Parity
for Mental Health and Addictions

NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (2008 Parity Act), signed into law on October 3, 2008, significantly expands upon the mental health protections of the Mental Health Parity Act of 1996 that have been in effect until this year. The Act will protect over 113 million people across the United States, including the 82 million individuals enrolled in Employee Retirement Income Security Act (ERISA) group health insurance plans who are not protected by State parity laws. This fact sheet outlines provisions of the 2008 Parity Act, reviews the history of mandates and parity in the States, and provides guidance to the States on how to take advantage of the new protections in the 2008 bill.

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For most plans, the new law will take effect January 1, 2010. Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate.

EXPANSION OF MENTAL HEALTH PARITY

The 1996 Act prohibited group plans from establishing annual or lifetime dollar limits for mental health services. The 2008 Act amends the 1996 Act to include substance use disorders and to require that a group health plan of 50 or more employees (or coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use benefits to ensure that:

(1) Financial requirements applied to mental health and addiction benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits that the plan covers. Such financial requirements include deductibles, copayments, coinsurance, out-of-pocket expenses, as well as annual and lifetime limits. The plan may not establish separate cost sharing requirements that are only applicable to mental health benefits.

(2) Treatment limitations applicable to mental health and addiction benefits must not be more restrictive than those applied to substantially all medical and surgical benefits covered by the plan, including limits on the frequency of treatments or similar limits on the scope or duration of treatment.

OUT-OF-NETWORK BENEFITS

A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits.

As under the 1996 Mental Health Parity Act:

- In-network mental health or substance use coverage is not mandated. However, if a plan offers such in-network coverage, it must be provided at parity in accordance with this 2008 Act.
- A group health plan (or coverage) may manage the benefits under the terms and conditions of the plan. A plan will make mental health/substance use disorder medical necessity criteria available to current or potential participants, beneficiaries or providers upon request. A plan must also make reasons for payment denials available to participants or beneficiaries on request or as otherwise required.
- Group health plans of employers with less than 50 employees are exempted from these requirements, although small business owners are still subject to applicable State Law. In addition, plans are exempt if the costs complying with this Act increase the total cost of coverage by more than 2% during the first plan year or exceed 1% of the actual total plan costs each subsequent year. The new law requires that determinations about increases in actual costs under a plan must be made and certified by a qualified and licensed actuary. The bill sets forth procedures for seeking a cost exemption, and authorizes audits of books and records relating to such an exemption.

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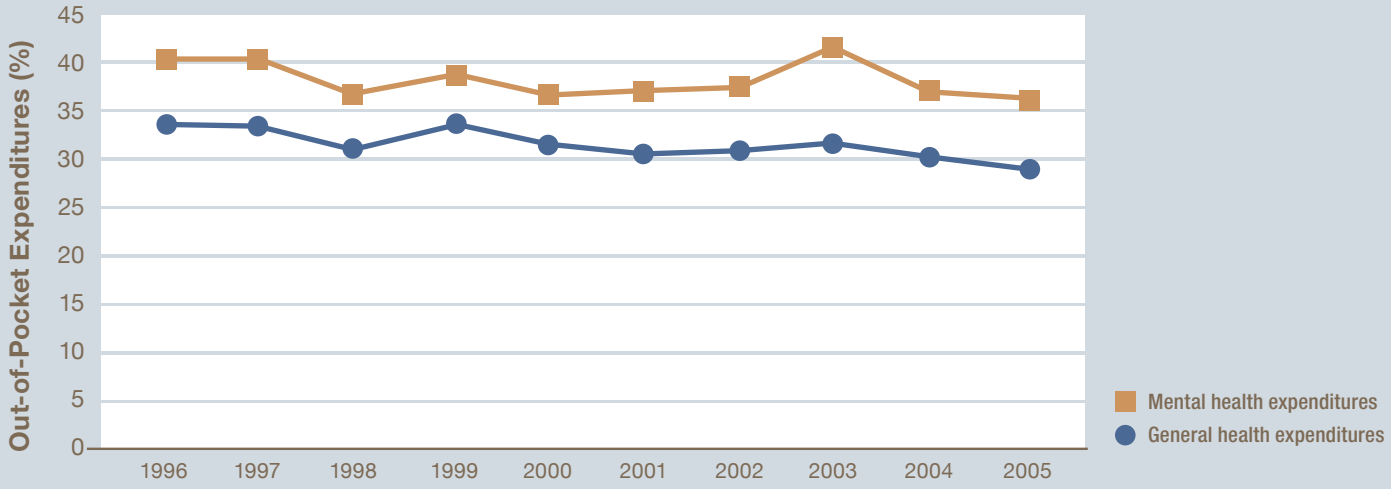
- The current HIPAA preemption standard applies and is extremely protective of State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place.
- Labor, HHS, and Treasury will continue to coordinate enforcement of the Federal mental health parity requirements and are required to issue regulations to carry out changes made in this Act not later then one year after the enactment date. Treasury may continue to impose an excise tax on any plan for failure to comply with the requirements of the Act.

