Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

What Employers Need to Know

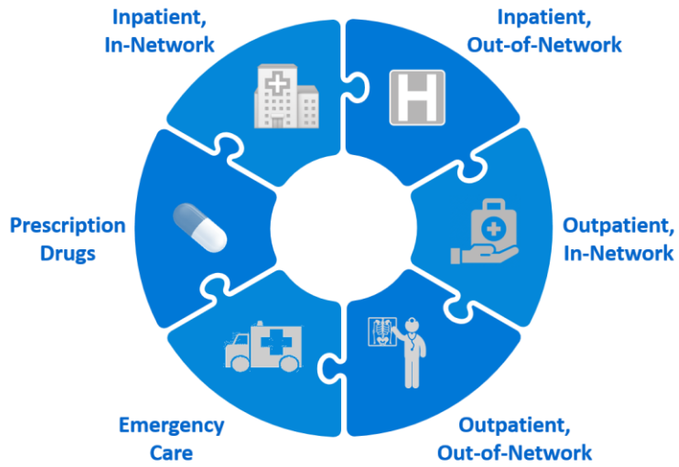
MHPAEA is a federal law that requires group health plans (GHPs) and insurers providing mental health and substance use disorder (MH/SUD) benefits to ensure that the financial requirements (such as copays and deductibles) and treatment limits applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical or surgical benefits. Treatment limits include both quantitative treatment limitations (QTL), which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations (NQTL), which otherwise limit the scope or duration of benefits for treatment (such as medical necessity or experimental treatment standards).

In addition, MHPAEA requires GHPs to disclose certain information to plan participants regarding coverage of MH/SUD benefits, such as medical necessity criteria and reason for denial of MH/SUD services. The Consolidated Appropriations Act, 2021 (CAA) recently amended MHPAEA to further require that GHPs perform a detailed comparative analysis of NQTLs and provide resulting documentation to regulatory agencies upon request.

What Plans are NOT Subject to MHPAEA?

■ FI or SF Grandfathered GHPs sponsored by employers with 50 or fewer employees; ■ SF GHPs sponsored by employers with 50 or fewer employees; ■ SF governmental (non-Federal) plans that have affirmatively elected to exempt the plan from MHPAEA; ■ Retiree-only health plans; ■ Excepted benefits; ■ Plans meeting the established standards and procedures for claiming an increased cost exemption (applies for one year)

While MHPAEA does not require any plan to offer MH/SUD benefits, if such benefits are offered they must be offered in parity with medical/surgical benefits in each of six classifications:



HIPAA Opt-Out

Self-Funded (SF) Governmental (Non-Federal) Plans

Sponsors of SF, governmental (non-Federal) plans may opt out of complying with certain benefit mandates, including the parity rules for MH/SUD benefits. To opt out, plan sponsors must notify HHS of the election via electronic submission **before the first day of each plan year** and must provide a notice to enrollees, both annually and at the time of enrollment. HHS has provided procedures and model election materials.

Financial Requirements and Quantitative Treatment Limitations

- A plan may not apply any financial requirement or QTL to MH/SUD benefits in any of the above classifications that is more restrictive than the *predominant* requirement or limitation that applies to *substantially all* (at least two-thirds) medical/surgical benefits in the same classification.
- Financial requirements include coinsurance, copayments, deductibles and OOP maximums.
- QTLs include limits on benefits based on frequency of treatment, number of visits, days of coverage, days in a waiting period or similar limits on the scope or duration of treatment that are expressed numerically (i.e., 50 outpatient visits per year).

