



FREQUENTLY ASKED QUESTIONS

Federal Mental Health Parity and Addiction Equity Act (MHPAEA) as It Applies to Self-Funded Groups

When do the new federal mental health parity regulations go into effect?

The new federal legislation, H.R. 1424, the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008" (MHPAEA), began on October 3, 2009, and goes into effect as health plans renew their coverage on or after October 4, 2009. If a member's group health plan covers mental health treatment, substance abuse treatment, or both, the member will continue to have their current benefits until their plan renews.

What does the law require?

The law, applicable to employers of 51 or more employees, requires that coverage (defined by elements such as financial requirements; treatment limitations, and out-of-network access) be "no more restrictive" for mental health and substance use disorders than for the medical coverage defined by those same elements. In other words, benefits for chemical dependency and mental or nervous conditions may not have copayments, coinsurance, deductibles, maximum out-of-pocket limits, or out-of-network access limitations that are greater or more restrictive than those applied to medical and surgical benefits.

Mental health parity applies to medically necessary:

- Inpatient and outpatient treatment
- Long-term residential mental health treatment
- Chemical dependency treatment, including alcoholism

Does the MHPAEA require that a self-funded group's health plan cover mental health or substance abuse treatment?

No. A self-funded group is not required to cover treatment for mental health or substance abuse under its health plan. However, if the health plan does cover mental health treatment, substance abuse treatment, or both, then it must comply with the federal regulations.

How does this affect self-funded groups?

Large self-funded plans that choose to cover mental health and/or substance abuse treatment must comply with the federal law effective with their new plan year beginning on or after October 4, 2009. Self-funded plans that do not provide any benefits for mental health and/or substances abuse benefits are not required to add them to their benefit plan.

Does the MHPAEA define covered diagnoses?

No, the legislation does not define covered diagnoses, nor does it require plans to cover all of the Diagnostic and Statistical Manual of Mental Disorders/DSM-IV-TR diagnoses. Covered diagnoses are determined by the plan documents.

Does the MHPAEA limit medical management?

Health plans are not restricted from applying utilization review and medical necessity determinations consistent with medical necessity reviews for all types of care.

Where can I find more information about the MHPAEA?

More details about the Mental Health and Addiction Equity Act are available online at www.GovTrack.us/congress/bill.xpd?bill=h110-1424

Who can I contact if my question is not addressed here?

If you have additional questions, you are welcome to contact us at (503) 598-8908 or toll-free at (800) 473-0509.