ABHW

# ISSUE BRIEF

## Mental Health Parity and Addiction Equity Act (MHPAEA)

*Updated July 2023*

### Background

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act (ACA)[1], generally requires group health plans and health insurance issuers to ensure that the financial requirements (e.g., deductibles, copays, out-of-pocket expenses, annual or lifetime dollar limits) and treatment limitations (e.g., number of visits, days of coverage) on mental health (MH) or substance use disorder (SUD) benefits are no more restrictive than those on the medical or surgical (med/surg) benefits. In other words, MH/SUD benefits must be at parity with med/surg benefits.

The regulation accompanying MHPAEA was published in 2010 by the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), and the U.S. Department of the Treasury (collectively the Tri-Departments). The finalized regulation reiterates the requirements in the law for determining parity concerning financial requirements and treatment

[1] As a result of provisions in the Affordable Care Act (ACA) and MHPAEA, parity applies to employer funded plans, individual and small group plans (including exchanges), Medicaid (managed care and Alternative Benefit Plans), and Children's Health Insurance Program plans (CHIP).

limitations, which limit the scope of the duration of benefits for treatment.[2] Quantitative treatment limitations (QTLs) are numerical in nature (e.g., visit limitations). Additionally, the regulation introduced a new concept not seen in the law, that treatment limitations may be non-quantitative treatment limitations (NQTLs), which are non-numerical limits placed on the scope or duration of benefits for treatment (e.g., prior authorization requirements). The rules that govern financial requirements and QTLs differ from those for NQTLs. **These varied rules have caused much confusion among stakeholders when complying with MHPAEA.**

Since 2008, the Tri-Departments have issued more than a dozen sub-regulatory guidance documents, and Congress has passed two additional laws that include parity provisions. First, the 21st Century Cures Act of 2016 directed the Tri-Departments to issue guidance on how a plan or issuer may comply with MHPAEA. In response, the DOL created the Self-Compliance Tool (Tool) in 2018 that health plans can use to assist in evaluating compliance with its requirements. For example, it helps heal plans identify red flags in their NQTL analyses. However, utilizing the Tool is voluntary and not determinative of parity non-compliance.

Then, in December 2020, Congress passed the Consolidated Appropriations Act 2021 (CAA 2021), which placed new reporting requirements for MHPAEA compliance. Effective February 10, 2021, the CAA 2021 requires plans and issuers to perform and document comparative analyses for NQTLs using a specified five-step analysis structure based on the Tool and to provide these analyses to regulators upon request. The legislation further requires the Tri-Departments to issue guidance on this section and an annual Report to

[2] Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 2013, available at https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act

Congress on the results of their investigations.[3] The first CAA -mandated *Report to Congress* was published on January 24, 2022. While the report did not name out-of-compliance payers, it signaled that the Tri-Departments would continue increasing focus on enforcement.

In addition to federal oversight, there is a state-level component to mental health parity. The National Association of Insurance Commissioners (NAIC) has issued numerous recommendations, and several states have passed laws that impose additional, unique parity compliance requirements.

**MHPAEA Implementation**

Since its inception, ABHW has been at the forefront of and an advocate for MH/SUD parity. ABHW was instrumental in drafting the legislative language of MHPAEA, and our members have worked tirelessly over the past 15 years to implement parity for behavioral health services. ABHW member companies have teams from multiple physical and behavioral health departments working diligently on the required NQTL analyses to ensure consumers are provided with the required parity benefits.

As a result of federal guidance and ABHW's communication with the Tri-Departments, mental health parity has progressed in meaningful ways since its adoption. ABHW member company implementation of MHPAEA has led to the following:

- Improved access to behavioral health treatment, services, and providers;
- Aligned behavioral health co-payments with medical visit co-payments;
- Eliminated arbitrary treatment limitations on the number of days of coverage for a condition, as well as financial limits on annual and lifetime dollar caps;
- Reduced the application of prior authorization requirements for MH and SUD services so that they are comparable to med/surg; and

[3] 42 U.S.C. § 300gg-26(a)(8)(C)(ii)

- Integrated medical, pharmacy, and behavioral health benefits to increase consumer engagement and reduce medical costs.

Though these actions by health plans have expanded access to MH and SUD treatment, systemic issues remain challenging due to other non-parity factors, such as the shortage of physicians, including psychiatrists and other behavioral health providers.

**Recommendations**

Despite the parity language in the 21st Century Cures Act and the CAA 2021, aspects of the law and regulations remain overly complex and technical. As a result, compliance has become a moving target through a patchwork of unclear and often conflicting guidance. We appreciate the flexibility built into the law. **Yet, we have seen that the proliferation of vastly differing compliance approaches, tools, and interpretations has led to confusion and strains on stakeholder resources.**

ABHW remains committed to providing equitable coverage of MH and SUD treatment and continues to seek avenues to work with regulators to ensure compliance with MHPAEA. In striving for quality, evidence-based care for individuals and to address the challenges that persist in MHPAEA, ABHW advocates for the following to improve compliance and move toward a uniform standard:

- Release de-identified information on compliance issues discovered by the regulating agencies and provide examples of parity compliance.
- Promote uniformity between state and federal parity compliance requirements.
- Issue a model disclosure form that identifies specific documents that health plans could use to respond to enrollee requests for the information required to be disclosed under MHPAEA.
- Define a core set of NQTLs and outline what an NQTL analysis should look

like.

- Identify the NQTLs that are the focus of the DOL audit and enforcement activity annually.
- Unequivocally state that MHPAEA does not require a specific process, strategy, evidentiary standard, or other factors to be used in applying an NQTL.
- Affirm that disparate results alone do not mean that the NQTLs in use fail to comply with the NQTL parity requirements.
- Identify and address important issues and challenges in the behavioral health system that are systematic issues, not plan parity compliance issues, including workforce shortage issues that create difficulties in network adequacy and out-of-network usage.
- Identify and design compliance-safe harbors for enforcement of the most investigated NQTL types, like those administered by the Office of Inspector General for HHS or compliance with the Anti-Kickback Statute and Civil Monetary Penalty Rules.
- Implement consistent parity compliance determinations that follow the intentions of MHPAEA for the definitions of MH, SUD, and med/surg benefits.
- Establish an appeals process to provide health plans with an adequate opportunity to contest findings of non-compliance that are not adequately substantiated by the MHPAEA statute and guidance.