OLR RESEARCH REPORT

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MENTAL HEALTH PARITY

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You asked a series of questions related to health insurance coverage for mental health services payable on the same basis as coverage for other medical conditions, commonly referred to as "mental health parity." We present the questions and answers below.

Does Connecticut have a mental health parity law?

The answer is yes. Connecticut requires individual and group health insurance policies delivered, issued, renewed, amended, or continued in the state to cover the diagnosis and treatment of "mental or nervous conditions." Policies cannot establish any provision that places a greater financial burden on an insured for the diagnosis or treatment of mental or nervous disorders than for the diagnosis or treatment of medical, surgical, or other physical health conditions (CGS §§ 38a-488a and 38a-514).

The law defines "mental or nervous conditions" as mental disorders, as that term is used in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM, currently DSM-IV, with DSM-5 scheduled for release in May 2013). But the law specifically excludes from "mental or nervous

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conditions" (1) mental retardation; (2) learning, motor skills, communication, and caffeine-related disorders; (3) relational problems; and (4) additional conditions not otherwise defined as mental disorders in the DSM.

For a detailed description of Connecticut's mental health parity law, see OLR Research Report 2009-R-0415.

Is there a federal mental health parity law?

The answer is yes. Congress enacted the federal Mental Health Parity Act (MHPA) in 1996 and the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. The MHPAEA expands upon the requirements of MHPA. Thus, federal law requires large group health plans (i.e., those with more than 50 employees) and health insurance issuers that sell coverage to them to ensure that financial requirements (e.g., co-payments, deductibles, coinsurance, and out-of-pocket limitations) and treatment limitations (e.g., visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applicable to substantially all medical and surgical benefits.

It is important to note that federal law does not require a plan to provide mental health and substance use disorder benefits. Rather, if a plan provides medical and surgical benefits and mental health and substance use disorder benefits, it must comply with the parity provisions.

For more details on the federal parity law, see the U.S. Department of Labor fact sheet on MHPAEA, available at http://www.dol.gov/ebsa/newsroom/fsmhpaea.html (accessed January 23, 2013).

What are the main differences between the state and federal parity laws?

We list the main differences between the state and federal parity laws below.

1. State law applies to individual, small group, and large group health insurance policies. Federal law applies to large group health plans only.

2. State law requires plans to cover the diagnosis and treatment of mental or nervous conditions. Federal law does not require coverage.

3. State law defines parity such that there is no greater financial burden on an insured for accessing diagnosis or treatment of mental or nervous conditions than for accessing diagnosis or treatment of medical conditions. Federal law defines parity in terms of financial requirements and treatment limitations.

For a more detailed comparison of Connecticut and federal mental health parity laws, see the Office of Program Review and Investigations December 18, 2012 report, *Access to Substance Use Treatment for Insured Youth: Phase 1*, available at http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf (accessed January 23, 2013).

Does the federal Patient Protection and Affordable Care Act affect mental health parity?

The answer is yes. The 2010 federal Patient Protection and Affordable Care Act (PPACA) contains provisions regarding mental health parity that will become effective January 1, 2014. Specifically, the PPACA requires health plans that offer insurance coverage in the individual and small group markets to ensure that such coverage includes an essential health benefits package. The essential health benefits package must include coverage for, among other things, mental health and substance use disorder services, including behavioral health treatment. The PPACA also extends mental health parity requirements to individual and small group health plans.

For more details on the PPACA and essential health benefits, see OLR Research Reports 2010-R-0255 and 2012-R-0022.

Does state or federal law specify cost-sharing requirements for mental health services?

The answer is no. Neither state nor federal law specifies cost-sharing requirements (e.g., copayments, deductible, coinsurance, out-of-pocket limitations) beyond the parity requirement.

Aside from insurance coverage, what are other barriers to accessing mental health services?

The state Office of Healthcare Advocate (OHA) reports that Connecticut residents face "significant barriers to access to preventive and treatment services for mental health and substance use disorders." OHA held a public hearing on October 17, 2012 to hear from consumers, providers, and state agencies about barriers to access. OHA's January 2, 2013 report provided six findings which follow below.

1. Connecticut lacks an overall vision of how to recognize, evaluate, and provide services for individuals with mental health and substance use delivery services.

2. Connecticut's current delivery system for mental health and substance use services is fragmented and inconsistent—benefits and access depend upon eligibility for healthcare coverage and whether the coverage is private or public.

3. Capacity for delivery of services is insufficient for the delivery of needed services—community-based services are available on a small scale only to those in public coverage, the workforce is insufficient, and there are inadequate provider networks for insured individuals covered by private coverage.

4. Health insurer or administrator processes for evaluation of the need for services, appeals of those decisions, and peer-review for insurance denials do not always reflect the need for prompt and accurate decision-making.

5. Mental health and substance use prevention services are largely unknown and not targeted broadly enough.

6. Mental health and substance use care largely is not integrated into overall healthcare models nor is it designed to improve outcomes and reduce racial and ethnic disparities.

The OHA report is available at http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf (accessed January 23, 2013).

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