



FACT SHEET

California Impact: Federal Mental Health Parity Act of 2008

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FREQUENTLY ASKED QUESTIONS

When are health plans and insurers expected to comply with the new Federal Mental Health Parity Act?

The requirements are effective for plan years beginning on October 3, 2009, unless a health plan is maintained pursuant to one or more collective bargaining agreements. Regulations were issued in January 2010. These apply to plans and insurers for plan years beginning on or after July 1, 2010.

What are the exemptions of the new Federal Mental Health Parity Act?

Employers with 50 or fewer employees are exempted from the law. Health insurance plans may be exempted from the legislation if they demonstrate that the parity requirements increase costs of all coverage by more than 2% (proven by an actuarial report after 6 months of implementation) and 1% for subsequent plan years.

How will a California health plan be affected?

Health plans will be affected if they provide any mental health/substance use disorder services that go beyond the minimum required by California's Mental Health Parity Law.

The Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,¹ included in The Emergency Economic Stabilization Act of 2008, went into effect on October 3, 2009. Regulations, issued in late January 2010, become applicable to plans and insurers for plan years beginning on or after July 1, 2010. It requires that group health plans apply **the same treatment and financial limits mental health and substance use disorder treatment benefits as are applied to health and surgical benefits.**

Facts

The new Federal Mental Health Parity Act **does not:**

- Mandate mental health or substance abuse benefits
- Apply to group plans for 50 or less employees

The 2008 Federal Mental Health Parity Act will apply to California by requiring mental health and substance use disorder treatment to be at parity with health care services for:

Self-insured plans that cover 51 or more employees

- *Approximately 3.4 million Californians are covered by employer based self-insured plans, accounting for 17% of the commercially insured market.²*

Health plans offering services that exceed the California AB 88 mandate

- *92% of health plans and insurers offer coverage above and beyond the AB 88 mandate for mental health disorders.³*
- *82% of health plans and insurers offer coverage above and beyond the AB 88 mandate for substance use disorders.³*

Summary

California passed its current state Mental Health Parity Law (AB 88) in 1999, shortly after the original federal Mental Health Parity Act was signed into law in 1996. AB 88 mandates California health care service plans and insurers to provide coverage for the diagnosis and medically necessary treatment of named severe mental illnesses (SMI) of all persons and serious emotional disturbances (SED) of children under the same terms and conditions applied to other medical conditions. In state-sponsored programs, the AB 88 mandate applies to the Healthy Families Program (HFP), which provides low-cost insurance to children up to age 19 who do not qualify for Medi-Cal. However, AB 88 expressly exempts Medi-Cal from its provisions. Because the provisions of AB 88 do not prevent the application of the federal Mental Health Parity Act, the federal Mental Health Parity Act does not preempt the California's Mental Health Parity Law.

On the federal side, the Medicaid and State Children's Health Insurance Program (SCHIP) statutes require the programs' compliance the federal Mental Health Parity Act if a state covers the services through health plans. However, California's Medicaid and SCHIP programs – Medi-Cal and the HFP, respectively – carve out mental health services from the health plans and instead provide the services through the counties. To the extent that mental health services are provided by the county and not health plans in Medi-Cal and the HFP, those services exempt from the provisions of the federal Mental Health Parity Act.

Mental Health Limits and Terms Must be on Par with Health Care

Treatment Limitations:

- Frequency
- Days of coverage
- Visits
- Other limits on scope or duration of treatment

Financial Terms:

- Deductibles
- Co-Payments
- Co-Insurance
- Out-of-Pocket expenses

*Annual and lifetime financial and treatment limits under the 1996 Act still apply.

¹ PL110-343 (HR 1424), Division C, Title V, Subtitle B.

² "Insurance Coverage in California, 2006." CHBRP Cost Analysis. Accessed October 2008. www.chbrp.org/costimpactsum.html

³ "Analysis of Assembly Bill 1887, Health Care Coverage: Mental Health Services." California Health Benefits Review Program. 8 April 08.

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