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Thank you for joining us.

Brown & Brown

Mental Health Parity and Addiction Equity Act (MHPAEA) Basics

MARCH 2024

Presented By:
Brown & Brown Regulatory and Legislative Strategy Group

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MHPAEA: General Requirements

MHPAEA: To Whom Does it Apply?

WHO MUST COMPLY?

Group Health Plans

- Fully insured and self-insured
- Grandfathered and Non-Grandfathered
- Both ERISA/Non-ERISA Health plans
- Generally, employers with ≥ 50 employees (on business days in the preceding calendar year)
- For non-federal governmental plans, employers with ≥ 100 employees in states that define large group as 100 or more employees

Insurance Carriers

Health Insurance Issuers (therefore, even small group fully insured plans could be subject to MHPAEA due to Essential Health Benefit Requirements)

MHPAEA: What Does it Compare?

WHAT DOES IT COMPARE?

Mental Health Benefits

- IF a health plan provides Mental Health/Substance Use Disorder (MH/SUD) benefits, parity rules apply
- Proposed regulations clarify that benefits for MH/SUD must be defined under generally recognized independent standards and current medical practice (e.g., DSM-5-TR, ICD, state laws)
  - » Autism
  - » Eating Disorders

Medical Surgical Benefits

Benefits for medical or surgical items that are consistent with generally recognized independent standards of current medical practice (e.g., as listed in the most recently released International Classification of Diseases (ICD) or other independent standards)

MHPAEA: Exceptions

COVERAGE THAT MAY NOT BE SUBJECT TO THE MHPAEA

Certain coverages may not be subject to the MHPAEA

1) Group health plans only offering **excepted benefits** (e.g., stand-alone dental/vision coverage)
2) Retiree-only coverage
3) Plans subject to the “Increased Cost Exemption”

Non-Federal Governmental Plan Opt-Out:

Previously, self-funded plans could opt-out of MHPAEA requirements, but as of December 29, 2022, no new MHPAEA opt-outs will be provided, and any MHPAEA opt-outs that expire on or after June 27, 2023, are unrenewable (a limited exception may apply for plans that adopted multiple collective bargaining agreements).

MHPAEA: Increased Cost Exemption

Increased Cost Exemption

If both of these criteria apply, then the health plan will be exempt under MHPAEA:

- Plan changes have been made to comply, resulting in increased costs of **at least 2% in the first plan year that MHPAEA applied** to the health plan, **and**
- Compliance with MHPAEA will result in **increased costs of at least 1% in subsequent plan years**

Application

If a plan incurs a 2% or 1% increase in costs due to MHPAEA compliance adjustments, the plan is exempt from the typical MHPAEA requirements in the plan year following the year the increased costs were incurred. Essentially, the exemption only lasts for a one-year period after each applicable increase in cost, and the plan must comply again each year to benefit from the MHPAEA exemption.

Other Plan Compliance Rules

- Requires written certification by qualified and licensed actuary
- Notice must be provided to applicable governmental agencies (e.g., DOL), participants and beneficiaries (typically, via the SPD for ERISA plans) that the plan does not provide benefits for MH/SUD that are at least equivalent to the predominant level of M/S benefits
- Health plans must retain reports and related documentation for six years after notification

(ACA Implementation FAQs Part 17)

MHPAEA: The Rule

General Parity Requirements

“A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.”

(Treas. Reg. §54.9812-1(c)(2)(i))

MHPAEA: Financial Requirements and Treatment Limitations

MHPAEA

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

GENERAL RULE: Plans must provide parity in both the financial requirements and quantitative treatment limitations between medical/surgical benefits and mental health/substance use disorder benefits in the same classification

Financial Requirements

Examples:
Deductibles, co-pays, co-insurance, MOOPs

Note: MH/SUD and M/S cost sharing must both count towards a combined deductible, MOOP

Quantitative Treatment Limitations

Examples:
Number of treatments, visits, or days of coverage

Note: Visit cap applies to both MH/SUD and M/S benefits

MHPAEA

NO SEPARATE CUMULATIVE FINANCIAL LIMITATIONS FOR M/S VS. MH/SUD

MH/SUD must accumulate towards the same cumulative financial requirements under the rules

A health plan cannot have two separate financial cumulative amounts (Deductible or MOOP) for M/S and MH/SUD

Example: A plan has both M/S items and services and MH/SUD items and services for a plan participant's out-of- pocket expenses for a plan year they accumulate towards the same $1,500 deductible and $5,000 MOOP under the plan.