Additional provisions of the 2008 Parity Act include a requirement for the Secretary of Labor and the Secretary of Health and Human Services to designate a group health plan ombudsman within their departments to serve as an initial point of contact for individuals to obtain information and provide assistance concerning coverage of mental health services under group health plans in accordance with this Act. The Secretaries are required to conduct random audits of group health plans to ensure compliance with this Act.

By 2012 and every two years after, the Labor Secretary shall submit to Congress a report on group health plan (or coverage) compliance with this Act. The report will include the results of any compliance audits or surveys, and if necessary, an analysis of reasons for any failures to comply with the law.

The law also requires the Government Accountability Office to evaluate the effect of parity requirements on the cost of health insurance coverage, access to such coverage, the quality of health care, and the impact on benefits and coverage for mental health and substance use disorders (including any exclusion of specific mental health and substance use diagnoses by health plans). GAO will provide a report to Congress within three years (and an additional report after five years) on the results of the study.

Americans Pay More Out of Pocket for Mental Health than for General Health Services.



SOURCE: Sherry A. Glied, Ph.D., and Richard G. Frank, Ph.D, "Shuffling toward Parity — Bringing Mental Health Care under the Umbrella," New England Journal of Medicine, 359:2; July 10, 2008. Data from the Medical Expenditure Survey Panel.

A TANGLED WEB OF REGULATIONS

The 2008 Parity Act amends Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHS Act), and the Internal Revenue Code (IRC). By amending all three federal statutes, the 2008 Parity Act standards apply to a broad range of group health plans, as well as state licensed health insurance organizations. The ERISA provisions apply to most group plans sponsored by private-sector employers and unions. The IRC provisions, which cover ERISA plans plus church-sponsored plans, permit the Internal Revenue Service to assess tax penalties on employers that do not comply with the parity requirements. The PHS Act provisions apply to insurers and some public-sector group health plans, such as the Federal Employees Health Benefits Program and to

some state and local government health plans. Self-insured state and local government health plans may elect exemption from parity. Under provisions included in the 1997 Balanced Budget Act (P.L. 105-33), Medicaid managed care plans and State Children's Health Insurance Programs also have to comply with the requirements of the 2008 Parity Act. Medicare is not subject to the provisions of the 2008 Parity Act.[1]

SETTING A FLOOR

Health insurance regulation is a patchwork of federal and state laws, and the rules for a health plan will differ depending on whether the health insurance is self-purchased, employer-purchased or if the insurance is part of a self-funded ERISA plan. Congressional leaders and advocates spent considerable time drafting language to ensure that the new parity bill does not undermine states with parity laws stronger and more comprehensive than the 2008 Parity Act, while also being sure to set a solid floor of protections for states with minimal or weak regulation of mental health and substance use benefits. The 2008 Parity Act does not undermine other Federal regulations, such as HIPAA, and generally allows more consumer-protective state-based parity requirements to continue to apply to state-regulated health insurance products and areas not preempted by ERISA.

WHY DOES ERISA MATTER?

