



Non-Federal Governmental Plans and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)



*Center for Consumer Information
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Please note: Due to time constraints, we may not be able to answer all questions posed during today's session either in writing, or during the live Q&A portion. However, CMS will review all questions and provide responses accordingly.

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Introduction

CMS is committed to providing Non-Federal Governmental Plan (Non-Fed Plan) sponsors the resources, support, technical assistance, and information they need to ensure their Plans are fully compliant with applicable federal requirements.

The purpose of this presentation is to:

- provide an overview of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- discuss how MHPAEA applies to Non-Fed Plans;
- provide information related to MHPAEA enforcement; and
- introduce MHPAEA resources and compliance tools.

Roadmap

- Overview and General Parity Requirements
- Applicability of MHPAEA to Non-Fed Plans
- MHPAEA Analysis: Lifetime & Annual Dollar Limits
- MHPAEA Analysis: Financial Requirements and Quantitative Treatment Limitations
- MHPAEA Analysis: Non-Quantitative Treatment Limitations
- MHPAEA Analysis: Disclosure Requirements
- Enforcement of MHPAEA
- Compliance Tools and Resources

MHPAEA: Overview & Important Dates

- MHPAEA, codified in statute at 42 U.S.C. § 300gg-26, is a federal law that generally prohibits group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing more stringent benefit limitations on those benefits than on medical and surgical (Med/Surg) benefits.
 - MHPAEA amended section 2705 of the Public Health Service Act (PHS Act), later re-designated section 2726 by the Affordable Care Act (ACA).
 - Regulations pertaining to MHPAEA are codified at 45 C.F.R. § 146.136.
 - Changes made by MHPAEA generally became effective for plan years beginning after October 3, 2009.
 - The MHPAEA Final Rule implementing the statute was published on November 13, 2013 (78 FR 68240).
 - The Final Rule became applicable to group health plans and health insurance issuers for plan years beginning on or after July 1, 2014.

General Parity Requirements: Overview

- A group health plan or health insurance issuer offering health insurance coverage in the group or individual market (that is not otherwise exempt) must ensure that parity requirements are met in the coverage of MH/SUD and Med/Surg benefits with respect to the following areas:
 - Annual and Lifetime Dollar Limits (*but see* PHS Act section 2711);
 - Financial Requirements; and
 - Treatment limitations, including:
 - Quantitative Treatment Limitations (QTLs);
 - Non-Quantitative Treatment Limitations (NQTLs).

Market Reforms (ACA & HIPAA) Non-Federal Governmental Plan Provisions, PHS Act section 2711, pages 22-23. 2016. See Compliance Tool slide for URL.

General Parity Requirements: Applicability

- MHPAEA **DOES NOT** mandate that Non-Fed Plans provide MH/SUD benefits.
- However, under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the regulations, MH/SUD benefits must be provided in every classification in which Med/Surg benefits are provided.

***Note:** Under MHPAEA regulations, a non-grandfathered Non-Fed Plan that provides MH/SUD benefits only to the extent required under PHS Act section 2713 (preventive services without cost-sharing) is NOT required to provide additional MH/SUD benefits in any classification.*

Self-Compliance Tool for MHPAEA, Department of Labor, 2, 4 (see Compliance Tool slide for URL); 45 C.F.R. § 146.136(c)(2)(ii)(A); 45 C.F.R. § 146.136(e)(3)(i), (ii).

General Parity Requirements: Applicability (continued)

Which Non-Fed Plans are NOT subject to MHPAEA?

- MHPAEA applies generally to grandfathered and non-grandfathered Non-Fed Plans that offer MH/SUD and Med/Surg benefits *with the following exemptions*:
 - Small Employer Exemption: Non-Fed Plans sponsored by employers with 50 or fewer employees.
 - Excepted Benefit Exemption: Non-Fed Plans offering only excepted benefits (e.g., dental-only or vision-only coverage) are exempt from MHPAEA.
 - Retiree-Only Non-Fed Plans*
 - Increased Cost Exemption: Non-Fed Plans that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. Standards and procedures for claiming this exemption may be found at 45 C.F.R. § 146.136(g).

*See 78 FR 68239 at 68251 (November 13, 2013). Also see 75 FR at 34538, 34540 (June 17, 2010).

The Mental Health Parity and Addiction Equity Act, CCIIO website (see resources for URL); 45 C.F.R. § 146.136(g).

