

New FAQs for the Mental Health Parity and Addiction Equity Act

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The federal Departments of Labor (**DOL**), Health and Human Services, and the Treasury have jointly issued a set of proposed frequently asked questions (**FAQs**) which address nonquantitative treatment limitations (**NQTLs**) and health plan disclosure issues under the Mental Health Parity and Addiction Equity Act of 2008 (**MHPAEA**). Generally, the MHPAEA prohibits group health plans and issuers from imposing financial requirements or treatment limitations on **mental health benefits** and **substance use disorder benefits** (collectively, **MH/SUD Benefits**) that are more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits (collectively, **Med/Surg Benefits**). With respect to NQTLs, which include medical management, step therapy, and pre-authorization (versus **quantitative treatment limitations**, which are numerical, such as visit limits and day limits), a group health plan cannot impose an NQTL on MH/SUD Benefits in any classification unless, under the terms of the plan *as written and in operation*, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD Benefits in the classification are comparable to, and are applied no more stringently than, those which are used in applying the limitation with respect to Med/Surg Benefits in the same classification. The FAQs address whether particular plan designs are NQTLs and, if so, whether such plan designs are compliant with the MHPAEA. For example, the FAQs clarify that an exclusion of all benefits for a particular condition or disorder is not an NQTL and does not violate the MHPAEA. On the other hand, the FAQs (i) confirm that step-therapy protocols and plan or coverage restrictions based on facility type are NQTLs and (ii) outline certain fact situations in which such NQTLs are applied in a manner that does not comply with the MHPAEA. The FAQs also discuss other MHPAEA topics, such as provider reimbursement rates and the scope of benefits provided for emergency room care. The FAQs include questions related to disclosure requirements for MH/SUD Benefits under ERISA. These FAQs confirm that ERISA-covered plans using provider networks are permitted to provide a hyperlink or URL address in enrollment or plan summary materials for accessing a directory of MH/SUD network providers and related information, and clarify that such directory must be up-to-date, accurate, and complete. The DOL published its **2018 Report to Congress** regarding MHPAEA implementation and enforcement concurrently with the FAQs. That report states that MHPAEA continues to be an agency priority and, in fact, MHPAEA enforcement has been designated a national initiative for fiscal year 2018. A violation of the MHPAEA could result in substantial liability for employer sponsors of group health plans. Therefore, plan sponsors should take the necessary steps now to ensure that their group health plans, both in written terms and in operation, are meeting MHPAEA's complex requirements. [View the FAQs](#). [View the DOL's 2018 Report to Congress](#).