Consolidated Appropriations Act, 2021

Part 4

Mental Health and Substance Use Disorder Benefits Parity

3-Minute Read

The Consolidated Appropriation Act, 2021 (Appropriations Act) signed into law on December 27, 2020, includes several provisions requiring that group health plans and health insurance insurers provide comparative analysis regarding utilization and compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the MHPAEA), with the goal of monitoring and improving access to mental health and substance use disorder benefits. The MHPAEA is a federal law that generally prevents group health plans and group and individual health insurance issuers that provide mental health and substance use disorder benefits from imposing less favorable benefit limitations on those benefits than imposed on major medical coverage. The rules reflect Congress' intent to have such benefits treated in the same manner as major medical benefits in regard to coverage and limitations. The MHPAEA generally applies to most group health plans and group health insurance coverage. Please also see our Advisors Part 1, Part 2, and Part 3 on the Appropriations Act for an overview of provisions affecting group health plans and group health insurance coverage outside of the MHPAEA.

Parity in Mental Health and Substance Use Disorder Benefits

The Appropriations Act amends the Public Health Service Act (PHSA), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC) to require that group health plans or health insurance issuers offering group or individual health insurance coverage perform and document comparative analysis of the design and application of nonquantitative treatment limitations (NQTLs) on mental health and substance use disorder benefits. The comparative analysis obligation only applies if the health coverage provides both medical and surgical benefits and imposes NQTLs on mental health and substance use disorder benefits.

On February 10, 2021 (that is, within 45 days of enactment of the Act), plans and issuers must make the comparative analysis and additional requested information available to the applicable state authority, the

Department of Labor (DOL), or Department of Health and Human Services (HHS) upon request. The information required to be disclosed includes the following information.

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each of the following six classifications: (i) inpatient in-network services, (ii) inpatient out-of-network services, (iii) outpatient in-network services, (iv) outpatient out-of-network services, (v) emergency care services, and (vi) prescription drugs.
2. The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
3. The evidentiary standards used for the six factors noted above, when applicable, provided that every factor must be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder 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 mental health or substance use disorder 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 or surgical benefits in the benefits classifications.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the comparative analyses that indicate that the plan or coverage is or is not in compliance with the NQTL requirements.

If HHS determines that a plan or issuer is not in compliance with the NQTL requirements based on its review of the requested comparative analyses, the plan or issuer must disclose to HHS the action the plan or issuer will take to become compliant and provide additional comparative analyses that demonstrate compliance with the NQTL requirements not later than 45 days after the initial determination by HHS that the plan or issuer is not in compliance. If the plan or issuer is still determined to not be in compliance with the NQTL requirements following the 45-day period, HHS will notify all individuals enrolled in the plan or insurance coverage that it has been determined to be not in compliance.

Not later than June 27, 2022, HHS will finalize draft or interim guidance and regulations relating to the MHPAEA's NQTL requirements as amended by the Appropriations Act.

The Appropriations Act provides that the DOL, HHS, and the Treasury will issue a compliance program guidance document to assist plans and issuers in complying with the NQTL requirements as they have been amended. The Appropriations Act further instructs the DOL, HHS, and the Treasury to issue additional guidance for plans and issuers regarding compliance with the NQTL requirements.

1/25/2021