General Parity Requirements: Interaction with EHB and 2707 of the PHS Act

- Section 2707(a) of the PHS Act, as added by the ACA, generally requires issuers offering coverage in the individual and small group markets to cover essential health benefits (EHB), including MH/SUD benefits.
 - Final rules implementing EHB requirements specify that MH/SUD EHB must be offered consistent with the requirements under MHPAEA.
 - **HOWEVER**, section 2707(a) of the PHS Act and its implementing regulations are not applicable to grandfathered plans, self-funded plans, or fully-insured large group market plans. Such plans are not **required** to offer MH/SUD EHB, **but if they do, they must comply with MHPAEA's parity requirements.**

Self-Compliance Tool for MHPAEA, 2; section 2707(a) of the PHS Act; 45 C.F.R. § 156.115(a)(3).

General Requirements: Who Must Comply?

Does MHPAEA Apply to the Plan?

- Non-Fed Plan is not required to and does NOT offer MH/SUD benefits → **MHPAEA does not apply.**
 - Plan is self-funded and is defined as a small employer plan (employer has 50 or fewer employees) → **EXEMPT**;
 - Plan incurs at least one (1) percent increase in cost in years since complying with MHPAEA (two [2] percent in the case of the first plan year in which this section is applied to the plan or coverage) and meets requirements for the increased cost exemption → **EXEMPT** for the applicable plan year.

General Requirements: Who Must Comply? (continued)

Does MHPAEA Apply to the Plan? (continued)

- Non-Fed Plan DOES offer MH/SUD benefits AND:
 - Plan is fully-insured and is defined as a small employer plan (employer has 50 or fewer employees) – subject to EHB rules and therefore subject to MHPAEA.

Key Terms to Remember

- **Classification of Benefits:** six (6) classifications of benefit types into which Med/Surg and MH/SUD benefits must be grouped in order to determine whether the benefits are offered in accordance with parity requirements. The law also permits certain limited sub-classifications (45 C.F.R. § 146.136(c)(2)(ii)(A)(1)-(6)).
- **Coverage Unit:** the groups into which plans (or health insurance coverage) aggregate members for purposes of determining benefits, premiums, or contributions. Different coverage units might include self-only, family, and employee-plus-spouse. (45 C.F.R. § 146.136(c)(1)(iv)).
- **Non-Quantitative Treatment Limitation (NQTL):** generally, a limitation on the scope or duration of benefits for treatment that is not expressed numerically (45 C.F.R. § 146.136(c)(4)(i),(ii)).
- **Predominant:** If a type of QTL or financial requirement applies to “substantially all” Med/Surg benefits in a classification, the level of the QTL or financial requirement is predominant if it applies to more than half of all Med/Surg benefits in the classification subject to that type of QTL or financial requirement (45 C.F.R. § 146.136(c)(3)(i)(A)).

Key Terms to Remember (continued)

- **Quantitative Treatment Limitation (QTL):** A limitation on the scope or duration of benefits for treatment that is expressed numerically. Different types of QTLs include annual, episode, and lifetime day and visit limits (45 C.F.R. § 146.136(c)(1)(ii)).
- **Substantially All:** A type of financial requirement or QTL is considered to apply to “substantially all” Med/Surg benefits if it applies to at least 2/3 of benefits in a classification (45 C.F.R. § 146.136(c)(3)(i)(B)).
- **Type of Financial Requirement:** Different types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. (45 C.F.R. § 146.136(c)(1)(ii)).

Self-Compliance Tool for MHPAEA.

MHPAEA Analysis: Overview of Questions

- **Question 1:** How does the Non-Fed Plan categorize its Med/Surg and MH/SUD benefits using the following classifications?
- **Question 2:** Does the Non-Fed Plan comply with parity requirements in lifetime & annual dollar limits?
- **Question 3:** Does the Non-Fed Plan comply with parity requirements in financial requirements and QTLs?
- **Question 4:** Does the Non-Fed Plan comply with parity requirements for cumulative financial requirements or cumulative QTLs?
- **Question 5:** Does the Non-Fed Plan comply with parity requirements for NQTLs?
- **Question 6:** Does the Non-Fed Plan comply with MHPAEA disclosure requirements?

MHPAEA Analysis: Classification of Benefits

QUESTION 1: How does the Non-Fed Plan categorize its Med/Surg and MH/SUD benefits using the following classifications (in 45 C.F.R. § 146.136(c)(2)(ii)(A)(1)(6))?

