May 2023

Table of Contents

Introduction to Mental Health Parity Rules

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans offering mental health (MH) or substance abuse (SA) benefits to provide such benefits "in parity" with (i.e., equal to or better than) the medical/surgical coverage available under the group health plan. The MHPAEA does not require group health plans to provide MH or SA benefits, but if they do offer such benefits beyond what is considered preventive under the Affordable Care Act (ACA), the parity requirements apply.

Group Health Plans Subject to Requirements

The MHPAEA applies to group health plans, but not excepted benefits (such dental or vision-only coverage) or retiree-only plans. The rules apply to both fully-insured and self-funded plans, and there is no exception for church plans. There is an exception for small employers (generally <50 employees) offering grandmothered, grandfathered or level-funded/self-funded plans, but most small employers with fully-insured plans will need to comply with the MHPAEA – see more on that aspect below. Originally, there was an option for non-federal government entities offering a self-funded plan to opt-out of MHPAEA, but this opt-out alternative was removed by legislation passed late in 2022.

For purposes of compliance with the parity rules, the term "group health plan" includes not only a major medical plan offering, but other benefits providing MH or SA benefits, as well. For example, telehealth benefits, carve-out prescription drug benefits, and employee assistance programs (EAPs) not qualifying as excepted benefits are subject to the law. If an employer or organization has multiple arrangements by which it provides health care benefits and any participant can simultaneously receive coverage for medical/surgical benefits and MH or SA benefits, such combination of arrangements is treated as a single group health plan subject to the parity requirements.

Most employers (especially smaller employers) who sponsor fully-insured plans will have very little control over the detailed structure of the MH and SA benefits provided in their plan. Carriers selling fully-insured group health plans are responsible under the law for structuring their plans to be in compliance with these regulations. However, employers sponsoring self-funded plans generally have more flexibility to determine their plan's design, and therefore must carefully consider the parity rules when applying financial, quantitative, or non-quantitative treatment limits on MH or SA benefits covered by the plan. Employers offering self-funded plans often need to rely on their third-party administrators (TPAs) for compliance assistance.

Small Employer Exception

Small employers are generally exempt from the MHPAEA. For this purpose, a small employer is defined as an employer who employed not more than 50 employees on business days during the previous calendar year. Non-federal governmental employers with fewer than 100 employees are also exempt. However, the ACA includes

MH and SA benefits as an essential health benefit for fully-insured small employers, and employers subject to the ACA essential health benefit rules are required to provide these benefits in a manner that meets the MHPAEA parity rules. Consequently, due to the ACA essential health benefit requirement, fully-insured employers who offer coverage through the small employer group health insurance market will generally be required to offer MH and SA benefits in parity with other benefits offered under their plan.

Significant Increase in Cost

Employers who experienced an increased cost attributable to the MH/SA benefits of at least 2% in the first year MH and SA benefits were offered, or any subsequent year's cost increase of 1% or more, may be able to avoid the MHPAEA requirements for one year. Reliance on this cost-based exemption is very rare. To take advantage of this exemption, an employer/plan sponsor must follow detailed financial analysis rules defined in the regulations and have their compliance certified by an actuary. Furthermore, the cost exception applies for only one plan year. If the plan continues to offer MH and SA benefits, it will need to return to meeting the parity rules for the next plan year after taking advantage of the exemption.

General Parity Rules

If a group health plan provides medical/surgical benefits and MH or SA benefits beyond preventive care as required by the ACA, the plan's MH or SA benefits are subject to the following parity requirements (as compared to the plan's medical/surgical benefits):

- Same or more generous annual/lifetime limits;
- Equal financial requirements and quantitative treatment limitations; and
- Equal treatment for non-quantitative treatment limitations.

The definitions of medical/surgical, MH, and SA benefits for this purpose are not necessarily uniform, but they are generally defined under the terms of the plan in accordance with applicable federal and state law. Such definitions must be defined to be consistent with commonly recognized independent standards of current medical practice.

For any MH and SA benefits provided by the plan, the parity rules must be followed, but FAQ guidance from the agencies indicates that an exclusion of all benefits for a particular condition or disorder would be permitted. However, such exclusions may run afoul of other statutory requirements (e.g., state insurance mandates, Americans with Disabilities Act prohibitions on discriminating against disabilities, ACA §1557 nondiscrimination rules).