The plan is considered compliant because the MH/SUD and the M/S out-of-pocket expenses accumulate towards the same $1,500 deductible under the plan (rather than the MH/SUD benefits accumulating towards a $1,500 deductible that is separate than the accumulation towards the M/S $1,500 deductible).

MHPAEA: Terms and Definitions

Terms and Definitions

Term	Definition
Classification	In-patient In-network, In-patient out-of-network, Out-patient in-network, Out-patient out-of-network, Emergency care, Prescription drug formularies
More Restrictive	Are the financial requirements or treatment limitations placed on MH/SUD benefits greater than those imposed on M/S benefits?
Type	Comparison of the exact same restriction/financial requirement within the classification (e.g., copayment of in-network out-patient MH/SUD benefit as compared only to copayment of in-network out-patient M/S, annual visit limits on MH/SUD as compared to annual visit limits on M/S benefits)
Substantially All	Applies to at least 2/3 of all medical surgical benefits in the classification, based on a dollar amount of all payments for the M/S benefits in the classification. Cannot be applied to book of business, however if plan-level claims data is not credible, qualified actuary may utilize reasonable claims data from outside structured products/plans to make an actuarial projection.
Predominant	MH/SUD benefits cannot be more restrictive than the predominant financial requirement/treatment limitation applied to M/S benefits. Predominant means the most common/frequent occurrence for such financial requirement/treatment limitation.

MHPAEA: Classifications

MHPAEA: Permitted Classifications

Inpatient, In-Network

Outpatient, In-Network

Emergency Care

Inpatient, Out-of- Network

Outpatient, Out-of-Network

Prescription Drug Formularies

MHPAEA: Classification Rule

Classifications of benefits used for applying rules:

In addition, MHPAEA requires that if the plan covers mental health or substance abuse treatment in any classification, the plan must provide coverage in every/all category classification(s) that medical/surgical benefits are also provided.

"If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided."

Exception: Group health plans or issuers that provide coverage for mental health or substance use disorder benefits only to the extent required to comply with the ACA's preventive care mandate (under PHSA §2713) are not required to provide additional mental health or substance use disorder benefits in any classification in accordance with the mental health parity rules.

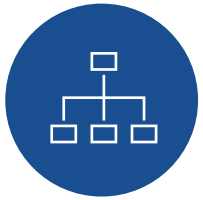
(Treas. Reg. §54.9812-1(c)(2)(ii))

MHPAEA: Subclassifications

ARE THERE ANY "SUBCLASSIFICATIONS" ALLOWED UNDER THE PLAN?

Office Visits

Final regulations provide that office visits may be a separate subclassification from all other outpatient services



Multiple Tiers for Network Providers

If a plan has multiple tiers for network providers, subclassifications can be created provided:

- Network tiering is based on reasonable factors (e.g., quality, performance and market standards)
- Without regard to whether a provider provides medical/surgical or mental health/substance use disorder services.
- A special rule applies if there are an uneven number of tiers between MH/SUD and M/S providers

MHPAEA

NO GENERALIST VS. SPECIALIST SUBCLASSIFICATION

Cannot Subclassify Generalists vs. Specialists

Generally, there can be no financial requirement/treatment limitation associated with a Generalist vs. Specialist (e.g., Psychotherapist) subclassification for MH/SUD benefits

Could occur IF – The predominant level of a type of financial requirement (e.g., copay) applies to "substantially all" M/S benefits in a classification is the one charged for a M/S specialist, then the specialist financial requirement may apply to all MH/SUD within that classification

Cannot occur IF – The predominant level of a type of financial requirement (e.g., copay) is charged for a M/S generalist, then the financial requirements for MH/SUD benefits (in the classification) cannot be greater than the M/S generalist financial requirement.