State parity laws include a wide variety of exemptions and limitations, such as applying only to services for serious mental illness, excluding coverage for addiction treatment, or excluding insurance products sold through individual and small group markets. The reach of ERISA laws is limited in that they generally do not apply to federally funded programs such as Medicaid and Medicare, and all self-funded insurance plans, typically offered by large employers are also exempt. Mid-to-larger sized employers will often choose to fund their own health benefits plans for their employees – these are ERISA plans. Originally created to set national standards for employee pension plans, ERISA limits state efforts to expand health care coverage and regulate insurance markets by essentially preventing states from requiring self-insured employee plans to participate in purchasing pools or even to report data. If a health plan is part of an ERISA plan, then the health plan has to comply with minimal federal regulations due to a law passed over two decades ago which exempts self-funded ERISA plans from state regulation.[2] But if an employer buys health insurance from an insurance company, or if a consumer purchases their own private plan, then additional state regulations apply. State regulations entitle the consumer (private individual or employer) to certain kinds of coverage, the specifics of which vary from state to state.

STATE OF PLAY

States began to address inequities in mental health and addictions coverage in the 1970s. Most of the legislative activity in the 70s and 80s involved *mandated offering* laws, and most of these focused on substance use disorders. Many of these laws mandated specific treatment benefits (e.g., 30 days of residential treatment) for substance use, and often focused more specifically on alcoholism. While these mandated-benefit laws increased coverage, they had important limitations. They seldom provided catastrophic coverage against the financial risk of severe mental illness and they did not apply to self-insured employers exempt under ERISA.[3]

In the 1990's, states began to enact broader parity laws that focused on equal coverage for physical and mental illness. There were 20 states with mandated offering laws by the time Texas and North Carolina became the first states to enact mental health parity legislation in 1991.[4] Today, at least 46 states have enacted some type of law addressing mental health and substance use coverage. These laws vary considerably in scope. Twenty-two states have enacted full parity legislation that vary in the types of health plans covered. In 10 states, the laws apply both to group health plans and to the individual health insurance market, whereas in another 10 of these states they apply only to group plans. In the remaining two states, the laws apply only to state employee plans.[5]

Some states require that some type of mental health benefit be included in insurance products, others establish a minimum acceptable mental health benefit, and still others mandate parity if mental health services are covered. At least 16 states require full parity meaning they require that mental health benefits be included in all group plans and that coverage is on par with other health services in all respects.[6] Only fourteen include substance use treatment.

State full parity laws also vary in the types of mental illnesses they cover. In only three states do the laws apply to the treatment of all the conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). All the other full-parity laws restrict coverage to specified "serious" or "biologically based" mental illness (e.g., schizophrenia, depression, bipolar disorder). About one-third of the state parity laws exempt small employers, typically those with 50 or fewer employees. In addition to the 22 states that have enacted full parity legislation, 13 states have passed laws mandating a certain minimum level of mental health benefits (but not full parity). Still other states have passed so-called mandated offering laws, under which covered plans that choose to offer mental health coverage must provide a specified minimum level of benefits.

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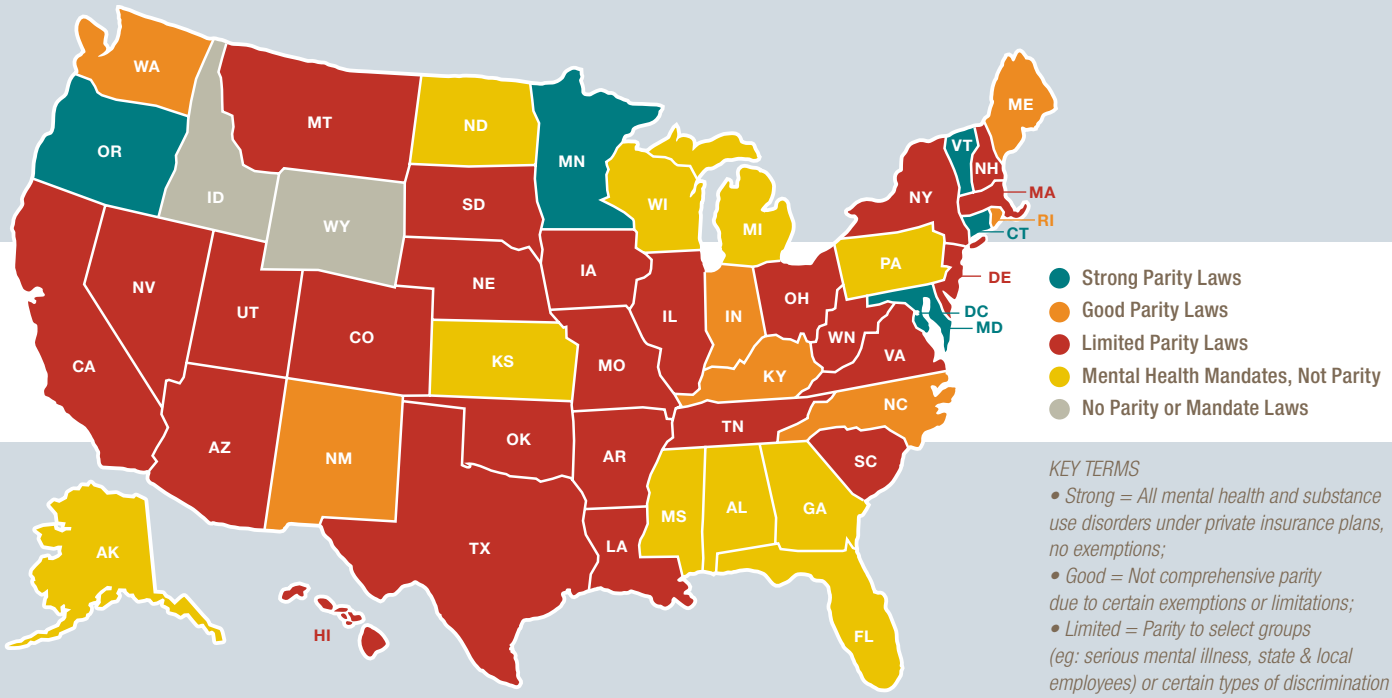
PARITY AND MANDATE LAWS IN THE U.S.



