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Fact Sheet: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Purpose

Enacted on October 3, 2008, the Act (Public Law 110-343) is intended to end health insurance benefits' inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. The law is projected to provide parity-protection to 113 million people across the country, including 82 million individuals enrolled in self-funded plans (regulated under ERISA and, under its terms, not subject to State parity laws).

The Parity Requirement

The Act amends the Mental Health Parity Act of 1996 to require that a group health plan of 51 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—ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than the predominant requirements and limitations placed on substantially all medical/surgical benefits.

* Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.

* The Act builds on the 1996 parity law, which requires parity coverage for annual and lifetime dollar limits.

* Mental health and substance use disorder benefits are defined broadly to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.

* A plan may not apply separate cost sharing requirements or treatment limitations to mental health and substance use disorder benefits.

* If a plan offers two or more benefit packages, the parity requirements apply to each package.

* As under the 1996 law, mental health or substance use benefit coverage is not mandated. But if a plan offers such coverage, it must be provided at parity in accordance with this Act.

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.

Transparency of Benefits-Management

The criteria for determining “medical necessity” with respect to mental health or substance use disorder benefits must be provided on request to current or potential participants, beneficiaries or providers. A plan must also make reasons for payment denials available to participants or beneficiaries on request or as otherwise required.

Preservation of State Law

This new federal law has only limited preemptive effect (in accordance with the applicable standard under HIPPA). It would only preempt a State law that “prevents the application” of this Act. So State parity and other consumer protection laws applicable to health-insurance continue to have force and effect unless the state law conflicts with this federal ban on inequitable financial requirements and treatment limitations.

Small Employer Exemption

As with the 1996 parity law, small employers of 50 or fewer employees are exempt from the requirements of the Act. State parity laws applicable to these employers, or to individual plans, will continue to apply.

Cost Exemption

If a group health plan (or coverage) experiences an increase in actual total costs with respect to medical/surgical and mental health/substance use benefits of 1% as a result of the parity requirement (2% in the first plan-year to which this Act is applicable), the plan can be exempted from the law for the following plan-year.

* An employer may elect to continue parity coverage regardless of any cost increase.

* Qualifying for an exemption requires a certification from licensed actuary (who is a member of the American Academy of Actuaries) documenting the plan's cost increase based on actual costs over the first six months of the plan-year involved.

* A plan electing an exemption must timely notify the Department of Labor (if self-funded) or the Department of Health and Human Services (if fully-insured), the appropriate State agencies, and participants and beneficiaries. Plan notification to Labor or HHS is confidential and is to include the number of covered lives in the plan and pertinent actual total costs. The Departments are to aggregate such data annually and identify by state, and size and type of employer, those electing exemptions, and provide that information on request.

* Labor or HHS (as appropriate) and State agencies may conduct audits relating to an exemption.

Compliance Report

By 2012 and every two years after, the Labor Secretary shall submit to Congress a report on group health plan (or coverage) compliance with the 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.

GAO Study

GAO will conduct a study that analyzes the specific rates, patterns and trends in coverage, any exclusion of specific mental health and substance use diagnoses by health plans, and the impact of this Act on such coverage and costs. GAO will provide a report to Congress within three years (and an additional report after five years) on the results of the study.

Consumer Assistance

The Labor Secretary, in cooperation with the HHS and Treasury Secretaries, shall publish and disseminate guidance for plans, participants and beneficiaries, applicable State agencies, and the National Association of Insurance Commissioners concerning the requirements of this Act, and the continued operation of applicable state law. The departments are to inform participants and beneficiaries as to how they can obtain assistance, including assistance from State consumer and insurance agencies.

Enforcement

As under the 1996 law, Labor, HHS, and Treasury will continue to coordinate enforcement of the Federal parity requirements, and are required to issue regulations to implement the Act not later than 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.

Effective Date

The Act will apply to plans beginning in the first plan coverage year that begins one year after the date of enactment. For most plans, this will mean the effective date begins on January 1, 2010. Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate (or until January 1, 2009, if this is a later date). The 1996 parity act requirements for annual and lifetime dollar limits remain in effect for all plans, while the annual "sunset" under the 1996 parity act is eliminated, effective January 1, 2009.