Annual & Lifetime Limits

In general, under the MHPAEA, a group health plan may impose lifetime or annual maximum limits on MH/SA benefits only if the group health plan imposes lifetime or annual limits on more than one-third (1/3) of all medical/surgical benefits. The ACA prohibits lifetime or annual dollar limits for any essential health benefits covered by a group health plan. Many MH/SA benefits are essential health benefits as set forth in the applicable state benchmark plan, in which case the plan cannot impose a lifetime or annual dollar limit on such benefits under the ACA rules. In addition, even for MH/SA benefits that may not be essential health benefits, it is unlikely that a plan will impose lifetime or annual limits on enough medical/surgical benefits to meet the one-third threshold, which would allow for such limits to apply to MH or SA benefits. Therefore, the ACA restriction on lifetime and annual maximum for essential health benefits renders the parity rule limits on lifetime or annual maximums largely irrelevant. But for very rare exceptions, a group health plan will not be able to impose lifetime or annual dollar limits on any MH or SA benefits.

Financial Requirements & Treatment Limitations

The parity of any financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations is determined on a classification-by-classification basis, as seen in the table below. Plans must provide MH or SA benefits in parity for all the following classifications in which medical/surgical benefits are available:

Inpatient, in-network	Inpatient, out-of-network
Outpatient, in-network*	Outpatient, out-of-network*
Emergency care	Prescription drugs

**Outpatient services may be sub-classified into (a) office visits and (b) all other outpatient items and services, but plans generally cannot further sub-classify generalists and specialists.*

Multiple providers for in-network tiers may be used as a further sub-classification so long as the tiering is not based on whether a provider is a provider of medical/surgical services or MH/SA services.

Additional Considerations

Tiers of Coverage

If a plan applies different financial requirements or treatment limitations to different tiers of coverage (e.g., single, family), then that financial requirement or treatment limitation must be reviewed separately for each coverage unit to determine the predominant level of that requirement or treatment limitation.

Prescription Drug Coverage

A plan is permitted to apply different financial requirements to different tiers of prescription drug benefits based on certain reasonable factors (e.g., generic versus brand name, and mail order versus pharmacy pick-up) so long as the difference is not tied to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to MH or SA benefits.

Network Requirements.

If the plan does not contract with a network of providers, all benefits are considreed out-of-network. If the plan provides coverage for out-of-network providers for medical/surgical benefits, then coverage must also be provided for out-of-network MH or SA benefits.

Cumulative Requirements and Limitations

No separate cumulative financial requirement or quantitative treatment limitation may apply to MH or SA benefits, even if the limits are equal to those imposed on medical/surgical benefits. In other words, separate but

equal is not allowed (e.g., deductibles, out-of-pocket maximums, visit limits for MH or SA that accumulate separately from those for medical/surgical benefits in the same classification are not permitted).

Intermediate Benefits

Coverage must be available for intermediate MH and SA benefits such as residential treatment, partial hospitalization, and intensive outpatient treatment in the same way that it is covered for medical/surgical benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH and SA benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH and SA services and partial hospitalization must be considered outpatient benefits as well.

Scope of Benefits

Scope of benefits has not been defined in detail, but the final regulations added that any restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration must also comply with the parity rules.

