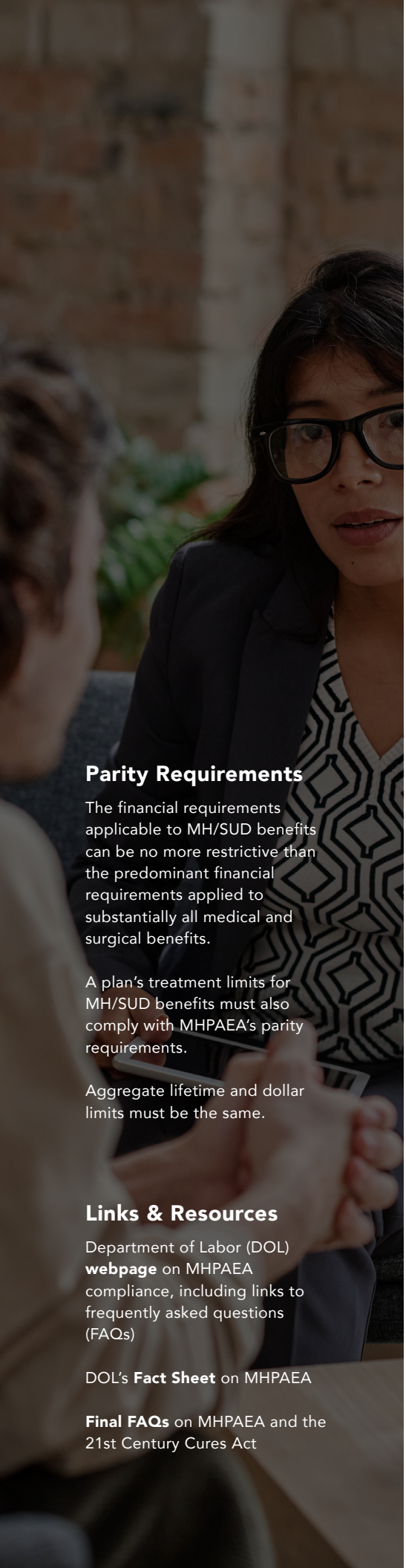

Mental Health **Parity** Compliance Overview & FAQs

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan's medical and surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. In general, if a health plan provides MH/SUD benefits, MHPAEA requires the plan to:

- Offer the same access to care and patient costs for MH/SUD benefits as those that apply to medical/surgical benefits;
- Treat MH/SUD coverage and medical/surgical coverage equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review; and
- Contain a single combined deductible for MH/SUD coverage and medical/surgical coverage.

Action Items

Talk with your Cottingham & Butler service team to help you understand:

- Your TPA/PBM's role in assisting your plan meet its mental health parity obligations.
- Risks associated with your current plan design.
- Potential consequences for failure to comply.

The following is a brief FAQ about how self-funded plans can maintain compliance and be prepared in the event of a Department of Labor (DOL) audit.

Parity Requirements

The financial requirements applicable to MH/SUD benefits can be no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.

A plan's treatment limits for MH/SUD benefits must also comply with MHPAEA's parity requirements.

Aggregate lifetime and dollar limits must be the same.

Links & Resources

Department of Labor (DOL) **webpage** on MHPAEA compliance, including links to frequently asked questions (FAQs)

DOL's **Fact Sheet** on MHPAEA

Final FAQs on MHPAEA and the 21st Century Cures Act

MHPAEA—General Compliance FAQs

Q1: What health plans must comply with the Mental Health Parity rules?

Essentially, every plan. Fully-insured insurance policies and self-funded group health plans must comply. Retiree-only plans, self-funded non-federal governmental health plans who have affirmatively elected to be exempt from MPHAEA and self-funded plans sponsored by employers with fewer than 50 employees are exempt.

Q2: What is required of plans to prove that they are compliant?