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

In determining the classification to which a benefit belongs, the Plan must apply the same standards for classifying MH/SUD benefits as for Med/Surg benefits. If a Non-Fed Plan offers MH/SUD benefits in any classification of benefits, it must offer MH/SUD benefits in every classification in which Med/Surg benefits are provided.

45 C.F.R. § 146.136(c)(2)(ii)(A)(1)-(6)

Sub-classifications and Intermediate-Level Services

In addition to classifying benefits, Non-Fed Plans:

- May sub-classify **outpatient services, i.e., in-network and out-of-network** classifications into office visits and all other outpatient services.
- Must classify intermediate-level services (e.g., skilled nursing and residential treatment) consistently between Med/Surg benefits and MH/SUD benefits and place them in the same classification for both.
- Must not use any sub-classifications not explicitly permitted under the final rules (such as classifying services as provided by generalists vs. specialists).

45 C.F.R. § 146.136(c)(2)(iii).

Special Rule for Multiple Network Tiers

- If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to Med/Surg or MH/SUD benefits.
- After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all Med/Surg benefits in the tier.

45 C.F.R. § 146.136(c)(3)(iii)(B); Self-compliance Tool for MHPAEA, 7.

Special Rule for Prescription Drug Benefits

Multi-tiered drug formularies typically involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the different levels of financial requirements must be based on reasonable factors determined in accordance with rules for NQTLs and without regard to whether a drug is generally prescribed for Med/Surg or MH/SUD benefits.

- Reasonable factors include:

- cost
- efficacy
- generic vs. brand name
- mail order vs. pharmacy pick up

45 C.F.R. § 146.136(c)(3)(iii)(A); Self-compliance Tool for MHPAEA, 6.

MHPAEA Analysis: Parity in Lifetime & Annual Dollar Limits

QUESTION 2: Does the Non-Fed Plan comply with parity requirements for lifetime & annual dollar limits?

“If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.”

Generally, a Non-Fed plan may not impose a lifetime or annual dollar limit on MH/SUD benefits that is lower than the dollar limit on Med/Surg benefits. If no aggregate limit is applied to Med/Surg benefits (or one applies to less than 1/3 of Med/Surg benefits), no limit may be applied to MH/SUD benefits.

Note: Under PHS Act section 2711, no lifetime or annual dollar limit may be applied to benefits that are EHB, including MH/SUD benefits that are EHB.

45 C.F.R. § 146.136(b)(2).

MHPAEA Analysis: Parity in Lifetime & Annual Dollar Limits (continued)

Application of the ACA Prohibition on Lifetime & Annual Dollar Limits (section 2711 of the PHS Act): the MHPAEA requirements only apply to MH/SUD benefits that are not EHB.

- The prohibition on lifetime & annual dollar limits on EHBs DOES APPLY to Non-Fed Plans. If the MH/SUD benefit is an EHB, it may not have lifetime or annual dollar limits.
- The parity requirements for lifetime & annual dollar limits apply only to the provision of MH/SUD benefits that are not EHB.
- The rule for cumulative QTLs and financial requirements, which do not include aggregate lifetime or annual dollar limits, is different and will be discussed in the next section concerning financial requirements/QTLs.

45 C.F.R. § 146.136(b)(2); section 2711 of the PHS Act; Self-compliance Tool for MHPAEA, 8.

Financial Requirements and QTLs: General Rule

QUESTION 3: Does the Non-Fed Plan comply with parity requirements for financial requirements and QTLs?

146.136(c)(2)(i): Parity requirements with respect to financial requirements and treatment limitations: GENERAL RULE–

“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.” *(emphasis added)*

45 C.F.R. § 146.136(c)(2)(i).

MHPAEA Analysis: “Substantially All” and Predominant Tests

Breaking it down:

“**Substantially all**”: A type of **financial requirement** or **QTL** is considered to apply to substantially all Med/Surg benefits in a classification of benefits if it applies to at least 2/3 of all Med/Surg benefits in that classification.

- If a type of financial requirement or QTL *does not apply* to substantially all (at least 2/3 of) Med/Surg benefits in a classification, then the financial requirement or QTL of that type **cannot be applied** to MH/SUD benefits in that classification.
 - Types of Financial Requirements include: copayments, coinsurance, deductibles, and out of pocket maximums.
 - Types of QTLs include: annual and lifetime day limits and visit limits, cumulative limits other than annual or lifetime dollar limits including limits on the number of treatments, visits, or days of coverage.