Financial Requirements & Quantitative Treatment Limitations

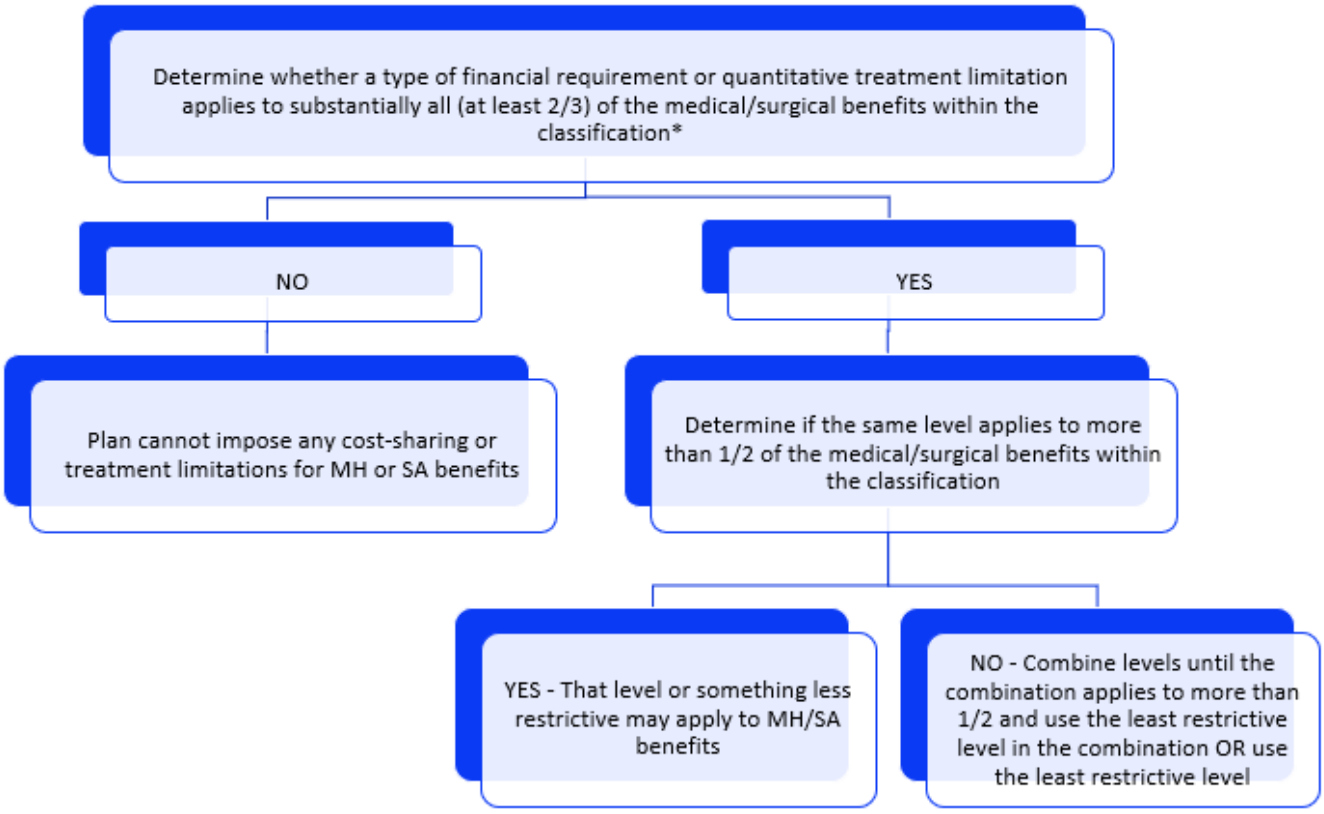
A group health plan must ensure that the financial requirements and quantitative treatment limitations are no more restrictive for MH or SA benefits than the "predominant" financial requirements and treatment limitations that apply for "substantially all", or two-thirds (2/3), of the medical/surgical benefits. For this purpose, financial requirements include deductibles, copays, coinsurance and out-of-pocket expenses, but exclude annual and lifetime limits. Quantitative treatment limitations also include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

The substantially-all test determines whether and what type of cost-sharing can apply to MH and SA benefits within a classification.

- If there is no type of cost-sharing that meets the two-thirds ("substantially all") threshold, then the plan cannot apply any cost-sharing for MH or SA benefits within that classification; all MH and SA benefits within that classification must be covered at 100%.
    - The calculation of whether a financial requirement or treatment limitation applies to at least two-thirds of the medical/surgical benefits within a classification is based on the dollar amount of plan payments expected to be paid for the plan year within the classification.
- If a type of cost-sharing meets the two-thirds threshold, then the predominance test determines the maximum level of that type of cost-sharing that can apply to MH and SA benefits within a classification or subclassification.

- The predominance test is used to determine if the same level of financial requirement or quantitative treatment limitation applies to more than one half , or fifty percent, of medical/surgical benefits within a classification. If no level does apply to more than one half of medical/surgical benefits, then levels should be combined until the combination applies to more than one half of medical/surgical benefits. Either the least restrictive level from that combination, or the least restrictive level in general, may then be applied to MH/SA benefits.

The following analysis should be performed within each classification or sub-classification:



Example 1:

For outpatient, in-network coverage other than office visits, the plan imposes a mix of copays and coinsurance for medical/surgical benefits. Neither copays nor coinsurance apply to at least two-thirds of the medical/surgical benefits within this classification (i.e., neither applies to substantially all medical/surgical benefits), therefore the plan cannot impose a copay or coinsurance on MH or SA benefits within this classification.

Example 2:

For outpatient, in-network office visits, the plan imposes a copay for at least two-thirds of the medical/surgical benefits. The copay is $25 for general office visits and $45 for specialist office visits. The $25 copay applies to more than 50 percent of the outpatient, in-network office visits, so a copay of $25 or less may apply to MH and SA benefits in this classification.

