁸

Q9: What do I do if I think my plan is violating MHPAEA?

If you have concerns about your plan's compliance with MHPAEA, you can contact the Federal government or your State Department of Insurance. You may contact the Department of Labor at 1-866-444-3272 or on the web at:

<http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>. You may also contact the Department of HHS at 1-877-267-2323 ext 61565 or at phig@cms.hhs.gov or your State Department of Insurance at http://www.dol.gov/cgi-bin/leave-dol.asp?exiturl=http://www.naic.org/&exitTitle=State%27s_Health_Insurance_Laws.

Regardless of which agency or State you contact, the Federal Departments and the States work together to ensure MHPAEA violations are corrected.

Q10: What are the Departments doing to promote compliance?

The Departments are working with plans, issuers, and their service providers to help them understand and come into compliance with MHPAEA and to ensure that participants and beneficiaries receive the benefits they are entitled to under the law. The Departments also coordinate with State regulators to ensure compliance and issue guidance to address frequently asked questions from stakeholders. Compliance assistance is a high priority for the Departments and our approach to implementation is marked by an emphasis on assisting plans and issuers that are working diligently and in good faith to comply with the requirements of the law. The Departments receive complaints from participants, beneficiaries, providers, and other stakeholders and work with these individuals and the regulated community to correct violations.

⁵ For more information on the small employer exception, see Q8 of the FAQs available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

⁶ For more information on MHPAEA's increased cost exemption, see Q11 of the FAQs available at <http://www.dol.gov/ebsa/faqs/faq-aca5.html>.

⁷ If you are an employee of a State or local government and would like to know if your employment-based plan has opted out, contact HHS at 877-267-2323, ext. 61565 or at phig@cms.hhs.gov.

⁸ See 75 FR 34538 at 34539 (June 17, 2010) for more information on special rules for retiree-only plans.

The Departments also engage in extensive outreach and compliance assistance activities throughout the year on MHPAEA. For a copy of MHPAEA outreach publications, and to get information on upcoming events, see <http://www.dol.gov/ebsa/mentalhealthparity/>.