45 C.F.R. § 146.136(c)(2)(i); 45 C.F.R. § 146.136(c)(1)(ii), (3)(i); Self-Compliance Tool for MHPAEA, 8.

MHPAEA Analysis: “Substantially All” and Predominant Tests (continued)

- The portion of Med/Surg benefits in a classification of benefits subject to a financial requirement or QTL is determined *based on the dollar amount of all plan payments* for Med/Surg benefits in the classification expected to be paid under the Non-Fed Plan for the plan year.
- **Any reasonable method** may be used to determine the dollar amount expected to be paid under a plan for Med/Surg benefits subject to a financial requirement or QTL.

45 C.F.R. § 146.136(c)(1)(i); Tri-Agency FAQ 34, 7 (for a further discussion of what constitutes a “reasonable method”), see Resources slide for URL; Self-Compliance Tool for MHPAEA, 10.

Example— Applying the “Substantially All” Test

Step 1: First determine whether a particular type of financial requirement or QTL applies to substantially all Med/Surg benefits in the relevant classification of benefits.

Example: The Gladville Fire Department’s self-funded Non-Fed plan applies copayments to some of its outpatient, in-network Med/Surg benefits, including physician office visits, and coinsurance to others, such as physical therapy and occupational therapy. The plan in this example does not subclassify the outpatient classification into office visits and all other outpatient items and services. What type of financial requirement can the plan apply to outpatient, in-network MH/SUD benefits (plan participants are not grouped into coverage units)?

- Applying the “Substantially All” Test: using a reasonable method, plan administrators project plan payments for Med/Surg benefits in this classification to be \$50 million.
 - The plan projects plan payments for benefits subject to a copay to be \$40 million for the classification.
 - Because \$40 million is greater than 2/3 of \$50 million, the 2/3 threshold for the substantially all standard is met for copayment as a type of financial requirement.
 - **Therefore, a copayment may be applied to outpatient, in-network MH/SUD benefits under MHPAEA.**

MHPAEA Analysis: “Substantially All” and Predominant Tests

Breaking it down, continued:

Predominant: If a type of financial requirement or QTL does apply to at least 2/3 of (“substantially all”) Med/Surg benefits in a classification, the predominant level of that financial requirement or QTL is the level that applies to *more than ½ of the Med/Surg benefits within the classification* subject to the financial requirement or QTL.

If a Non-Fed Plan applies different levels of a financial requirement or QTL to different coverage units in a classification of Med/Surg benefits, the predominant level that applies to substantially all Med/Surg benefits is determined separately for each coverage unit.

45 C.F.R. § 146.136(c)(3)(i)(B)(1); 45 C.F.R. § 146.136(c)(3)(ii); *Self-Compliance Tool for MHPAEA*, 9-10.

Example– Applying the Predominant Test

Step 2 – Next, determine what level of financial requirement or QTL is predominant; in other words: the level that applies to more than half the Med/Surg benefits in the relevant classification subject to the financial requirement or QTL.

Example: The Gladville Fire Department plan includes a \$35 copay for visits to a specialist, like a cardiologist, under the Med/Surg outpatient, in-network classification. The copay for primary care physician office visits within the same classification is \$20. Which level of copayment may be applied to the MH/SUD benefits in the same classification?

- Applying the “Predominant” Test: using the same reasonable method as in the “Substantially All” Test, the plan projects plan costs of \$25 million for the specialist visit benefits, to which the \$35 copay applies and \$15 million for the primary care physician benefit, to which the \$20 copay applies.
 - The \$35 copay is the predominant copay because it applies to more than half of the Med/Surg benefits subject to a copay.
 - The plan may impose any level of copay for outpatient, in-network MH/SUD benefits that is **no more restrictive (not higher) than the \$35 copay.**

“Substantially All” and Predominant Tests: Threshold Requirements

- Clarification of certain threshold requirements when doing “substantially all” and “predominant” tests:
 - **Deductible:** the dollar amount of the plan payments includes all plan payments with respect to claims that would be subject to the deductible if it had not been satisfied.
 - **Out-of-pocket maximum:** the dollar amount of plan payments includes all plan payments associated with out-of-pocket payments that are taken into account towards the out-of-pocket maximum as well as all plan payments associated with out-of-pocket payments that would have been made towards the out-of-pocket maximum if it had not been satisfied.
 - **Two-thirds minimum:** if a type of financial requirement or QTL does not apply to at least 2/3 of Med/Surg benefits in a classification, it may not be applied to MH/SUD benefits in that classification.
 - **Over one-half minimum:** if no individual level of financial requirement or QTL applies to more than half the Med/Surg benefits in a classification subject to the financial requirement or QTL, plans may combine the most restrictive levels first until the combination meets the over one-half threshold. In such cases, the least restrictive level within the combination is the predominant level.