The Consolidated Appropriations Act of 2021 (CAA) requires that plan sponsors perform a detailed and ongoing, "comparative analysis" of the nonquantitative treatment limitations (NQTLs) used for medical/surgical benefits as compared to MH/SUD benefits. This comparative analysis must be made available upon request to applicable federal agencies (mostly, the DOL) beginning February 10, 2021.

Q3: What's the enforcement look like?

The DOL, recognizing that most plans haven't even started performing a comparative analysis of their NQTLs, is actively enforcing parity by requesting comparative analysis reports from plan sponsors. Mostly, the DOL wants to ensure that carriers, TPAs and PBMs are operating in compliance. However, their regulatory authority of these companies is limited and is instead auditing the actual employer-sponsored health plan through the power of ERISA. In fact, by law, the DOL must review compliance from a sampling of group health plans every year and must require those plans to take corrective action when noncompliance is found. After their first year of audits, the DOL released a report to Congress in January of 2022 indicating that zero of the 156 audit request letters sent to self-funded plans and insurance companies produced a satisfactory response.

Q4: What is an NQTL?

If we think of a quantitative requirement, it means the plan has something that can be easily numerically measured in place, such as a copay or doctor visit limit. Nonquantitative treatment limitation (NQTLs) are processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Certain utilization reviews, prior authorization and plan provisions may only be applied to mental health/substance use disorder benefits if they are comparable to or less restrictive than those for medical surgical services. While there is a numerical and actuarial component to analyzing this data, NQTLs are less obvious and driven by the results of processes and claims adjudication. Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity, medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review).
- Formulary design for prescription drugs.
- Exclusions based on failure to complete a course of treatment.
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage. It is important to note that the NQTL provisions referred to above are not prohibited outright; but are prohibited if they are applied more stringently to mental health/substance use disorder benefits than to medical surgical benefits.

Q5: Are there any "red flags" to watch for that might be written in the plan document which could signal noncompliance with mental health parity rules?

Just like the examples of NQTLs above, including the following limitations doesn't mean the plan is out of compliance; however, if the plan is applying one of following example limitations only to mental health/substance abuse services, the comparative analysis may not turn out favorably:

- Preauthorization and pre-service notification requirements
- Fail-first protocols
- Probability of improvement conditions
- Written treatment plan requirements
- EAP gatekeeper conditions

Q6: Who is responsible for producing a comparative analysis report?

If the plan is fully-insured, the insurance carrier shares the responsibility with the employer plan sponsor and in most cases will provide the comparative analysis report.

If the plan is self-insured, the employer plan sponsor is responsible. However, the plan sponsor must ultimately rely on its vendor partner(s) (third-party administrators, pharmacy benefit managers, etc.) to either conduct the comparative analysis itself or produce the data for a specialty vendor to use to generate the report.

Q8: What are the consequences for a plan or its employer sponsor for failing to comply with the comparative analysis requirement?

If, upon review of the comparative analysis, the DOL finds that a plan is out of compliance with MHPAEA, corrective actions will be specified for the plan to come into compliance. If the plan is still not in compliance after 45 days of the DOL issuing a corrective action directive, the plan must notify all individuals enrolled in the non-compliant plan within seven days.

While unlikely, it's also possible for the DOL or a court to assess a fine to the plan under ERISA for "failure to provide requested documentation."

The most significant risk is that of litigation, including a class-action lawsuit. Civil action against the plan can occur when a plan denies medical care or prescriptions for mental health/substance abuse disorders in a manner inconsistent with parity laws. Because a participant may request comparative analysis, and because plaintiff's attorneys are a savvy and opportunistic bunch, it becomes much easier to prove a plan is acting discriminatory if the plan didn't even comply with the comparative analysis portion of mental health parity rules.

Q9: How often does a plan have to do this?

First, it's advisable to conduct initial comparative analysis. Then, the best practice is to complete the comparative analysis on an annual basis. But if there are not any significant plan changes or changes to TPA processes, it's reasonable to expect the original comparative analysis to remain relevant.