MHPAEA: Substantially All and Predominant Level

MHPAEA

APPLICATION OF THE “SUBSTANTIALLY ALL" AND “PREDOMINANT LEVEL" TESTS

Tests Based Upon Spending Associated within a Health Plan

Generally, this is based upon the expected "dollar amount of all plan payments for the M/S benefits in the classification" that will be" paid under the plan for the plan year."

Health Plan Expenses – These tests are based solely upon the health plan of the plan sponsor, and typically cannot be based upon the overall book of business to be paid for the year, or even on local/regional book of business

If Health Plan does not have Credible Data – A plan sponsor may utilize a qualified actuary that uses reasonable claims data from other comparable/similarly situated products/plans to draw a conclusion for an actuarily sound projection for those plan payments for the plan year.

MHPAEA: Substantially All

For purposes of financial requirements and quantitative treatment limitations (QTLs), "substantially all" means that the limitation *"applies to at least two-thirds of all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification."*

(Treas. Reg. 54.9812-1(c)(3)(i)(A))

MHPAEA: Substantially All Test

WHAT HAPPENS AFTER APPLYING THE "SUBSTANTIALLY ALL" TEST?

Does not satisfy "substantially all" test

The financial requirement/treatment limitation cannot apply to MH/SUD benefit

Satisfies the "substantially all" test

Go on to the "predominant benefits" test

MHPAEA: Predominant Test

IF PLAN SPONSOR PASSES THE "SUBSTANTIALLY ALL" TEST, WHAT HAPPENS NEXT WITH THE "PREDOMINANT TEST”?

Predominant Test

The application of the financial requirement/treatment limitation to MH/SUD in the classification (or subclassification) cannot be more restrictive than the "predominant" financial requirement/treatment limitation that applies to M/S benefits

Comparison of Predominant Level(s) vs. Substantially All

Once the "type" of restriction/limit that is permitted is understood (substantially all test), then we discuss how much the plan will actually cover/level of treatment is covered under the health plan (predominant benefits test)

Definitions

Predominant:

"(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to ***more than one-half of medical/surgical benefits in that classification*** *subject to the financial requirement or quantitative treatment limitation.*

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)"

MHPAEA: Predominant Level Test

HOW TO APPROACH THE "PREDOMINANT LEVEL" TEST?

Predominant Test: Single Level

If there is only a single level of requirement/limitation that applies to more than 50% of the M/S benefits, then this one level is considered the "predominant level."

Predominant Test: Multiple Levels

If no single level applies to more than 50% of M/S benefits subject to limit/requirement, then health plan can combine levels until the level applies to more than 50% limit/requirement within the classification (Aggregate rule), and the least restrictive level in the combined levels is considered the "predominant level."

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EXAMPLES – SINGLE PREDOMINANT LEVEL TEST

Examples of the single "predominant levels" of benefits test:

If a plan has two different levels of copayments - $20 (PCP), $40 (Specialist)

- 60% of all in-network copayments are projected to be for primary care, subject to a $20 copay, and 40% of in-network copayments are projected to be for specialty visits.
- Office visits (OV) constitute 80% of all outpatient, in-network services.
- The PCP copay constitutes the predominant level if:
  - The OV copay applies to substantially all benefits for in-network outpatient care, and
  - More than 50% of copayments for office visits (60%) apply to the PCP network.

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EXAMPLES OF "AGGREGATE RULE" FOR PREDOMINANT LEVEL TEST

When doing an analysis of the "predominant levels" of benefits and the “aggregate rule”:

If a plan has THREE different levels of copayments $20 (PCP) Preferred Network, $40 (PCP) Standard Network, $60 Specialist

- 30% of all in-network copayments are projected to be for preferred network primary care, subject to a $20 copay, 40% of in-network standard PCP copayments ($40) and 30% are projected to be for specialty visits.
- Office visits constitute 80% of all outpatient, in-network services.
- The rule permits aggregation of the two highest network copay tiering levels ($20 and $40)
  - The Standard PCP OV copay ($40) is the least restrictive cost-sharing level for in-network outpatient care and would be considered the predominant level because no single tier is attributable to more than 50%

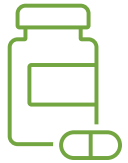
MHPAEA: Special Rules

WHAT ARE SOME SPECIAL RULES UNDER THE "PREDOMINANT LEVEL" TEST?

