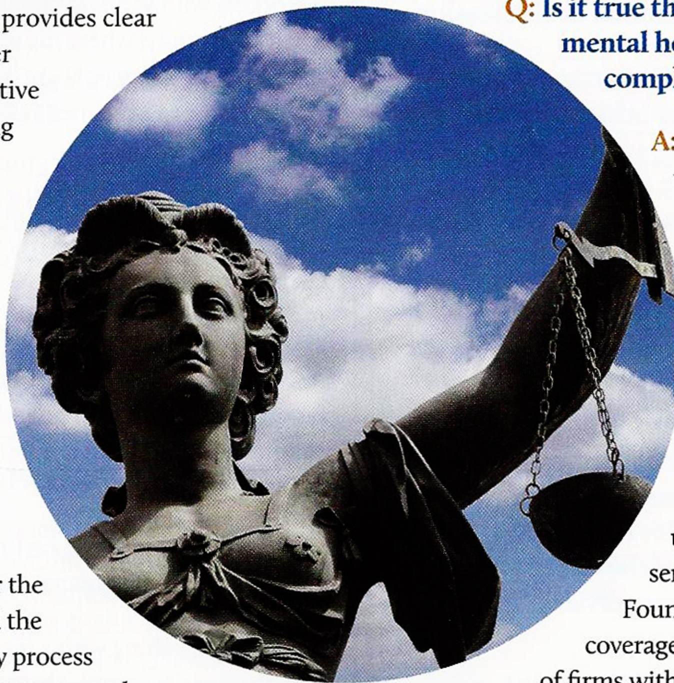
Q&A The Wellstone-Domenici Mental Health & Parity Addiction Equity Act

A question-and-answer guide for psychologists

The Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act (MHPAEA) became law in October 2008. The federal government published its Interim Final Rule (IFR) in February 2010 to implement this full mental health insurance parity law. The IFR provides clear guidance and strong consumer protections that become effective for health plan years beginning on or after July 1, 2010. For most plans, this means that the IFR will apply on January 1, 2011.



A group of managed behavioral health organizations filed a lawsuit against the federal government in the spring of 2010 to block implementation of the IFR. On June 21, a judge with the U.S. District Court for the District of Columbia dismissed the lawsuit, allowing the regulatory process governing the federal parity law to proceed.

Practicing psychologists have raised numerous questions about MHPAEA and its impact on practitioners and consumers of psychological services. This question-and-answer article addresses several common inquiries.

Q: Can I assume that all my patients are covered by the federal parity law?

A: No. MHPAEA covers most but not all health plans. The federal law applies to employer-sponsored group health plans of more than 50 employees. State and local government employee plans may opt out of the federal parity law, though few of these plans have done so.

If a plan does not cover mental health benefits, MHPAEA would not pertain to your patients in such a plan. Fortunately, nearly all employer-sponsored health plans cover mental health services.

Q: Is it true that health plans may drop mental health benefits rather than comply with the new parity law?

A: MHPAEA does not mandate the inclusion of mental health or substance use benefits in insurance plans. Instead, the parity law contains "coverage conditions" that apply only if a plan covers such services. We do not expect implementation of the rule governing the federal parity law to have any substantial impact on the nearly universal extent of mental health services coverage. 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.

Q: Some state parity laws apply only to the "biologically based" disorders involving serious mental illness (SMI) such as schizophrenia or bipolar disorder. Is it true that the new federal parity law requires insurance companies to extend parity coverage to a broader range of mental health services?

A: Under MHPAEA, parity requirements apply to all diagnoses covered by a plan, not just a narrow list of SMI diagnoses. The federal law "wraps around" state laws like New York's Timothy's Law. For example, insurance plans in

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New York must still cover the state's list of "severe mental illnesses" in their benefit packages. For health plans in New York provided by employers of more than 50 people, MHPAEA further requires any additional mental health/ substance use services covered by the plan to be at parity with medical/surgical services.

Although not a common practice, an insurer may exclude coverage of particular diagnoses—for example, autism or ADHD—in its coverage agreement with an employer. Check with the employer's human resources office to verify that a diagnosis exclusion applies.

Q: My patient's insurance plan has an arbitrary limit on the number of outpatient mental health sessions per year. What should I do?

A: A plan that continues to use a prior mental health benefit limit—for example, 30 inpatient days and 20 outpatient sessions per year—is in violation of MHPAEA if the same limits are not placed on medical/surgical benefits. You or your patient may wish to contact the health plan to urge compliance with the law. Alternatively, your patient may want to contact his or her human resources office for assistance.

Q: My patient's insurance company does not require pre-authorization for outpatient medical/surgical visits to primary care physicians such as internists and family physicians, but does require pre-authorization of outpatient psychotherapy visits in order to be reimbursed for these services. What should I do?

A: The Interim Final Rule goes beyond what many people normally think of as benefits requirements. Under the Wellstone-Domenici parity law, a health plan may manage benefits under the terms and conditions of the plan. If a plan does so, the IFR requires that management of benefits must be at parity.

The Interim Final Rule stipulates that mental health benefits may not be managed more stringently than medical/surgical benefits. Pre-authorization requirements are one form of benefits management. If a plan imposes pre-authorization requirements on mental health benefits that it does not impose on most medical/surgical benefits, that plan would be violating the parity law. Pre-authorization requirements and

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other "non-quantitative treatment limitations" (NQTL) that may be applied to mental health services must be comparable to NQTLs that apply to medical/surgical benefits.

Insurance companies seem to be interpreting and applying this requirement differently, and they may continue doing so after January 1, 2011. Staff for the APA Practice Organization is working with state psychological associations to help resolve situations where insurance companies appear to be applying the "comparable to" standard inappropriately. We will continue to keep members informed about relevant developments.

Q: My patient's health plan is requiring a higher patient copayment for my services because the plan considers me a "specialist." Does the new law consider me a specialist?

A: No. The Interim Final Rule explains that a plan that requires mental health providers to be classified as specialists for the purposes of calculating copayments is violating the law.

Q: Should my patient or I report non-compliance by an insurer to the government?

A: Beyond speaking with a human resources office and the insurance company, you and/or your patient may file a formal complaint with the federal government.

Complaints about insurance plans regulated under state law may be made via a toll-free Health & Human Services help line at 1-877-267-2323, extension 61565 or by emailing phig@cms.hhs.gov.

For "self-funded" plans governed by the federal law known as ERISA (generally those of large employers), the Labor Department may be reached at 1-866-444-3272 or with an online form found at askebsa.dol.gov/SecInit.

A word of caution to temper expectations: There may not be adequate staffing to investigate each complaint received.