

The Mental Health Parity Act

The Mental Health Parity Act (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. In general, group health plans offering mental health benefits cannot 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.

The law provides that the parity requirements do not apply to benefits for services furnished on or after a sunset date set in the law. This sunset has been extended several times. If you have questions about the sunset provision, contact the EBSA office nearest you.

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

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

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

No. There are two exceptions to these rules. The mental health parity requirements do not apply to small employers who have fewer than 51 employees, and 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.



How does a plan claim the exemption for a 1 percent increase in costs?

The increased cost exemption must be based on actual claims data, not on an increase in insurance premiums. The plan must implement the provisions of MHPA 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:

- Group health plans covered under ERISA claiming the increased cost exemption must notify the Department of Labor and plan participants and beneficiaries 30 days before the exemption becomes effective.
- A formula for plans to calculate the increased cost of complying with parity is provided in the interim regulations (see www.dol.gov/ebsa under Laws & Regulations, 29 CFR section 2590.712(f)(2)).
- 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.

May a plan impose other restrictions on mental health benefits?

Yes. Plans can generally 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. However, a plan may not impose a “constructive” dollar limit on mental health benefits that is lower than that for medical/surgical benefits. A limit on the number of visits coupled with a maximum dollar amount payable per visit by the plan is a “constructive” dollar limit.

For example, a 50-visit annual limit on mental health benefits that is payable to a maximum of \$100 per visit is a constructive annual limit on mental health benefits of \$5,000. If the plan’s limit for medical/surgical benefits is greater than \$5,000 or if there is no limit, then the plan is in violation of MHPA. The plan should eliminate any constructive dollar limits on mental health benefits that are lower than for medical/surgical benefits.