FAQs About The Mental Health Parity Act

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What is The Mental Health Parity Act (MHPA)?

The Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

How does MHPA affect my benefits?

Under MHPA, group health plans, insurance companies and HMOs offering mental health benefits are no longer allowed to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

Does MHPA require all health plans to provide mental health benefits?

No. Health plans are not required to include mental health in their benefits package. The requirements under MHPA apply only to plans offering mental health benefits.

May a plan impose other restrictions on mental health benefits?

Yes. Plans are still able to set the terms and conditions (such as cost-sharing and limits on the number of visits or days of coverage) for the amount, duration and scope of mental health benefits.

Do all plans offering mental health benefits have to meet the parity requirements?

No. There are two exceptions to these new rules. First, the mental health parity requirements do not apply to small employers who have fewer than 51 employees. Second, any group health plan whose costs increase 1 percent or more due to the application of MHPA's requirements may claim an exemption from MHPA's requirements.

How does a plan claim the 1 percent increased cost exemption under MHPA?

The increased cost exemption must be taken based on actual claims data, not on an increase in insurance premiums. The provisions of MHPA must be implemented for at least 6 months and the calculation of the 1 percent cost

exemption must be based on at least 6 months of actual claims data with parity in place. In addition:

- Plans claiming the increased cost exemption must notify the appropriate government agency and plan participants and beneficiaries 30 days before the exemption becomes effective.
- A formula is provided for plans to calculate the increased cost of complying with parity.
- A summary of the aggregate data and the computation supporting the increased cost exemption must be made available to plan participants and beneficiaries free of charge upon written request.
- Once a plan qualifies for the 1 percent increased cost exemption, it does not have to comply with the parity requirements for the life of the MHPA provisions.

When do the MHPA requirements take effect? Are these changes permanent?

MHPA applies to group health plans for plan years beginning on or after January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended six times. The current extension runs through December 31, 2007.