Example 3:

For outpatient, in-network office visits, the plan imposes a copay for at least two-thirds of the medical/surgical benefits. The plan applies copays of $50, $25, $15, and $10 to different in-network office visits. No single copay amount applies to at least 50 percent of the medical/surgical outpatient, in-network office visits, but a combination of copays of $50, $25, and $15 does. In this case, $15 would be the predominant level, so a copay of $15 or less may apply to MH and SA benefits in this classification. Alternatively, a copay of $10 or less could be used since $10 is the least restrictive level.

Non-Quantitative Treatment Limitations (NQTLs)

Under MHPAEA, a group health plan that provides both medical/surgical benefits and MH or SA benefits may not impose any processes, strategies, evidentiary standards or other factors used to apply NQTLs to MH or SA benefits that are any more stringent than those applied to medical/surgical benefits within a classification. In addition, the plan cannot impose any separate NQTLs that are applicable only to MH or SA benefits. Unlike the mathematical analysis used to determine compliance for financial requirements or quantitative treatment limitations, compliance for NQTLs is more nuanced and objective. Much of the less formal guidance from the agencies provided via FAQs and otherwise, as well as the comparative analysis discussed later in this summary, are focused on helping plans understand what is permitted for any NQTLs imposed on MH and SA benefits.

NQTLs are restrictions and exclusions on the scope or duration of care. For this purpose, "scope" refers to the types of treatments and treatment settings that are covered by a group health plan. Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or appropriateness, or based on whether treatment is experimental/investigative;
- Formulary design for prescription drugs;
- 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;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Network adequacy;
- Network tier design for plans with multiple network tiers (e.g., preferred versus participating providers);
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for high-cost therapy until it is shown that a lower-cost therapy is not effective (aka fail-first or step therapy policies);
- Limitations on inpatient services for situations where the participant is a threat to self or others;
- Exclusions for court-ordered and involuntary holds;
- Experimental treatment limitations; and
- Exclusions based on failure to complete a course of treatment.

Earlier regulations included an exception that allowed variation to the extent that recognized clinically appropriate standards of care permitted a difference. This exception was eliminated in the final regulations. The agencies have acknowledged that not all treatments or settings for MH and SA correspond to those for medical/surgical benefits. Therefore, until further guidance is provided, the best practice is to determine whether there is an analogous medical/benefit treatment or setting and design the plan accordingly.

The regulations require that NQTL factors, standards, and processes be in parity both "as written" and "in operation." In other words, compliant written processes and procedures do not make a plan compliant if those written processes and procedures are not actually followed. As a result, demonstrating a plan's compliance with the NQTL parity standards requires not only analysis of the plan's written terms and coverage provisions, but also of the recent MH and SA claims covered and/or denied by the plan, and the specific reasons for the plan's administrative decisions.

Required Disclosures

Plan information and claim adjudication disclosures related to MH and SA coverage are subject to existing ERISA requirements and other disclosure rules such as inclusion in an SBC. If the plan is not subject to ERISA, the reason for the claim denial must be provided upon the request of a participant or beneficiary within a reasonable time and manner.

Claims Processing

The criteria for medical necessity determinations made under the plan with respect to MH or SA benefits shall be made available by the plan administrator or carrier to any current or potential participant, beneficiary, or contracting provider upon request. In addition, the reason for any denial under the plan of reimbursement or payment for services with respect to MH or SA benefits must be made available by the plan administrator or carrier to the participant or beneficiary. This will generally be handled by the carrier for a fully-insured plan and the TPA for a self-funded plan.

Comparative Analysis Requirements

Group health plan sponsors are required to prepare a written comparative analysis documenting compliance for any non-quantitative treatment limitations (NQTLs). The analysis does not need to be submitted annually (or otherwise), but instead must completed and kept up-to-date in the employer's files and provided if requested by a federal or state agency, or by plan participants. Ideally, the analysis will be conducted and updated on an annual basis to include the plan's recent claims data.

The DOL's Self-Compliance Tool describes NQTLs and then goes on to provide a four-step process for analyzing NQTLs. Applying and documenting the four steps for each of the plan's NQTLs should generally satisfy the comparative analysis requirements. The DOL Self-Compliance Tool (must be updated every 2 years) can be found at this link.

FAQ guidance indicates the comparative analysis is required to clearly identify each NQTL and which benefits may be impacted by the NQTL. In addition, the analysis must identify any factors, evidentiary standards, strategies, and processes used to design the NQTLs and then also document how the NQTLs are actually applied. Exactly what is required will depend on the type of NQTL and the processes, strategies, evidentiary standards, and other factors used by the plan, but the FAQs make it clear that "conclusory or generalized statements without specific supporting evidence and detailed explanations, or a mere production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analyses are insufficient."

