



ABHW

ISSUE BRIEF

Mental Health Parity and Addiction Equity

Background

In October 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), P.L. 110-343, was signed into law. MHPAEA requires group health plans and health insurance issuers that provide mental health and/or substance use disorder (MH/SUD) benefits to provide coverage that is comparable to general medical and surgical care. 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). MHPAEA and its accompanying regulations require parity for financial (e.g., copayments), quantitative treatment (e.g., visit limits) and nonquantitative treatment limits (NQTs) (e.g., preauthorization requirements), as well as out-of-network benefits. MHPAEA also includes requirements related to information disclosure.

Since 2008, federal agencies have issued approximately a dozen sub-regulatory guidance documents and Congress has passed two additional laws that include parity provisions. The 2016 21st Century Cures Act directed the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury to issue a compliance program guide to provide guidance on how a plan or issuer may comply with the law, which the DOL did by creating a Self-Compliance Tool (Tool). In December 2020, the Consolidated Appropriations Act, 2021 (CAA) passed placing additional new reporting requirements for MH and SUD parity compliance. These laws are in

addition to recommendations from the National Association of Insurance Commissioners and multiple state laws that have their own unique parity compliance requirements.

Since its inception, ABHW has been an active supporter of equitable coverage of mental health and addiction treatment. ABHW has worked closely with DOL, HHS, and Treasury to ensure that its member companies understand the intent of the regulations to properly implement MHPAEA. ABHW member companies have teams of people from multiple departments in both physical and behavioral health working diligently on the required parity analyses so that they can provide a parity benefit to consumers.

Parity has progressed since its adoption in a meaningful way and access to MH and SUD treatment providers has greatly expanded – though systemic issues continue to be a challenge due to other non-parity factors such as the looming shortage of physicians, including psychiatrists, and other providers. Examples of key changes since the parity law and regulations were enacted include: the fact that routine MH outpatient treatment no longer habitually requires prior authorization or has explicit quantitative treatment limits; evidence-based levels of care for MH conditions are no longer subject to blanket exclusions (e.g., residential treatment for eating disorders); and transparency, documentation, attention to medical necessity criteria all have improved.

Recommendations

Despite the parity language in the 21st Century Cures Act and the CAA, aspects of the law and regulations remain overly complex and technical. As a result, compliance has become a moving target through a patchwork of conflicting and changing guidance. We support the flexibility built into the law, yet we have seen the proliferation of different compliance approaches, tools, and interpretations, which has led to confusion and is costly for stakeholders.

ABHW remains an active supporter of 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 still 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.
- Develop and implement uniform MHPAEA 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. Unequivocally state that MHPAEA does not require a specific process, strategy, evidentiary standard, or other factors 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 issues that create challenges in network adequacy and out-of-network usage.