NAMI National Alliance on Mental Illness | Fact Sheet

Federal Parity for Mental Illness and Addictions

On October 3, 2008, the President signed into law The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (P.L. 110-343), marking historic bipartisan support by Congress for equitable coverage of treatment for mental illness and addictions.

Federal Parity

Over 82 million Americans (about half of all people covered by private health insurance) are enrolled in large self-insured health insurance plans that are not subject to state parity laws. For many, this has meant minimal or unequal mental health benefits that were exhausted long before coverage for other health conditions. The passage of federal parity is significant because it will help ensure fair and equal coverage of mental health and substance use disorders for those in large self-insured plans, as well as for 31 million more people in fully-insured large group plans.

Federal parity does not require plans to offer coverage for mental health or substance use disorders, but *if* these conditions are covered, the new law requires coverage that is equitable with coverage for other health conditions. Federal parity is effective when large group health plans renew on or after October 3, 2009. For many, the effective date will be in 2010.

Plans Subject to Federal Parity

Federal parity law will apply to **group health plans for employers with 51 or more employees.** This includes group plans that are subject to both state and federal law, as well as self-insured group plans that are regulated only by the U.S. Department of Labor.[1]

Federal parity will also apply to the Federal Employees Health Benefits Program, Medicaid managed care plans (but not fee-for-service Medicaid), State Children's Health Insurance Programs (S-CHIP), and some state and local government health plans. **Federal parity does not apply to Medicare[2], individual plans, or group plans of fifty or fewer employees.**

Covered Conditions

Federal parity law allows health insurance plans to define which mental health and substance use disorders, if any, they will cover. However, state-regulated group plans must continue to comply with any state requirements to offer or provide coverage of specific (or all) mental health and/or substance use disorders.

Treatment and Financial Limits

Federal parity law requires that treatment limitations and financial requirements for covered mental health and substance use disorders may not be more restrictive than for substantially all other health conditions. This includes the number of covered inpatient days and outpatient visits, as well as co-pays, deductibles, and maximum out-of-pocket limits.

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[1] Self-insured plans are often referred to as "ERISA" plans because they are governed by the federal Employee Retirement Income Security Act (ERISA).

[2] Medicare's current 50% cost-sharing requirement for outpatient mental health services will lower to 20% by 2014.

Cost Increase Exemption

Federal parity law allows health plans to seek an exemption from parity requirements for a period of one year if they can document that compliance with the law resulted in costs going up more than 2% in the first year or 1% thereafter. An actuarial analysis must demonstrate that increased costs were directly related to parity. If an exemption is granted, a plan must come back into compliance with parity after one year.

This cost exemption is a new option for state-regulated large group plans. However, the administrative costs of obtaining and using this cost increase exemption are expected to exceed any potential savings to a health plan from using this exemption.

Out-Of-Network Coverage

Federal parity law does not require that plans provide out-of-network coverage. However, *if* out-of-network coverage is provided for medical/surgical benefits, the plan must provide equivalent out-of-network coverage for covered mental health and substance use disorders.

Utilization Management

Federal parity law permits health plans to manage benefits under their own terms and conditions, including applying medical necessity criteria. Medical necessity criteria must be made available upon request of a current or potential plan enrollee or contracting provider and the reason for any denial of payment or reimbursement must be made available upon request of a person covered by a plan.

Preservation of Stronger State Laws

Federal law does not preempt stronger state parity provisions; state-regulated large group plans must comply with more comprehensive state parity requirements. For example, if state law *requires* plans to cover mental health conditions, then they must do so, even though coverage is optional under federal parity.

Federal parity may preempt state law only in cases where state law “prevents the application” of federal parity requirements. For example, if a state law requires a minimum benefit for mental health disorders, rather than equitable coverage, the federal requirement of equal coverage is expected to preempt the "weaker" state law.

Regulations and Reporting

Regulations regarding federal parity were initially expected to be issued by the Secretaries of Labor, Health and Human Services, and the Treasury by October 2009, but will likely be delayed.

The Labor Secretary is directed to publish information about the requirements of federal parity, including how to obtain assistance from State consumer and insurance agencies. The Labor Secretary will also submit a report to Congress on compliance of group health plans with federal parity requirements by 2012 and every two years thereafter. The GAO (Government Accountability Office) is required to study rates, patterns, and trends in the coverage and exclusion of specific disorders by health plans, including the impact on enrollee health, trends in coverage, and the costs of delivering health care. The GAO will submit a report to Congress by October 3, 2012, with a second report due two years later.

The Role of Advocates

For parity to achieve its intended goals, it is important for mental health advocates to work closely with their state insurance divisions. Together, advocates can promote education of and compliance with parity requirements, monitor results, facilitate handling of consumer complaints, enhance transparency and accountability, and expand needed consumer protections.