Units of Coverage

If there are different plan requirements/limits that apply to different tiers (employee, employee+) then analysis must be done on each unit of coverage.

Example: Different deductible limits for single vs. family coverage.



Multi-tier Rx Benefits

If different $$ requirements are applied to different tiers of Rx drugs, then plan satisfies the parity requirements, so long as:

- The different tiers are based on certain reasonable factors (e.g., generic/non-generic, cost, mail order, efficacy); and
- The Rx drug is generally prescribed to a patient, regardless of whether the Rx drug is used for M/S or MH/SUD

MHPAEA

EXAMPLES OF MULTI-TIERED RX COVERAGE UNDER THE PREDOMINANT LEVEL TEST

Multi-tiered Rx Coverage under the "predominant levels" of benefits test:

A plan applies the same financial requirements for use of a prescription drug benefit in both the M/S and MH/SUD environment. In addition to that, any drug tiers (generic, preferred/non-preferred brand name, and specialty) all comply with the non-quantitative treatment limitation (NQTL) rules.

- This Rx drug program would satisfy the "predominant level" test, along with passing the parity requirements under the rules.

NQTL COMPARATIVE ANALYSIS REQUIREMENT

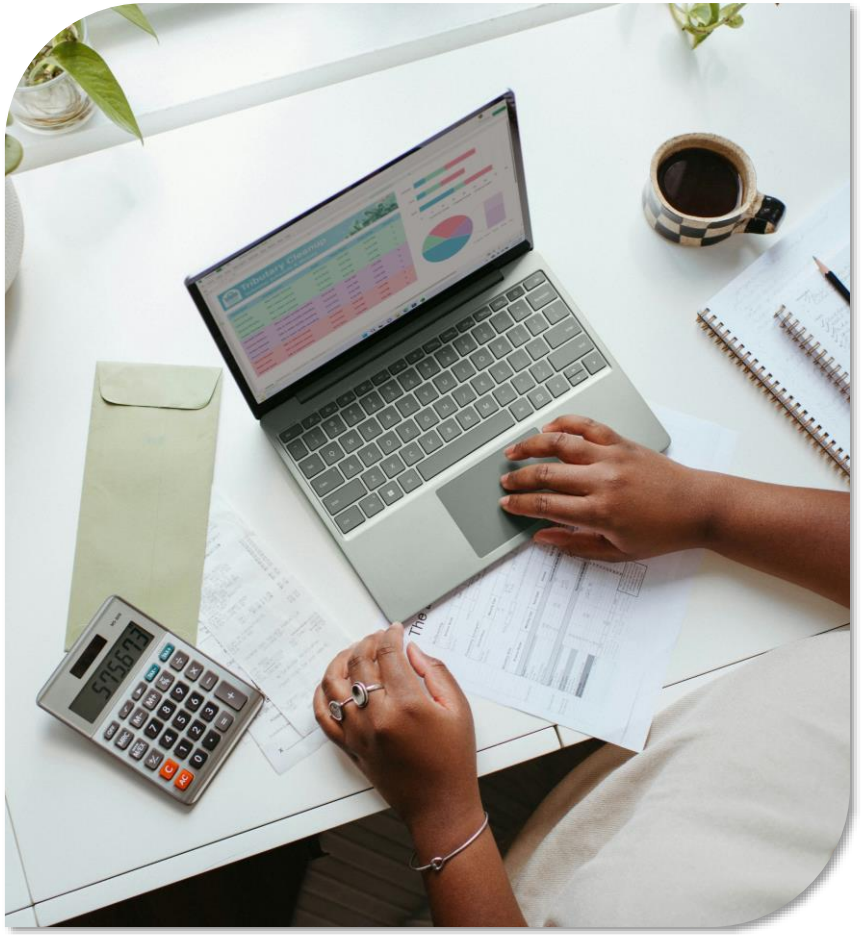
Non-Quantitative Treatment Limitations

GENERAL RULE: Plans must also provide parity with respect to non-quantitative treatment limitations between medical/surgical benefits and mental health/substance use disorder benefits in the same classification