45 C.F.R. § 146.136 (c)(3)(i)(A), (B)(2), (D)

Example– Combining Financial Requirements and QTLs

Example: The Pleasant City municipal health plan includes a copayment on its physician office visits. Based on a reasonable method, the plan projects it will pay \$40 million for visits subject to a copay out of \$50 million for all Med/Surg benefits in the outpatient, in-network classification, confirming that the copay applies to substantially all Med/Surg benefits in the classification. The plan in this example does not subclassify the outpatient, in-network classification into office visits and all other outpatient items and services.

Based on a reasonable method, the plan projects that its four copayment levels of \$5, \$10, \$15, and \$25 (within a single coverage unit), will apply to payments of \$10 million, \$15 million, \$5 million, and \$10 million respectively. Individually none meets the over one-half threshold. What level of copayment may the plan apply to MH/SUD benefits in the outpatient, In-network classification?

- The plan may combine copay levels to meet the over one-half threshold.
 - If the plan combines the \$25 copay (\$10 million projected payments), the \$15 copay (\$5 million projected payments), and the \$10 copay (\$15 million projected payments) levels for a total of \$30 million, it will meet the over one-half threshold (\$30 million/\$40 million).
 - The least restrictive level, \$10, is the predominant level: **the plan can charge a copay up to \$10.**
 - Alternatively, the plan may treat the least restrictive level of financial requirement or QTL applied to the Med/Surg benefit in the classification as the predominant level: **based on this analysis, the plan could charge a copay of up to \$5.**

45 C.F.R. § 146.136 (c)(3)(i)(B)(2), Example 2; Self-Compliance Tool for MHPAEA, 8.

Financial Requirements and Quantitative Treatment Limitations

QUESTION 4: Does the Non-Fed Plan comply with parity requirements for cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for MH/SUD benefits in a classification that accumulates separately from any established for Med/Surg benefits in the same classification.

Example: A plan may not establish a \$250 deductible for MH/SUD benefits in a classification, and a separate \$250 deductible for Med/Surg benefits in the same classification. A \$500 combined deductible for all Med/Surg and MH/SUD benefits would comply with the rule above.

- Note: As noted on slide 21, different rules apply to aggregate lifetime and annual dollar limits. MHPAEA excludes lifetime and annual dollar limits from the definition of “financial requirement.”

45 C.F.R. § 146.136 (c)(3)(v)(A), 45 C.F.R. § 146.136 (c)(3)(v)(B) Examples 1, 2.

MHPAEA Analysis: Non-Quantitative Treatment Limitations (NQTLs)

QUESTION 5: Does the Non-Fed Plan comply with parity requirements for NQTLs?

45 C.F.R. § 146.136(c)(4)(i): General rule—

“A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.”

45 C.F.R. § 146.136 (c)(4)(i).

MHPAEA Analysis: Identifying NQTLs

Step 1: Identify the NQTL(s) and all MH/SUD and Med/Surg benefits to which it (or they) applies.

A non-exhaustive list of NQTLs includes:

- Medical management standards that limit/exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Refusal to pay for higher-cost therapies until it can be shown a lower-cost therapy is not effective, also known as fail-first policies or step therapy protocols;
- Exclusions based on failure to complete a course of treatment;
- Coverage restrictions based on geographical location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services.

Additional information may be found here: “Warning Signs: Plan or Policy Non-Quantitative Treatment Limitations that Require Additional Analysis to Determine MHPAEA Compliance.” (see Resource slide 44 for URL)

45 C.F.R. § 146.136(c)(4)(ii)(A)-(G)

NQTLs and Factors Considered in Design

Step 2: Identify the factors considered in the design of the NQTL. Factors considered may include (but are not limited to):

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with a high percentage of fraud;
- Current and projected demand for services.

Self-Compliance Tool for MHPAEA, 14.

