advo CAT series

theolsongroup Benefits Team

Self-Compliance FAQ

Mental Health Parity and Addiction Equity Act (MHPAEA) Self Compliance Tool for Group Health Plans

The Mental Health Parity and Addiction Equity Act (MHPAEA) was first signed into law in 2008. This act aimed to reduce the disparity around benefits for mental health illnesses and substance disorders. This law states that the limitations on treatment for mental health illnesses and substance disorders must be similar to the limitations placed on medical and surgical benefits.

Recently, the U.S. Department of Labor, Health and Human Services, and the Treasury under the 21st Century Cures Act, created a self-compliance tool for employers who offer the benefits as a resource in order to help make sure they are in compliance. This resource outlines a few different areas and provides tips on how to stay compliant.

Below is a brief FAQ to help guide employers in understanding this new self-compliance tool. Remember, this guide should not be substituted for legal advice, and employers should also make sure to view state regulations to make sure to comply with those rules as well.

Question 1: Is the group health plan exempt from MHPAEA?

Not all employers are subject to MHPAEA. Here are a few reasons why an employer could be exempt from MHPAEA requirements:

- If they offer a retiree-only group health plan
- Self-insured, non-federal governmental plans
- Individual health insurance coverage offering only excepted benefits
- Small employers: Employers who have between 2 and 50 employees are not subject to MHPAEA requirements

Question 2: If not exempt from MHPAEA, does the group health provide Mental Health/Substance Use Disorder benefits in addition to providing medical/surgical benefits?

If not exempt and Mental Health/Substance Use Disorder (MH/SUD) benefits are provided, continue to question 3.

Question 3: Does the group health plan provide Mental Health/Substance Use Disorder benefits in every classification in which medical/surgical benefits are provided?

Classifying Benefits

The standards must be the same for both medical/surgical benefits and MH/SUD when determining classification. Mental health and substance abuse disorder benefits have to be provided for every classification just like medical/surgical benefits offered.

For reference here is a breakdown of the classifications:

1. Inpatient, in-network
2. Inpatient, out-of-network
3. Outpatient, in-network
4. Outpatient, out-of-network

5. Emergency care
6. Prescription drugs

Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications.

Question 4: Does the group health plan comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

A plan generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.

If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits.

Compliance Tip

There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in Question 6. A plan/issuer may impose an annual out-of-pocket dollar limit on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

Question 5: Does the group health plan comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

A plan may not impose a financial requirement or Quantitative Treatment Limit (QTL) applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification.

Types of financial requirements:

- Deductibles
- Copayments
- Coinsurance
- Out-of-pocket maximums

Step One: "Substantially All" Test

First, determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.

Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. Any reasonable method can be used for this calculation.

Step Two: "Predominant" Test

A plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Note

The six classifications and the sub-classifications outlined in Question 3 above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. A plan may not use a separate sub-classification under these classifications for generalists and specialists.

Compliance Tip

Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.

A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification.

Question 6: Does the group health plan comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

A plan may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements).

Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Question 7: Does the group health plan comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

A Non-Quantitative Treatment Limit (NQTL) is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan from imposing NQTLs on MH/SUD benefits in any classification.

However, they may do so *only* under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

Question 8: Does the group health plan comply with the MHPAEA disclosure requirements?

The plan administrator or health insurance issuer must make available the criteria for medical necessity determinations made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider upon request.

With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, medical necessity criteria for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided within 30 days of the request to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant.

If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents.

To view the whole compliance tool, please click below: [Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)]

To stay up to date with all things compliance please visit https://theolsongroup.com/hr-consulting/