COMPLIANCE ALERT

Enforcement Efforts for Mental Health Parity – New Comparative Analysis

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Quick Facts

- New rules were effective February 10, 2021, but guidance is expected to be released over the next 18 months.
- Group health plans providing mental health or substance abuse disorder benefits and imposing any non-quantitative treatment limitations on such benefits must perform and document a comparative analysis.
- Employers with fully-insured group health plans will likely be able to rely on the carrier to show compliance.
- Employers offering self-funded group health plans may want to further explore whether their plans really do meet parity requirements and coordinate with the TPA to begin preparing a comparative analysis for potential audit purposes.

Recent legislation prioritizes enforcement efforts for existing rules that require parity for group health plan coverage of mental health and substance use disorder benefits. Group health plans that provide coverage for mental health or substance use disorder benefits and are therefore subject to mental health parity rules will soon be required to prepare a comparative analysis and have it available upon request. The carrier will handle this responsibility on behalf of fully-insured group health plans, but employers offering a self-funded group health plan should coordinate with their third-party administrator (TPA) to determine compliance responsibilities for this new requirement.

Background

The Mental Health Parity and Addiction Equity Act (MHPAEA) does not require group health plans to provide mental health or substance use disorder benefits, but if a plan does offer such benefits beyond just preventive services, then parity requirements (including the new comparative analysis requirements) apply.

Small fully-insured group health plans must offer essential health benefits (EHBs), which include mental health and substance use disorder benefits, so such plans are subject to the parity rules. However, large fully-insured group health plans and all self-funded group health plans could potentially exclude any such coverage not considered to be preventive, and the rules clarify that if a plan provides only preventive coverage, then the parity rules do not apply.

For those group health plans offering mental health or substance use disorder benefits beyond what is considered preventive, the parity rules can be summarized as follows:

Any annual or lifetime limits must be the same or more generous than those applicable to medical/surgical benefits. This requirement is generally met because plans are broadly prohibited

by the ACA from placing annual or lifetime limits on EHBs, and most often mental health and substance use disorder benefits will be EHBs.

Equality of financial requirements and quantitative treatment limitations. This requirement considers financial requirements (e.g. deductibles, copays, or coinsurance) and quantitative treatment limitations (e.g. frequency of treatment, number of visits, or days of coverage) and indicates such requirements or limitations cannot be more restrictive than the predominant requirements and limitations that apply for substantially all of the medical/surgical benefits. When considering this rule, it is necessary to determine whether there is a type of financial requirement or treatment limitation that applies to at least two-thirds of the medical/surgical benefits. If yes, the predominant level of that financial requirement or treatment limitation, or something less restrictive, may apply to mental health or substance use disorder benefits. However, if there isn't a financial requirement or treatment limitation that applies to at least two-thirds of the medical/surgical benefits, then the plan cannot impose any cost-sharing or treatment limitations for mental health or substance use disorder benefits. For example, if 50% of outpatient office visits are subject to coinsurance and 50% are subject to a copay, then the plan could not charge anything for mental health or substance use disorder office visits.

Equal treatment for non-quantitative treatment limitations. Any non-quantitative treatment limitations (NQTLs) imposing processes, strategies, evidentiary standards or other factors before providing coverage cannot be more stringent than those applied to medical/surgical benefits. Of the three requirements, parity for NQTLs has proven to be the most difficult to understand and implement. The agencies have issued several FAQs and a self-check tool to clarify exactly what is required. The new comparative analysis requirement discussed below is focused on NQTLs.
The financial requirements, quantitative treatment limitations and NQTLs must be provided in parity with medical/surgical benefits within each of 6 designated classifications: (i) inpatient, in-network; (ii) inpatient, out-of-network; (iii) outpatient, in-network; (iv) outpatient, out-of-network; (v) emergency care; and (vi) prescription drugs. Outpatient services may be sub-classified into: (a) office visits; and (b) all other outpatient items and services, but plans may not further sub-classify generalists and specialists.

Comparative Analysis Requirements

The latest efforts to improve compliance with these parity requirements was included in the Consolidated Appropriations Act of 2021. The legislation requires that group health plans providing mental health or substance abuse disorder benefits and imposing any NQTLs on such benefits (i.e. restrictions not tied to dollar value or frequency) must perform and document a comparative analysis. The comparative analysis is required to contain the following information (copied directly from the legislation):

- 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 respective benefits classification.
- The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
- The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall 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.
- 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 classification.

- 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 analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

Beginning 45 days after the legislation goes into effect (in early February), the comparative analysis must be made available to the applicable state or federal agency upon request. The analysis does not need to be sent anywhere, but it should be kept in a file for audit purposes in case it is ever requested. If an agency audit of the analysis determines that any NQTL does not comply with the parity requirements, the plan may be required to take corrective action to bring the plan into compliance. If the plan fails to do so 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.

For fully-insured plans, the carrier is primarily responsible for ensuring the plan design and claims processing comply with the MHPAEA, and the carrier should prepare this comparative analysis and handle any audit of such analysis if requested. Some carriers are already subject to such requirements and audits at the state level.

For self-funded plans, the TPA will likely take responsibility for this new requirement, or at least assist with it. For self-funded plans, the employer is primarily responsible for compliance with MHPAEA requirements. The TPA may have some fiduciary responsibility depending upon the terms of the contract for services and the TPA's role in plan design and claims processing, so it would make sense for the TPAs to assist with this comparative analysis, but employers cannot automatically assume that it will be handled by the TPA.

Summary

The agencies are required to provide further guidance in the next 18 months and are unlikely to perform a significant number of audits before then. However, in the meantime, employers offering self-funded group health plans may want to further explore whether their plans really do meet parity requirements and coordinate with the TPA to begin preparing a comparative analysis for potential audit purposes.

The DOL's self-compliance tool will be helpful for this analysis. You can find the tool here: **https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf**

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