Mental Health Parity: The Basics

Federal Mental Health Parity and Addiction Equity Act
The Mental Health Parity and Addiction Equity Act, or the Federal Parity Law, was enacted in 2008 to address health insurance practices that unfairly limited consumers' access to mental health and substance use care. In general, the Federal Parity Law requires health insurance plans to cover mental health and substance use disorders services at least to the extent the plans cover other medical services. The Affordable Care Act, passed in 2010, expanded the reach of the law. In 2013, the federal government also issued federal regulations that spell out how the law should be implemented. Additional regulations were proposed in 2015 but these have not been finalized.

Does the Federal Parity law apply to everyone?
No. The Federal Parity Law applies to many types of health insurance, including employer-sponsored, individual policies, and certain Medicaid plans, but not all health plans are covered by the law.

What health plans must comply with the Federal Parity Law?

- Employer-sponsored health plans with 51+ employees. Both self-funded and fully-insured large group employer plans are subject to the Federal Parity Law.
- Individual health plans purchased through a state health insurance Marketplace.
- Small-group health plans purchased through a state health insurance Marketplace.
- State or local government employee plans. However, these plans do have an option to "opt out" of Federal Parity Law requirements.
- Certain Medicaid insurance plans, including:
    - Managed Care Organizations (MCO)
    - Alternative Benefit Plans (ABP)
    - Children's Health Insurance Program (CHIP)

What health plans are exempt from the Federal Parity Law?

- Medicare
- Medicaid fee-for-service (FFS)
- Tricare
- Federal Employee Health Benefits
- Self-funded, small-group employer plans

What does the law say?
The Federal Parity Law and its regulations establish certain rules that health plans must follow to ensure that they are providing comparable coverage for behavioral health and medical benefits.

The Federal Parity Law requirements may seem complicated, but they can be broken out into five major rules.

Rule One: Benefit Classifications

- **The Rule**: Under the Federal Parity Law, all of the health care benefits offered by a health plan are organized into six benefit classifications. Services must be at parity in each of these categories:

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

- **Example:** If a health plan provides coverage for inpatient hospital care at an out-of-network hospital, it must also cover inpatient mental health or substance use disorders services at an out-of-network facility.

Rule Two: Financial Requirements and Treatment Limitations

- **The Rule**: Consumer cost-sharing and treatment limitations cannot be more restrictive than those that apply to most medical or surgical benefits

- **Definitions**: Consumer cost-sharing includes co-payments, deductibles and co-insurance. The law also covers out-of-pocket maximums, and annual or lifetime dollar limits on services. Treatment limitations include lifetime, annual or day limits on treatment.

- **Example:** If a health plan allows unlimited outpatient visits for medical care, it cannot restrict outpatient mental health or substance use disorders treatment to 12 visits per year.

Rule Three: Nonquantitative Treatment Limitations

- **The Rule**: Nonquantitative Treatment Limitations (NQTLs) applied to mental health or substance use disorders benefits must be comparable to, and applied no more stringently than, NQTLs applied to other medical or surgical benefits. NQTLs include prior authorization policies, medical necessity guidelines, standards for provider networks, and drug formulary design.

- **Example**: If a health plan requires prior authorization (an NQTL) for inpatient substance use disorders treatment, the plan must show (1) it also requires prior authorization for inpatient medical treatment, and (2) the prior authorization policy for substance use disorders treatment is not applied more stringently than the prior authorization policy for medical treatment.

Rule Four: Transparency of Health Plan Information

- **The Rule**: For any denial of service, health plans must make information available to members upon request that includes the reason and criteria used to make the decision.

- **Example:** If a plan denies access to a medication used to treat addiction, it must disclose the specific reason it is denying coverage, and it must provide a copy of any guidelines it used to deny coverage.

Rule Five: Out-of-Network Benefits

- **The Rule**: Health plans must not make access to out-of-network mental health or substance use services tougher than access to other services.

- **Example**: If a health plan offers out-of-network coverage for urgent medical services, it must offer comparable out-of-network coverage for urgent mental health and substance use disorders treatment.

What about state parity laws?
In addition to the Federal Parity Law, almost every state has enacted its own state parity law. State parity laws vary. Some states have "limited" parity laws that require health plans to cover a minimum amount of behavioral health benefits; other states have more comprehensive parity laws that require nondiscriminatory health insurance coverage for behavioral health benefits. The National Alliance on Mental Illness compiled a chart of parity laws in each U.S. state. In many cases, a health plan must comply with both the Federal Parity Law and a relevant state parity law. In the event that a state parity law conflicts with and "prevents the application" of federal parity requirements, the federal law would trump the state law.

How is the Federal Parity Law enforced?
State Insurance Commissioners have primary enforcement authority over commercial health plans subject to the Federal Parity Law. For Medicaid MCOs, ABPs, and CHIP, the state Office of Medicaid has enforcement authority. The federal government also has some enforcement responsibility; the U.S. Department of Labor is responsible for employer-sponsored health plans, and the U.S. Department of Health and Human Services oversees certain state government employee health plans.

Enforcement activity at the state level has been slow to catch on, but recent efforts by state insurance regulators and Attorneys General reveal an encouraging trend. Some state Insurance Commissioners are using their consumer complaint process to accept complaints of potential parity violations; other states have established parity compliance "audit" processes, through which health plans must demonstrate their compliance with parity rules. Parity enforcement efforts in some states have improved care for consumers: in California, the Department of Managed Care took action in 2013 (and again in 2015) to hold a behavioral health plan accountable for violations of state and federal parity rules. Beginning in 2014, the New York Attorney General launched multiple investigations and reached settlements with several health plans over parity violations.

While recent state enforcement news is promising, there is much more work to do. To protect consumers, state Insurance Commissioners, Offices of Medicaid, and Attorneys General need to take on a stronger role in monitoring health plans' compliance with parity laws. For tips and strategies on how to advocate for improved parity enforcement in your state, click here.