Non-Quantitative Treatment Limitations

- A plan may not impose an NQTL on MH/SUD benefits unless any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD are comparable to, and are applied no more stringently than, the ones used for medical/surgical benefits in the same classification.
- Examples of NQTLs include medical management standards (i.e., medical necessity), formulary design for Rx, **standards to participate in a network including reimbursement rates**, exclusion of specific treatments for certain conditions (i.e., ABA therapy) **concurrent review of inpatient and outpatient services**, **prior authorization**; **OON reimbursement rates**.*

** The DOL has indicated it will focus its enforcement efforts on the bolded NQTLs.*

GHP = Group Health Plan INN = In-Network OON = Out-of-Network OOP = Out-of-Pocket FI = Fully Insured SF = Self-Funded
MH = Mental Health SUD = Substance Use Disorder QTL = Quantitative Treatment Limitation NQTL = Non-Quantitative Treatment Limitation

As of October 1, 2021

Does Your Plan …

Place limits on how many days a patient can stay in a treatment facility or times they can see a behavioral healthcare provider?

Cover skilled nursing facilities and rehabilitation hospitals for medical or surgical services as inpatient benefits but deny coverage for residential treatment for MH/SUD services?

Include higher copays to see behavioral health (MH/SUD) providers or to purchase prescription drugs for behavioral health treatment?

Apply separate deductibles or OOP maximums for behavioral health services?

Require preauthorization or written treatment plan to start/continue behavioral health treatment but not to start/continue other types of health care?

Refuse to cover higher-cost behavioral health therapies until it can be shown a lower-cost therapy is not effective (apply a "fail-first" policy or "step therapy" protocol")?

Deny court-ordered or involuntary MH/SUD treatment?

Deny benefits for behavioral health treatment outside a specific state or region or otherwise impose a geographical limitation on treatment for MH/SUD conditions?

Apply different standards for "experimental," "medical necessity" or similar qualifiers for MH/SUD treatments versus medical/surgical treatments (or fail to disclose criteria to plan participants)?

Condition payment of MH/SUD benefits on the patient's compliance with or completion of the plan for treatment?

If so, your plan may require additional analysis to determine and substantiate MHPAEA compliance.

Consolidated Appropriations Act's NQTL Comparative Analysis Requirement

As of Feb. 10, 2021, plans that impose NQTLs on MH/SUD benefits must be prepared to make available a comparative analysis containing a detailed, written and reasoned explanation of the specific plan terms and practices at issue and including the bases for the conclusion that the NQTLs comply with MHPAEA. At a minimum, the analysis must include: ■ Identification of the NQTLs; ■ Factors considered in the design of the NQTLs; ■ Evidentiary standards and sources used to develop the factors; ■ Analysis of the NQTLs as written and in operation; and ■ Findings and conclusions establishing compliance. FAQs issued by the Agencies provide a detailed discussion of these complex requirements; although, most plan sponsors will need to consult with counsel to ensure compliance as they will not have the expertise or information to independently perform the required analysis.

Action Steps for MHPAEA Compliance

FI plans sponsors share responsibility for MHPAEA compliance with their carrier and should request written confirmation of compliance from their carrier.

SF GHPs are liable for compliance, and sponsors should proactively consult with their TPAs and PBMs to:

- Review the DOL's self-compliance assessment tool, NQTL Warning Signs, MH/SUD Parity website and recent FAQs on the CAA's comparative analysis;
- Revise service provider contracts to address ongoing MHPAEA compliance and the respective responsibilities of the plan sponsor and the TPA/PBM:
  - Who is responsible for disclosures to participants and regulators, including content and timeliness?
  - Who is responsible for reviewing the plan for and identifying non-compliant financial requirements and treatment limitations (QTLs and NQTLs)?
  - If the plan contains any NQTLs, what assistance will the TPA/PBM provide in conducting and documenting the required comparative analyses?
  - Is the sponsor required to adopt any standard plan design and/or processes to secure the TPA's/PBM's participation in and confirmation of compliance?
  - As coverage and claims review practices change, what is the process for updating all analyses?
- Request a copy of any NQTL comparative analyses and supporting documentation and review with the plan sponsor's benefit attorney; and
- Develop internal controls, including training for individuals involved in plan administration, regular plan audits and a process for participants to file complaints.

Note that not all TPAs/PBMs have indicated a willingness to perform the comparative analysis. Some GHPs may need to contract with a third party vendor for these services or revaluate the existing TPA/PBM relationship.