FYI

Mental Health Insurance Under the Federal Parity Law

Most people in the United States have health insurance coverage, typically provided by their employer. Historically, many health insurance plans provided far less coverage for mental health services compared to physical health (medical/surgical) services. For example, a health plan might have covered only 50 percent of costs related to seeing a psychologist but 80 percent of costs related to seeing a primary care physician.

To help end discriminatory insurance coverage of mental health and substance use services, Congress passed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. This question-and-answer guide explains how this historic federal law affects insurance coverage for mental health and substance use services.

What is the Mental Health Parity and Addiction Equity Act?

The Mental Health Parity and Addiction Equity Act, or MHPAEA, requires private health insurance plans to provide equal coverage for mental and physical health services. Congress passed MHPAEA so adults and children suffering from mental health disorders, such as anxiety and depression, and substance use disorders, such as those related to alcohol use, would have better access to the treatment they need.

When does MHPAEA take effect?

The law took effect on January 1, 2010. The following month, the federal government published a rule that provides guidance for group health insurance plans on how to comply with MHPAEA. For most health plans affected by the federal parity law, the federal rule pertaining to MHPAEA will begin to apply on January 1, 2011.

Does the law apply to my health insurance plan?

The law applies to all group health insurance plans for more than 50 employees that provide mental health or substance use disorder benefits as part of the plan. MHPAEA does not apply to smaller group health plans or to Medicare. State and local government employee plans may opt out of the federal parity law, though few of these plans have done so. Importantly, plans for 50 or fewer employees are subject to the requirements of state mental health parity laws.

Does MHPAEA require my health plan to provide mental health benefits?

MHPAEA does not require private health insurance plans to include mental health benefits. Even so, nearly all employer-sponsored health plans in the United States include these important benefits.

Is my employer likely to stop providing mental health benefits as a result of MHPAEA?

Employers are very unlikely to do so. The Kaiser Family Foundation's 2010 survey of health coverage found that less than 2 percent of firms with more than 50 employees – those to which MHPAEA applies – dropped mental health insurance coverage because of the federal law.

What does "mental health and substance use parity" mean?

Mental health and substance use parity means that coverage for mental health and substance use benefits must be at least equal to coverage for physical health benefits. In other words, all of the financial requirements and treatment limitations applied to mental health and substance use benefits may be no more restrictive than those applied to physical health benefits.

Financial requirements include lifetime and annual dollar limits, deductibles, copayments, coinsurance and maximum out-of-pocket expenses. Treatment limitations include frequency of treatment, number of visits, days of coverage and other similar limits.

What kinds of treatment limitations and financial requirements are prohibited under MHPAEA?

A health plan may not place a treatment limitation or financial requirement on mental health and substance use benefits unless the same limit is placed on physical health benefits.

For example, a plan covered under MHPAEA may not apply a 20-visit annual limit to seeing a psychologist but no annual limit to seeing a physician. If annual office visits to your physician are not limited, annual office visits to a psychologist may not be limited.

Another example: A patient may not be required to make a $50 copayment for a psychotherapy session but only a $20 copayment for a physician's office visit. The patient's out-of-pocket expense must be the same for both visits.

Does a health insurance company have to tell me why it has denied an insurance claim?

An insurance company may deny a claim for a variety of reasons. A common reason is that health plans only pay for services that they consider to be "medically necessary." MHPAEA requires insurance plans to make their medical necessity criteria available to current or potential participants. A health plan must inform participants why a claim has been denied, whether due to decisions about medical necessity or other reasons.

Is MHPAEA limited to coverage of certain mental health diagnoses?

No. MHPAEA does not exclude any mental and substance use disorders diagnoses. Under the federal law, parity requirements apply to all services covered by a health plan.

MHPAEA does not prohibit a health plan from denying coverage of individual mental health or substance use disorder diagnoses. Although not a common practice, a health plan may disallow coverage for individual diagnoses as specified in the terms of its coverage contract with an employer.

Does MHPAEA apply to out-of-network services?

Yes. When people have access to "out-of-network" (OON) services through their health plan, it means they may receive services from health care providers such as psychologists and physicians who do not participate in the health plan's network of providers. If a health plan that must comply with MHPAEA provides both OON physical and mental health/substance use disorder benefits, these benefits must be provided at parity. If a plan offers OON benefits only for medical/surgical services, the parity law requires the plan to add OON mental health and substance use disorder benefits, at parity.

What should I do if I think my health plan may not be complying with MHPAEA?

Speak with the human resources staff person or other employee in your company or organization who oversees the health insurance plan. You may also want to contact a representative of the insurance company that administers the health plan to raise your questions and concerns.

Further, you have the option of filing a formal complaint with the federal government. Complaints about insurance plans regulated under state law may be made via a toll-free Department of Health and Human Services help line at 1-877-267-2323, ext. 61565. For "self-funded" plans governed by the federal law known as ERISA (generally those of large employers), you may contact the Department of Labor at 1-866-444-3272.

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Visit the Psychology Help Center at apa.org/helpcenter for additional information and to find psychologists in your area.

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