Non-Quantitative Treatment Limitations

Examples:

Medical management standards, prescription drug formulary design, prior authorizations



NQTL Comparative Analysis Requirement

Comparative analyses under Consolidated Appropriations Act (CAA):

Beginning February 10, 2021, health plans and issuers that provide coverage for both MH/SUD and M/S services must collect and evaluate data demonstrating the plan's compliance with MHPAEA's requirements

Plans and issuers "must make their comparative analyses available to the Departments or applicable State authorities, upon request" and include:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits in each respective benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and
5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

NQTL Comparative Analysis Requirement

Comparative analyses under Consolidated Appropriations Act (CAA):

Must include nine specific elements along with supporting documentation:

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. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

NQTL Comparative Analysis Requirement

Comparative analyses under Consolidated Appropriations Act (CAA):

6. If the application of the NQTL requires specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, 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.

(FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45)

NQTL Comparative Analysis Requirement

Comparative analyses under Consolidated Appropriations Act (CAA):

- Relevance of supporting documents must be clearly explained
- The US Dept. of Labor has released a mental health parity self-compliance tool that can assist with the evaluation process, but completion of this tool does not constitute a compliant NQTL analysis
- Analysis must be retained and provided to participants, beneficiaries and state or federal agencies upon request
  - » Health plans currently have 45 days to respond a Department request for the Comparative Analysis and documentation
  - » Proposed 2023 regulations shorten this to 10 business days

NQTL Comparative Analysis Requirement

Comparative analyses under Consolidated Appropriations Act (CAA):

- If the secretary determines that insufficient information has been submitted, the additional information requested by the secretary must be provided within 10 business days (or an additional time period as specified) after the additional required information is requested

- If the secretary makes an initial determination that the plan is not in compliance, a detailed corrective action plan must be provided along with additional comparative analyses no later than 45 calendar days after the initial determination of noncompliance

- In the case of a final determination of noncompliance, within 7 calendar days from receipt of the final determination, the plan or issuer must:
  - » Provide notice of the final determination of noncompliance to all participants and beneficiaries, and
  - » Provide a copy of the notice to the Secretary, any service provider involved in the claims process, and any fiduciary responsible for deciding benefit claims

Compliance Steps

1. Group health plan sponsors should determine whether the plan is subject to MHPAEA, or if exemptions may apply under the cost basis or because the plan constitutes an excepted benefit.

2. Determine whether a comparative analysis has been completed by the insurer or service provider (such as a third-party administrator), that will be made available to the plan sponsor if a request for the comparative analysis is received.

3. Review financial and quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs) to ensure the plan design does not contain any restrictions or limitations on MH/SUD that are more restrictive than the restrictions or limitations applicable to M/S benefits. (A self-compliance tool to assist with this review is available on the DOL website.)

4. Collect the necessary claims and procedural data to conduct the NQTL analysis. Cooperation of carriers/TPAs is necessary. Data collection and analyses may be outsourced to a third-party service provider.

5. Consider corrective plan adjustments if the analysis identifies areas where QTLs or NQTLs may be more restrictive for MH/SUD benefits than apply to M/S benefits.

6. Complete and retain the analysis and provide it to the DOL, state agencies and beneficiaries upon request.

Plan sponsors should consult with their employee benefits attorney for specific advice on how to comply with MHPAEA.

MHPAEA: Proposed Rules

Proposed Rules

Technical Release 2023-01P

- Set forth proposed parameters for data necessary to complete nonquantitative treatment limitations (NQTL) analyses relative to network composition, evaluation of access to behavioral health care providers and network adequacy, and demonstration of compliance in the plan's operation

- Soliciting comments (deadline was 10/2/2023) "to inform:
  - » Future guidance on the type, form, and manner of data…; and
  - » Standards for relevant data…and a potential enforcement safe harbor."

