

Quick Facts

Official Title	MHPAEA – Mental Health Parity and Addiction Equity Act of 2008
Compliance Date	July 1, 2010 for all benefit plans renewing on or after this date
Excluded Plans*	<ol style="list-style-type: none"> 1. Small Employers (under 51 employees) 2. Individual Health Plan <p>*Note: California State Parity may still apply for these members.</p>
Requirements	<ol style="list-style-type: none"> 1. MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits* are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. 2. Upon request, plans must make available the criteria for medical necessity determinations with respect to MH/SUD benefits and provide the reason for any denial of reimbursement or payment for MH/SUD services. <p>*Note: MHPAEA does not mandate that a plan provide MH/SUD benefits</p>

Definition of Mental Health or Substance Use Disorder (MH/SUD) Benefits

MH/SUD benefits are 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. MHPAEA provides that the plan terms defining whether the benefits are MH/SUD benefits must be consistent with generally recognized independent standards of current medical practice (e.g., DSM-IV, ICD-9).

Parity Coverage

MHPAEA defines **six classifications of benefits** for matching MH/SUD coverage with Medical coverage.

1. Outpatient In-Network
2. Outpatient Out-of-Network
3. Inpatient In-Network
4. Inpatient Out-of-Network
5. Emergency Room
6. Pharmacy

Benefit plans that **include MH/SUD coverage** and **qualify for MHPAEA** will be required to have the same **quantitative limits** (deductible, visit limitations, co-payment, and out-of-pocket maximums, etc.) as the medical benefit in the same classification. *Note: MHPAEA allows only one combined deductible for all covered services, rather than separate deductibles for medical and MH/SUD.*

Example: Health plan offers coverage for MH/SUD. The in-network co-payment for outpatient primary care is \$25.00 and there are no visit limits. Under Federal Parity, the benefit for outpatient in-network MH/SUD will be \$25.00 co-payment with no visit limits. All MH/SUD diagnoses will be covered.

Not all levels of care are included within the six classifications of benefits (e.g., Intensive Outpatient, Partial Hospitalization, and Residential Treatment). Health plans are responsible for determining if they will cover these levels of care, and if so, how they will be classified as inpatient or outpatient for purposes of determining parity coverage.

Impact on Case Management

For evaluating parity MHPAEA added a new definition of benefit limitations: **Non-Quantitative Limitations**, which include

- Medical management standards
- Formulary design for prescription drugs
- Standards for provider admission to participate in network
- Plan methods for determining UCR
- Refusal to pay for higher-cost therapies until it can be show that a lower-cost therapy is not effective
- Exclusions based on failure to complete a course of treatment

In regards to medical management standards MHPAEA requires that the **processes, strategies, evidentiary standards, or other factors used in applying medical management** for MH/SUD are comparable to, and **are applied no more stringently than**, the processes, strategies, evidentiary standards, or other factors used in applying medical management to medical/surgical benefits.

While MHPAEA eliminates most session limitations for MH/SUD, providers are expected to participate in the case management process as required by the health plan. These processes will be defined further as health plans become eligible for MHPAEA.

Frequently Asked Questions

When did Federal Parity become effective?

The **Federal Parity legislation became effective October 2009** for all plans renewing on or after that date. However, the Interim Final Regulations governing Federal Parity were not released until February 2010. Due to the delay in issuing regulations, **the compliance date for Federal Parity is July 1, 2010** for all plans renewing on or after that date. Between October 2009 and July 2010, health plans have been acting under a “good faith” guideline. Many plans are already offering Federal Parity coverage based upon their interpretation of the original legislation.

How do I know if a patient qualifies for Federal Parity?

Check the benefit information on your CHIPA service notification. In the majority of cases, when the first member co-payment has unlimited sessions (e.g., 1-999=20) Federal Parity applies. However, there are a few plans that offer unlimited sessions regardless of parity.

What is the difference between California Parity and Federal Parity?

California Parity	Federal Parity
Small employers and individual plans included	Small employers and individual plans excluded
For mental health only	For mental health and substance abuse
Nine specific diagnoses plus SED for children	All diagnoses designated by the health plan in accordance with state guidelines
Can be restricted to in-network only	If benefit includes out-of-network option, then out-of-network must be offered for MH/SUD
Applies to quantitative limits only (co-payment, session limitations, etc.)	Applies to both quantitative and non-quantitative limits

Does Federal Parity apply to EAP?

Federal Parity does not apply to EAP benefits with the exception that EAP benefits cannot be used as a gatekeeper for the mental health benefit, e.g., member cannot be required to use his/her EAP benefit prior to accessing their mental health benefit.