Tennessee Parity Project

Mental Health & Addiction Care Parity

Mental health is just as important as physical health when it comes to leading a healthy, productive life. That is why federal law requires insurers to cover mental health and addiction treatment on par with other medical care.

What is Mental Health Parity?

Parity means that health insurance plans must provide benefits for mental health and addiction care at the same level as medical and surgical care.

Why is it Important?

Health insurance should help millions of Americans get the mental health or addiction treatment they need, yet too many health plan members face lower visit limits, higher out of pocket costs and stricter rules for how care is reviewed than for medical or surgical benefits.

Federal Parity Laws

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

MHPAEA applies to large group and self-insured health plans and Medicaid managed care plans. This law does not *require* health plans to provide mental health or addiction benefits, but *if* they do, treatment limits and out of pocket costs must be at the same level as medical and surgical care.

The Patient Protection and Affordable Care Act of 2010 (ACA)

The ACA strengthens coverage for mental health and addiction through:

- **Essential Health Benefits:** All individual and small group plans must cover 10 Essential Health Benefits (EHB) including *Behavioral health*. EHBs must meet parity standards, not only within the 'behavioral health' category, but also in other categories.
- **Individual, small group and Medicaid expansion plans:** Requires individual and small group plans to meet federal parity requirements regardless of whether they are sold through an exchange. Parity also applies to Medicaid expansion and Children's Health Insurance Plans.

Parity Protections

Federal parity law protects health plan members for care delivered by in-network and out-of-network providers. Parity applies to out-of-pocket costs, treatment limits and other types of limits.

Types of care:

- Hospital or residential treatment
- Outpatient visits
- Emergency or crisis care
- Prescription drugs
- Both in-network and out-of-network

Out-of-Pocket Costs for mental health or addiction care must not be greater than for other medical care

Treatment limits: Visits or day limits must be no more restrictive than for other medical care

Other limits must not be more restrictive than for other types of medical care

- Prescription drug costs or requirements
- Prior-approval requirements
- Clinical standards used to approve or deny care
- Availability of providers

Tennessee Department of Commerce and Insurance

Telephone: 800-342-4029
Complaint form: http://bit.ly/tninscomp

Federal HHS parity complaint portal:

www.hhs.gov/mental-health-and-addiction-insurance-help

For more information and to sign up for newsletter, contact Bonnie Hannah at bhannah@namitn.org

Common Parity Violations

If the following has happened to you, contact your health plan customer service line. If not satisfied, go through the HHS parity complaint portal to contact your state health insurance agency.

- **Fewer visits or days** covered for mental health or addiction care.
- **Residential or partial hospital care not covered** for mental health or addiction. Example: Addiction residential care is not covered, but a skilled nursing facility is covered for stroke.
- **Higher out-of-pocket costs** for mental health or addiction care. Example: the copay for a mental health therapy visit is higher than copay for an endocrinologist for diabetes.
- **Separate deductible** for mental health or addiction care on top of the overall deductible. A deductible is the expenses you are responsible for before the health plan begins to pay.
- **More frequent denial** for mental health or addiction care than for other medical care because the health plan determines that the care is not *medically necessary.*
- **Prior approval** required more often for mental health or addiction care than for medical care.
- **Step therapy:** The least expensive mental health or addiction treatment is required before the prescribed care can be considered.
- **In-network mental health or addiction professionals not available** and the health plan does not pay for the out of network providers in your local area.

What Types of Plans Must Comply with Parity?

The following chart shows the health plans that must comply with federal parity law.

Type of Plan	Parity?	Description
Large employer > 50 employees, includes self-insured	**Yes**	Not required to provide mental health or addiction benefits, but if they do, coverage must be on par with other medical benefits.
Small employer 2 to 50 employees	**Depends**	*If created after 3/23/2010,* must provide mental health and addiction benefits. Must follow federal parity law.
Individual health plans (You buy for self or family)	**Yes**	*M*ust provide mental health and addiction benefits; required to follow federal parity law.
Federal Employee Health Benefits Plan (FEHBP)	**Yes**	Must provide mental health benefits; required to follow federal parity law.[1]
Non-federal government	**No**	Some health plans for state or local government workers can opt out of federal parity law.
Faith-based organizations	**No**	Plans for employees of faith-based organizations can opt out of federal parity law.
Retiree only	**No**	Plans that only cover retirees can opt out of federal parity law.
Medicare	**No**	Federal health plan for age 65 or older and people with disabilities. Federal parity law does not apply.
Children's Health Insurance Program (CHIP)	**Yes**	Government health plan for low to middle income children. Federal parity law applies.
Medicaid	**Depends**	Federal/state health plan for certain low-income children and adults.[2] Federal parity law applies to Medicaid managed care, but not Fee-for-Service (FFS) plans.
TRICARE	**No**	Federal health care program for uniformed military service members and their families

[1] U.S. Office of Personnel Management, FEHB Program Carrier Letter, No. 2008-17 (November 10, 2008), https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf

[2] Federal law restricts the use of Medicaid dollars for service to adults between the ages of 21 and 64 in certain types of free standing psychiatric hospitals and residential facilities. 42 U.S.C. 1369(d).