NQTLs and Sources Considered in Design

Step 3: Identify the sources used to define the factors identified to design the NQTL (including any processes, strategies, evidentiary standards, or other factors used).

Non-Fed Plans should be ready to provide:

- A list of the NQTLs that apply to MH/SUD and/or Med/Surg benefits offered under the plan or coverage.
- Records documenting NQTL processes and how the NQTLs are being applied to both Med/Surg as well as MH/SUD benefits to ensure they can demonstrate compliance with the law.
- All appropriate documentation including any guidelines or other standards that the plan or issuer relied upon as the basis for its compliance with the parity requirements for NQTLs.
- For the period of coverage under review, a record of all claims (MH/SUD and Med/Surg) submitted and the number of those denied within each classification of benefits.

Tri-Agency FAQ 31, Self-Compliance Tool for MHPAEA, 16-20 (contains links to reports summarizing MHPAEA enforcement actions by EBSA (DOL) and CCIIO (CMS) for reference).

MHPAEA Analysis: Application of NQTLs

Step 4: are the processes, strategies, evidentiary standards, and other factors used by the Non-Fed Plan in applying the NQTL comparable and no more stringently applied to the MH/SUD benefits than to the Med/Surg benefits both as written and in operation?

Plans and issuers should be ready to demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL for MH/SUD services and Med/Surg services are comparable.

Tri-Agency FAQ 31, Self-Compliance Tool for MHPAEA, 16.

MHPAEA Analysis: Application of NQTLs (continued)

Examples of methods and analyses substantiating comparable factors, strategies, and evidentiary standards between MH/SUD and Med/Surg benefits:

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and Med/Surg benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and Med/Surg conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and Med/Surg benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and Med/Surg benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and Med/Surg benefits were the same, both as developed and applied.

Self-Compliance Tool for MHPAEA, 17 (contains additional compliance tips).

Disclosure Requirements

Question 6: Does the Non-Fed Plan comply with the MHPAEA disclosure requirements?

- The Non-Fed Plan sponsor must make available the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider upon request.
- The Non-Fed Plan sponsor must make available the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee.
- The Non-Fed Plan sponsor who provides the reason for the denial in a form and manner consistent with the requirements of 29 CFR 2560.503-1 (the DOL claims procedure rules for group health plans) complies with the requirements for disclosure of the reason for denial (45 C.F.R. § 146.136(d)(2)).

*Self-Compliance Tool for MHPAEA, 21-22; (45 C.F.R. § 146.136(d)(1),(2),(3); 45 C.F.R. § 147.136(b); 29 CFR 2560.503-1; PHS Act section 2719; *2018 maximum penalty amount; see: 42 C.F.R. § 102.3.*

Disclosure Requirements (continued)

Compliance with disclosure requirements in 45 C.F.R. § 146.136(d) is not determinative of compliance with other provisions of state or federal law, including the internal claims and appeals and external review processes regulations (45 C.F.R. § 147.136).

- The internal claims and appeals rules include the right of claimants (or their authorized representative) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
 - This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to Med/Surg benefits and MH/SUD benefits under the plan.
- If a Non-Fed plan sponsor fails to provide these documents, it may be liable for up to \$177* a day from the date of failure to provide these documents.

**2023 maximum penalty amount.*

Self-Compliance Tool for MHPAEA, 21-22; (45 C.F.R. § 146.136(d)(1),(2),(3); 45 C.F.R. § 147.136(b); 29 CFR 2560.503-1; PHS Act section 2719; see: 42 C.F.R. § 102.3.

Template for Disclosure Requirements

- The Departments of HHS, Labor, and Treasury have issued a model disclosure request form that enrollees may use to request information about MH/SUD treatment limitations from a plan or issuer.
 - The model forms may be found here:
www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf
 - www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf

Who Enforces MHPAEA?

