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COMPLIANCE OVERVIEW

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New Agency Initiatives to Enforce MHPAEA

MHPAEA Is Impacted by The Appropriations Act

The federal mental health parity laws were enacted through the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA is one of the Department of Labor's (DOL) highest enforcement priorities since its enactment on October 3, 2008. MHPAEA was preceded by the Mental Health Parity Act which restricted the use of annual and lifetime dollar limits on mental health treatments and benefits. The Consolidated Appropriations Act (CAA) was enacted on December 27, 2020. The CAA includes new requirements that apply to health care plans that provide mental health benefits or substance use disorder benefits to participants. The CAA requires plans to make an analysis and to make a report available to the Department of Labor (DOL), Health and Human Services (HHS), and/or the Treasury. This requirement is also applicable, upon request, by state authorities.

A Federal agency may request to see an analysis of non-quantitative treatment limitation ("NQTL") comparative analysis requirements from plans to evaluate whether their analysis has sufficient information to show compliance with MHPAEA. That means that if a plan offers medical/surgical and mental health or substance use disorder benefits, and also imposes NQTLs on those benefits, they are now also required to perform an analysis of the design and application of NQTLs.

Important: The Agencies are required to provide an annual report to Congress regarding compliance (or non-compliance) with MHPAEA and to publish their findings annually.

Health Plan Requirements

The CAA requires plans to provide their NQTL analysis to participants upon request. These reports must include specific plan and coverage terms regarding the NQTLs, and a description of all mental health/substance use disorder and medical/surgical benefits. Plans are required to show their comparative analysis and the processes, strategies, evidentiary standards and factors used to apply the NQTLs to the mental health/substance use disorder benefits. They must show they are comparable to medical and surgical benefits. Plans must share their analysis, findings and conclusions with the Agencies, if requested to do so.

Most importantly, plans must report to the Agencies any results that show that the benefit plan is <u>not compliant</u> with MHPAEA's NQTL requirements.

IMPORTANT:

Enforcement Time Lines:

If the DOL finds noncompliance, the plan will have 45 days to correct the problem. The plan will be required to show the DOL the comparative analysis and show that the plan was altered to be in compliance. If a plan is still not in compliance, the plan has an additional 7 days to notify all individuals in the plan that coverage is in violation with MHPAEA. The agencies will report this non-compliance to the States where the employer does business.

New requirements under the Consolidated Appropriations Act of 2021 (CAA) apply to the Mental Health Parity and Addiction Equity Act (MHPAEA). The Consolidated Appropriations Act was enacted on Dec. 27, 2020.

MHPAEA Compliance --cont'd

What are the Department of Labor's MHPAEA requirements?

Financial Requirements or quantitative treatment limitations (QTL)

- Lifetime and annual dollar limits on mental health and substance use disorder benefits that are lower than the limits imposed on medical/surgical benefits are prohibited.
- Annual and lifetime dollar limits for essential health benefits are prohibited.
- A lifetime or annual dollar limit that applies to less than one-third of medical/surgical benefits is prohibited.

MHPAEA prohibits cumulative financial requirements or cumulative QTLs for mental health and substance use disorder benefits.

Financial requirements or quantitative treatment limitations are based on a cumulated amount. They can be those that accumulate separately from any financial requirements or QTL established for medical/surgical benefits in the same classification.

The CAA added a disclosure requirement on the criteria for medical necessity and reasons for denial of mental health and substance use disorder benefits. What does this mean to your plan?

- A plan can combine levels until it reaches more than 50%. Only the least restrictive in that group can apply to mental health and substance use disorder benefits.
- Plans can sub-classify outpatient services, office visits, and all outpatient benefits.
- Plans can have a subclassification for financial requirements for different tiers of prescription drug benefits, as long as, it is without regard to whether a drug is generally prescribed for medical/surgical conditions or for mental health and substance use disorder.

Classification of Benefit Limits

This general rule is applied within each of the six classifications of benefits: **Inpatient, In-network, Out-of-network, Outpatient, Emergency Services and Prescription Drugs**. Analysis may include the following:

- Determine whether a financial requirement or QTL applies to substantially all medical/surgical benefits in the classification.
- Determine if there is a dollar amount of medical/surgical benefits in a classification subject to the financial requirement or QTL.
- Determine if there is a dollar amount of medical/surgical benefits in the classification.
- If this is a financial requirement or QTL that applies to more than two-thirds of medical/surgical benefits in a classification, it applies to substantially all.

KEY DEFINITIONS:

Financial Requirements and Quantitative Treatment Limitations (QTL):

Financial requirements and quantitative treatment limitations include things such as co-pays, deductibles, out-of-pocket maximums, or cost sharing.

Limits on benefits, scope or duration of treatment that are generally expressed numerically such as visit limits.

If applicable to mental health/substance use disorder benefits, they can be no more restrictive than the predominant financial requirement or QTL applied to substantially all medical/surgical benefits covered by the plan or provider network.

Non-Quantitative Treatment Limitations (NQTLs):

NQTLs are limitations on the scope or duration of benefits for treatment such as medical necessity determinations, preauthorization requirements or fail-first policies that are generally non-numerical.

NQTLs are generally defined as treatment limitations that aren't expressed numerically, but the application of an NQTL in a numerical way doesn't modify its nonquantitative character.