# CONSOLIDATED APPROPRIATIONS ACT, 2021: MENTAL HEALTH PARITY REQUIREMENTS

## OVERVIEW

Group health plans that provide either mental health or substance use disorder (MH/SUD) benefits in addition to medical/surgical benefits are subject to the mental health parity provisions as set forth by the Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). As a result of that legislation, group health plans that offer MH/SUD benefits must provide parity between such benefits and medical/surgical benefits. This means that plans cannot impose financial requirements or treatment limitations on the MH/SUD benefits that are more restrictive than those applied to medical/surgical benefits.

***Group health plans that offer mental health and substance use disorder benefits must provide parity between such benefits and medical/surgical benefits.***

Specifically, group health plans that are subject to these provisions must ensure parity as to annual and/or lifetime limits, financial requirements and quantitative treatment limitations, and nonquantitative treatment limitations (NQTLs). NQTLs affect the scope and duration of treatment and include, but are not limited to:

- Medical management standards that limit or exclude benefits based on medical necessity.
- Experimental treatment exclusions.
- Prior authorization or ongoing authorization requirements.
- Step therapy protocols (e.g., requiring lower cost drugs to be prescribed before more expensive options).
- Methods for determining usual, customary and reasonable charges for out-of-network (OON) services.
- Standards for providing access to OON providers.
- Standards for provider admission to participate in a network, including reimbursement rates.
- Restrictions based on geographic location, facility type or provider specialty.

DOL enforcement of MHPAEA has routinely revealed that plans are most likely to violate MHPAEA by imposing NQTLs that are not in parity. To encourage compliance with MHPAEA's provisions concerning NQTLs, the DOL released a document entitled Warning Signs on NQTLs in addition to the MHPAEA Self-Compliance Tool they had already released.

To further address this issue, a provision in the Consolidated Appropriations Act, 2021 (CAA) requires group health and insurance carriers to perform and document their comparative analyses of the design and application of any NQTLs imposed upon MH/SUD benefits. Beginning February 10, 2021, plans must be prepared to provide the analyses to the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury (the departments) (or applicable state authorities or participants) upon request.

The Q&As below address the latest information and insight on the CAA comparative analysis requirement and its impact to group health plans.

## Q&A ON THE CAA MENTAL HEALTH PARITY REQUIREMENTS

**Which plan sponsors are subject to the CAA's requirement to provide NQTL analysis?**

The CAA's requirement to provide NQTL analysis applies to all plans that would be subject to MHPAEA. Specifically, plans and insurers offering group or individual health insurance coverage that offers both medical/surgical benefits and MH/SUD benefits and that impose NQTLs on MH/SUD benefits would have to complete the analysis. Plans sponsored by small employers (under 50), retiree-only plans and excepted-benefit plans are exempt from MHPAEA (and therefore the CAA NQTL analysis provision).

**What does the CAA require of plan sponsors and issuers?**

Plans and issuers must provide an analysis that provides a detailed, written and reasoned explanation regarding the basis for the plan's conclusion that the NQTLs comply with the MHPAEA. Amongst other items, the analysis must describe each NQTL, the plan benefits to which the NQTL applies, and the factors (e.g., high variability in cost of care, lack of clinical efficacy of a treatment) and sources (e.g., internal claims analysis, medical expert review) upon which the NQTL is based.

**What is the required content and format of the NQTL analysis?**

Currently, there is no guidance regarding the format of the NQTL comparative analysis. However, guidance does provide that the analysis at minimum must include a "robust discussion" of nine specific elements (as explained in the FAQ referenced in the Resources section), including:

1. A clear description of the specific NQTL, plan terms and policies at issue.
2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. It must include the precise definitions used and any supporting sources (to the extent the plan or issuer defines any of the factors, evidentiary standards, strategies or processes in a quantitative manner).
5. An explanation of any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decisionmaker(s), the timing of the decisions and the qualifications of the decisionmaker(s).
7. If the analyses rely upon any experts, the analyses should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
8. A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
9. The date of the analyses and the name, title and position of the person or persons who performed or participated in the comparative analyses.

**To whom and when must the NQTL analysis be provided?**

Plans and issuers that are subject to this requirement must make their comparative analysis available to the departments or to state authorities upon request, beginning February 10, 2021. Plans and issuers must also make the comparative analysis available to participants, beneficiaries and enrollees (or their authorized representative) upon request.

**What party is ultimately responsible for drafting the NQTL analysis?**

Since the law applies this responsibility to both plans and issuers, the obligation to complete the analysis will vary based on the nature of the plan. Insurance carriers will be required to provide the analysis for fully-insured plans. Employers sponsoring fully-insured plans should request the analysis from the insurer and provide it to regulators or participants that request it. Insurers have already begun to provide this analysis in many instances.

The entity responsible for providing the analysis for a self-funded plan is the plan itself. Employers sponsoring self-funded plans should work with their third-party administrator (TPA) to create the analysis and distribute it upon request from regulators or participants. Insurers serving as TPAs would potentially assist with this obligation for their self-funded clients who have not customized their NQTL provisions. Ultimately, though, self-funded plans will be responsible for ensuring that the analysis is completed.

**How will the government enforce this provision?**

The departments may request that certain plans and issuers produce their comparative analysis. This request could be random or in response to potential violations or complaints regarding noncompliance with the MHPAEA.

While the DOL's review will not be limited to any specific issues, the DOL expects to focus its enforcement efforts on:

1. Prior authorization requirements for in-network and out-of-network inpatient services.
2. Concurrent review for in-network and out-of-network inpatient and outpatient services.
3. Standards for provider admission to participate in a network, including reimbursement rates.
4. Out-of-network reimbursement rates (plan methods for determining usual, customary and reasonable charges).

If a plan's submission of a comparative analysis results in a determination that the plan is not in compliance with the MHPAEA, the plan would be required to submit additional comparative analyses that demonstrate compliance within 45 days. If the departments make a final determination that the plan is still not in compliance following the 45-day corrective action period, all enrollees would need to be notified within seven days. In addition, the compliance findings would be shared with the state where the group health plan is located.

Plan sponsors that receive a request from the departments or a participant should work with their insurer, TPA or other service providers to honor the request. Legal counsel may also be necessary to address any potential violations of MHPAEA.

## RESOURCES

**Consolidated Appropriations Act, 2021**

**FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021**

**Warning Signs – Plan or Policy NQTLs that Require Additional Analysis to Determine Mental Health Parity Compliance**

**Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)**



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