KEY TERMS

- *Strong = All mental health and substance use disorders under private insurance plans, no exemptions;*
- *Good = Not comprehensive parity due to certain exemptions or limitations;*
- *Limited = Parity to select groups (eg: serious mental illness, state & local employees) or certain types of discrimination*

IMPACT AND OPPORTUNITIES AT THE STATE LEVEL

Federal parity requirements for mental health and substance use benefits establish a uniform "floor" of coverage across all plans. The passage of the 2008 Parity Act is an opportunity to evaluate scope and protection laws in your state, particularly where there are opportunities to strengthen parity laws that are not comprehensive or weak in their protections. National Council Members may want to work with advocates, other provider groups, and state officials to:

> > Identify opportunities to publicize the importance of mental health and addictions parity, to dispel myths about the costs and administrative burden of parity legislation, and to examine current state regulations regarding parity of mental health benefits with medical and surgical benefits.

> > Establish, or reconvene, a parity task force inclusive of providers and advocates across the state to develop an advocacy agenda for advancing state regulation of mental health and addiction benefits.

> > Speak with your state attorney general, insurance commissioner and other state officials about the significance of the 2008 Parity Act, and to discuss where state regulations could support or augment the federal bill. As part of this conversation, advocates should take advantage of the wide body of evidence in support of these laws.[7]

> > Monitor compliance with the Federal laws and report concerns to the ombudsman of the Secretary of Labor or and the Secretary of Health and Human Services.

> > Examine fee structures to be sure that insurers are reimbursing at rates comparable to medical and surgical benefits. Consider opportunities for press stories that highlight inequities in pay and to highlight the value of your specialty services.

1. *US Congressional Research Services, Mental Health Parity: Federal and State Action and Economic Impact, Updated August 8, 2006, Report number RL31657*
2. *For more information, see ERISA Preemption Manual for State Health Policymakers authored by the Alpha Center and the National Academy for State Health Policy http://statecoverage.net/erisa2-2000.pdf*
3. *CRS, Report number RL31657*
4. *Robinson, G., Connolly, J., Whittier, M. & Magana, C. (2006), State Mandates for Treatment for Mental Illness and Substance Use Disorders (DHHS Pub. No. (SMA) 07-4228). Rockville, MD: Center for Mental Health Services (SAMHSA).*
5. *National Council of State Legislatures, State Laws Mandating or Regulating Mental Health Benefits, March 2005. www.ncsl.org/programs/health/Mentalben.htm*
6. *Kathryn Allen, General Accounting Office, Testimony before the Senate Committee on Health, Education, Labor, and Pensions, Mental Health Parity Act: Employers Mental Health Benefits Remain Limited Despite New Federal Standards, May 18, 2000.*
7. *See for example facts sheets on the Mental Health Liaison Group website at www.mhlg.org/page18.*

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