For fully-insured plans, the carrier will generally take responsibility for preparing a comparative analysis and should make the analysis available upon request. For self-funded plans, when this comparative analysis requirement initially went into effect, many TPAs were unwilling to assist because many considered the data involved propitiatory.

However, recently, it appears more TPAs have begun to generate a more general comparative analysis for their standard plan designs, though it may lack the plan-specific claim analysis that the enforcement agencies call for.

For self-funded plan sponsors who are using off-the-shelf plan designs from their TPA without making changes or adding extra coverage provisions, relying on the TPA's analysis may be adequate unless we receive direction from the agencies indicating otherwise. Self-funded plan sponsors whose benefits align with this category should ask their TPAs to supply their NQTL comparative analysis that includes an examination of their plan's unique, recent MH and SA claim history. Alternatively, for employers who are creative with the plan design, who play a role in claims processing or decisions, or who add additional coverage beyond what is covered in their TPA's analysis, it is likely necessary to hire a specialized third-party vendor to conduct and document the analysis. In those cases, and wherever the TPA is unwilling to conduct an analysis of a self-funded plan's particular claim history, it is recommended to have an analysis done independently that considers the entire group health plan offering.

Enforcement & Consequences of Non-Compliance

The Department of Labor (DOL) enforces MHPAEA among group health plans subject to ERISA, while the Centers for Medicare and Medicaid Services (CMS) and state agencies also have the authority to exercise enforcement over non-ERISA group plans and health insurers. The federal agencies under the Biden administration have publicly acknowledged that enforcement of MHPAEA is a top priority.

Over time, the focus of the agencies has changed as different compliance issues have been identified, and as others have been addressed and generally brought into compliance. For example, clarification was provided, and corrective action required, by the agencies for many plans around coverage for autism, including applied behavioral analysis (ABA) therapy; medication assisted treatment (MAT) for opioid use disorders; and eating disorders, and many plans have now made the necessary adjustments to provide such coverage in accordance with the parity rules. More recently, the agencies have indicated a desire to focus current efforts on the enforcement of: (i) prior authorization requirements for in-network and out-of-network inpatient services; (ii) concurrent review for in-network and out-of-network inpatient and outpatient services; (iii) standards for provider admission to participate in a network, including reimbursement rates; and (iv) out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

In addition to audits, the comparative analysis as required under the Consolidated Appropriations Act of 2021 provides another tool to help with enforcement. If the comparative analysis of a plan's MH/SA and medical/surgical benefits is requested by a federal or state enforcement agency, plans generally have no more than 14 days to make the written analysis available. If the analysis is found to be insufficient by that federal or state agency, the agency will suggest corrective action be taken within 45 days. If the plan fails to comply with the suggested corrective action in a timely manner, the agency will notify enrolled individuals of the non-compliance and may also include the plan in a public report along with other non-compliant plans.

Keep in mind, the purpose of the comparative analysis is to provide further visibility into whether plans are compliant with the mental health parity requirements. Whether the analysis is determined to be sufficient or not, if an agency audit determines that any financial, quantitative, or non-quantitative treatment limitations do not comply with the parity requirements, the plan may be required to take corrective action (e.g., reprocess claims and refund participants when applicable). In addition, non-compliant group plans could be subject to a penalty of up to $100/day per affected individual, and if disclosures are not available upon request, general ERISA penalties could apply (e.g., up to $110 per day that the failure persists).

Summary

For fully-insured plans, the carrier is primarily responsible for plan design, claims processing and the comparative analysis. Employers who sponsor fully-insured plans should be aware of the coverage requirements for MH and SA benefits and the disclosure requirements, but most will have little control over the MH and SA coverage provided in their plans.

For self-funded plans, the employer is primarily responsible for compliance with the MHPAEA, so employers offering self-funded plans must work carefully with their administrators and advisors to ensure that MH and SA plan coverage and claims processing comply with the parity rules. In addition, the employer is responsible for ensuring that a comparative analysis has been completed and is available if requested by either the DOL or a plan participant. TPAs typically play a large role in plan design and claim processing, and could potentially help with the comparative analysis, making it important for employers to carefully select a TPA willing to assist with compliance in this area. In many instances, the services of a specialized third-party vendor that's independent of the plan's TPA will be necessary to conduct and issue the required written comparative analysis.

For further reference, you can find the DOL's resource site concerning mental health and substance use disorder parity at this page.