Final regulations not yet released

Proposed Rules

Proposed Rules on the Requirement Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)

- Issued 8/3/2023
- Requires that plans and states must apply a “generally recognized” standard for determining which items and services are considered MH/SUD
  - Examples: American Psychiatric Assn. Diagnostic and Statistical Manual of Mental Disorders (DSM), International Classification of Disease (ICD) or state guidelines according to the parity toolkit
- Proposed new regulations implementing the NQTL comparative analyses requirements
  - Amend existing standards to require plans and issuers to collect and evaluate outcomes data and take action to ensure there are no material differences in access to network providers based on composition of network standards
  - Establish content requirements for comparative analyses, including evaluation of network composition, out-of-network reimbursement rates and prior authorization NQTLs
  - Specify rules on how they must be made available to the Departments
  - Proposes amendments to implement sunset provisions for opt-out elections by self-funded, non-federal governmental plans
  - Solicited public comments on ways to improve MH/SUD benefits through other provisions of federal law (deadline 10/2/2023)

Final regulations not yet released

(88 FR 51552)

MHPAEA: Enforcement

DOL and CMS Enforcement Priorities

AS IDENTIFIED IN JULY 2023 MHPAEA COMPARATIVE ANALYSIS REPORT TO CONGRESS

DOL Enforcement Priorities:

1. Plan requirements for prior authorizations related to in-network and out-of-network inpatient services
2. Concurrent care review for in-network and out-of-network inpatient services
3. Provider admission standards to participate in a network, including reimbursement rates
4. Reimbursement rates for out-of-network services (reasonable, usual and customary
5. Updated list of prohibited exclusions for key MH/SUD treatments
6. Updated standards for network adequacy

CMS Enforcement Priorities:

1. Prior authorization as a treatment limitation applicable to inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network benefit classifications
2. Concurrent review treatment limitations for outpatient in and out-of-network benefit classifications
3. Updated guidance on specific treatment exclusions for certain prescription drug classifications related to certain health conditions

Enforcement Activities

July 2023 MHPAEA Comparative Analysis Report to Congress

- Presented by Secretaries of Labor, Health & Human Services and Treasury
- Demonstrated enforcement activity by the Departments since February 2021:

Date(s)	Agency	Requests	# of NQTLS	Investigations	Findings
2/2021-7/2022	DOL (EBSA)	182	450+	102	• 138 insufficiency letters issued for over 290 NQTLs • 22 initial determinations letters identifying 26 NQTL violations • 3 final determination letters finding ERISA violations
2/2021-9/2022	CMS	26	44		• 35 insufficiency letters issued for over 23 NQTLs • 15 initial determinations letters identifying 15 NQTL violations • 5 final determination letters finding 7 MHPAEA violations • 13 cases of insufficient comparative analyses

Prospective Plan Change Examples

104 plans agreed to make prospective changes to their plans, affecting benefits of 4 million + participants and beneficiaries between 2/2021 and 7/2022.

Overall changes made to plans from these corrective action plans include:

- A health plan that covers over 22,000 participants removed an exclusion for opioid treatment programs (OTPs) for opioid use disorder.
- A health plan added direct access to MH/SUD benefits (rather than having an EAP act as the gatekeeper to MH/SUD benefits) for over 4,000 participants in a health plan.
- A service provider removed a non-compliant exclusion of applied behavior analysis (ABA) therapy for treating autism spectrum disorder (ASD), affecting approximately 1,000 plans covering over 1 million participants.
- A continued stay and discharge requirement that only applied to MH/SUD benefits for inpatient, out-of-network services was removed from an issuer's policy.
- Two issuers chose to adopt an annual comparative analysis of NQTLs to help ensure their NQTL policies are updated and reviewed yearly.

Resources

Resources

Resource	Website
Mental Health Parity Act of 1996	https://www.govinfo.gov/content/pkg/PLAW-104publ204/pdf/PLAW-104publ204.pdf#page=72
Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008	https://www.govinfo.gov/content/pkg/BILLS-110hr1424enr/pdf/BILLS-110hr1424enr.pdf#page=117
21st Century Cures Act	https://www.congress.gov/114/plaws/publ255/PLAW-114publ255.pdf
Consolidated Appropriations Act (CAA) February 2021	https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
Proposed Rules on the Requirement Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)	https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act
Technical Release 2023-01P	https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/23-01
MHPAEA Comparative Analysis Report to Congress	https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf
Mental Health and Substance Use Disorder Parity Web Page	https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45	https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
MHPAEA Self-Compliance Tool	https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

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