CMS has direct enforcement authority with respect to Non-Fed Plans and the provisions of Title XXVII of the PHS Act that apply to them, including MHPAEA (see: 45 C.F.R. § 150.101(b)(1)):

- CMS investigates Non-Fed Plans that are not otherwise exempt when it receives information indicating potential non-compliance. (see: 45 C.F.R. § 150.303 *et seq.*)
- CMS also has the authority to initiate a market conduct examination to determine whether a Non-Fed Plan is out of compliance with MHPAEA. (see: 45 C.F.R. § 150.313)
- CMS partners with State Department of Insurance (DOI's) with respect to fully-insured Non-Fed Plans: the DOI typically has primary authority over the issuer and CMS has primary authority over the Non-Fed Plan.*

**CMS also has primary authority with respect to health insurance issuers selling products in the individual and fully-insured group markets in states that elect not to enforce or fail to substantially enforce MHPAEA, including TX, and WY. 45 C.F.R. § 150.101(b)(1), 45 C.F.R. § 150.303 et seq., 45 C.F.R. § 150.313.*

Sunset of – HIPAA Opt-Out Elections for MHPAEA

- The Consolidated Appropriations Act, 2023 (CAA), Sec. 1321 amends Public Health Service Act Section 2722(a)(2) by adding a sunset provision to the HIPAA opt-out election framework that ends the ability of self-funded non-fed plans to newly elect or renew an existing election to opt-out of MHPAEA.
- This provision provides that “(I) no election described in subparagraph (A) *{references section 2722(a)(2) of the Public Health Service Act (PHS Act) – 42 U.S.C. 300gg-21(a)(2)}* with respect to section 2726 may be made on or after the date of the enactment of this subparagraph; and (II) except as provided in clause (ii), no such election with respect to section 2726 expiring on or after the date that is 180 days after the date of such enactment may be renewed.

Sunset of – HIPAA Opt-Out Elections for MHPAEA (continued)

- Clause (ii) states “Exception for certain collectively bargained plans. – Notwithstanding clause (i)(II), a plan described in subparagraph (B)(ii) that is subject to multiple agreements described in such subparagraph of varying lengths and that has an election described in subparagraph (A) with respect to section 2726 in effect as of the date of the enactment of this subparagraph that expires on or after the date that is 180 days after the date of such enactment may extend such election until the date on which the term of the last agreement expires.”

Sunset of - HIPAA Opt-Out Elections for MHPAEA (continued)

What this means for Plans:

- No new HIPAA opt-out elections for MHPAEA on or after December 29, 2022.
- No renewal of HIPAA opt-out elections for MHPAEA expiring on or after June 27, 2023.
- Special rule for certain Collective Bargaining Agreement (CBA) plans: Plans subject to CBA of varying lengths with a HIPAA opt-out election for MHPAEA that expires on or after June 27, 2023 may extend such election until the date on which the term of the last such agreement expires.

42 U.S.C. § 300gg-21(a)(2)

Compliance Tools

- 2018 MHPAEA Self-Compliance Tool:
<https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>
- Warning Signs: Plan or Policy NQTLs that Require Additional Analysis to Determine MHPAEA Compliance: <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>
- MHPAEA Draft Disclosure Form Template:
<https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf>

Resources

- **CCIIO MHPAEA website:** https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
- **Non-Fed Team website on CMS.gov:** <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html>
- **The Final Parity Rule:** <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>
- **FAQs on the Tri-Departmental Implementation of MHPAEA:** <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/understanding-implementation-of-mhpaea.pdf#page=3>
- **Tri-Agency ACA Implementation FAQ 45:** <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>
- **Tri-Agency ACA Implementation FAQ 31:** <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>
- **Tri-Agency ACA Implementation FAQ 34:** <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>

Resources (continued)

- **List of active HIPAA Opt-Out elections:** <https://www.cms.gov/ccio/Resources/forms-reports-and-other-resources/index.html#Self-Funded%20Non-Federal%20Governmental%20Plans>
- **HHS MHPAEA Enforcement Report (December 2017):** <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf>
- **HHS MHPAEA Enforcement Report (Fiscal Year 2018):** <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/FY2018-MHPAEA-Enforcement-Report.pdf>
- **2022 Mental Health Parity and Addiction Equity Act Report to Congress:** <https://www.hhs.gov/about/news/2022/01/25/us-dol-hhs-treasury-issue-2022-mental-health-parity-addiction-equity-act-report-to-congress.html>
- **Mailbox for questions regarding Non-Fed Plans:** NonFed@cms.hhs.gov
- **Mailbox for questions regarding MHPAEA requirement compliance:** MHPAEA_Enforcement@cms.hhs.gov
- **Mailbox for questions, complaints, and concerns regarding HIPAA Opt-Out:** HIPAAOptOut@cms.hhs.gov

How to Contact us Directly

Non-Federal Governmental Plan Team Email Resource:
NonFed@cms.hhs.gov



Questions & Answers



Closing Remarks