

Departments Ramp Up Mental Health Parity Compliance and Enforcement Efforts

The Departments of Labor, Treasury, and Health & Human Services recently issued guidance that clarifies how MHPAEA rules apply to nonquantitative benefit limitations, such as pre-authorization and medical management techniques — with specific examples of parity standards in the context of experimental or investigative treatment limitations, formulary design, and provider networks. The departments also issued a revised disclosure template to help participants and beneficiaries request information on limitations that may affect their mental health and substance use disorder benefits, as well as a self-compliance tool plans can use to review coverage terms and policies and to monitor those of vendors. With MHPAEA enforcement a stronger priority than ever, now is a good time to work with advisors to evaluate parity compliance.

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Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally prohibits group health plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable conditions or more stringent limits on those benefits than they do on the same classification of medical and surgical benefits. This federal law requires parity in financial requirements (like deductibles or copayments) and quantitative treatment limitations (like number of covered visits). It also requires parity in nonquantitative treatment limitations (NQTLs) —which are non-numerical limits on the scope or duration of benefits, such as a pre-authorization requirement or a medical management technique. MHPAEA does not require a plan to cover any specific MH/SUD conditions; rather, it requires that if it covers an MH/SUD condition, it covers it in parity with medical/surgical benefits. Regulations issued in 2013 set out the rules for determining parity. (See our [January 14, 2014 For Your Information](#) publication.)

DOL Review of Plans

As part of its 2017 fiscal year enforcement efforts, the DOL reviewed 187 ERISA plans for MHPAEA compliance and identified 92 MHPAEA violations. Additionally, it answered over 127 public inquiries in 2017 relating to MHPAEA.

In 2016, the Departments of Labor, Treasury, and Health & Human Services (departments) issued guidance on MHPAEA disclosure requirements and sought comments on developing model forms for participants and beneficiaries to obtain information on NQTLs. In 2017, responding to a congressional directive in the 21st Century Cures Act, they solicited more feedback on disclosures and clarified that treatment for eating disorders is a mental health benefit. (See our [July 5, 2017](#), [December 2, 2016](#), and [May 19, 2016](#) *For Your Information* publications.)

MHPAEA does not apply to retiree-only plans or to excepted benefits.

On April 23, 2018, the departments issued a package of guidance on mental health parity implementation comprised of proposed [FAQs](#) (with comments due June 22, 2018), a revised [disclosure template](#), a self-compliance [tool](#), an enforcement [fact sheet](#), DOL’s 2018 report to Congress entitled [Pathway to Full Parity](#), and HHS’ [action plan](#). Below is a detailed summary of the guidance, which we covered initially in our [April 24, 2018](#) *FYI Alert*.

Proposed FAQs on NQTLs

Penalties

Under current law, DOL cannot impose civil monetary penalties for parity violations – and for now, at least, Congress does not appear inclined to implement such penalties. Sen. Chris Murphy, D-Conn., proposed implementing civil monetary penalties for parity violations as part of the Opioid Crisis Response Act of 2018, but that bill reported out of the Senate HELP Committee last month without Sen. Murphy’s amendment.

Failure to comply with MHPAEA may also trigger an excise tax under Internal Revenue Code Section 4980D.

The departments proposed FAQs addressing the following types of “methods, processes, strategies, evidentiary standards, and other factors” that plans may use in developing and applying NQTLs. As discussed below, the FAQs identify certain plan features as NQTLs and plan designs that violate (and, in a few cases, do not violate) parity requirements.

Experimental or Investigative Treatments

Parity in Plan Design. Where a plan defines Autism Spectrum Disorder (ASD) as a mental health condition, it cannot deny claims for Applied Behavior Analysis therapy to treat children with ASD as “experimental or investigative” if it approves treatment for medical/surgical conditions that are supported by similar professionally recognized treatment guidelines. (See our [January 12, 2018](#) *For Your Information* on autism treatment benefits and coverage limitations for background on this topic.)

Parity in Application. Where a plan document sets forth the same evidentiary standard for MH/SUD as medical and surgical benefits, a plan nevertheless violates MHPAEA where, in practice, it applies more stringent evidentiary standards to MH/SUD benefits. For example, a plan may not unconditionally exclude all experimental or investigative treatments for MH/SUD conditions while covering certain experimental or investigative treatments for medical and surgical conditions on a treatment-by-treatment basis.

Proposed FAQs?

It’s unusual for subregulatory guidance like FAQs to be proposed for notice and comment – a process typically reserved for proposed regulations. The departments may have chosen this approach to retain the flexibility of subregulatory guidance while incorporating specific stakeholder feedback.

Formulary Design

P&T Committee Processes. Many plans use a pharmacy and therapeutics (P&T) committee to determine coverage for

prescription drugs and evaluate whether to follow or deviate from professionally recognized treatment guidelines for setting dosage limits.

The departments make it clear that using a P&T committee to determine dosage limits is permissible, so long as, in practice, the committee’s processes comply with parity requirements. For example, if the committee deviates from nationally recognized treatment guidelines in setting dosage limits for prescription drugs used to treat MH/SUD conditions but does not deviate for prescription drugs used to treat medical/surgical conditions, the deviation should be evaluated for MHPAEA compliance. This evaluation may involve, for instance, determining whether the expertise of P&T committee members in MH/SUD conditions is comparable to their expertise with medical/surgical conditions and whether the committee’s evaluation of nationally recognized guidelines in setting dosage limits for both MH/SUD and medical/surgical conditions is comparable.

Comment. Plans with carve-out prescription drug benefits should ensure that vendors are aware of, and are administering benefits in compliance with, parity requirements.

Exclusions of specific MH/SUD conditions. MHPAEA rules do not require plans to cover any specific MH/SUD condition. For example, a large group health plan can generally exclude all items and services to treat bipolar disorder, including prescription drugs — subject to any state laws prohibiting such an exclusion for insured coverage.

“Step Therapy” Protocols and “Fail-First” Policies

A plan must be able to demonstrate that any step therapy or fail-first policies it imposes on MH/SUD benefits are based on evidentiary standards or other factors comparable to those applied to medical/surgical benefits.

For example, a plan with a “step therapy” protocol or “fail-first” policy that requires two unsuccessful attempts at outpatient treatment in the past 12 months before it will cover inpatient treatment of MH/SUD conditions but only requires one outpatient attempt in the past 12 months for medical/surgical conditions before covering inpatient treatment would fail the parity analysis unless it can show that evidentiary standards or other factors were used comparably in developing these requirements.

“Step Therapy” and “Fail-First” Step Therapy protocols are medical management techniques in which a plan will not cover a higher-cost treatment until it is shown that lower-cost treatment is not effective.

Provider Network Issues

Participation. A plan’s standards for admitting a provider to participate in a network constitute an NQTL.

Reimbursement Rates. Although a plan is not required to have identical provider reimbursement rates for medical/surgical and MH/SUD providers, it cannot arbitrarily pay reduced reimbursement rates to the latter. Thus, if a plan generally has the same reimbursement rates for physicians and non-physician practitioners in the medical/surgical context, it violates parity rules if it pays reduced reimbursement rates to non-physician practitioners only for MH/SUD conditions.

Network Adequacy. If a plan uses factors like distance standards and waiting times for appointments in assessing network adequacy, these factors must be comparably applied to MH/SUD and medical/surgical benefits. Plans must satisfy this requirement even if they meet applicable state and federal network adequacy standards for MH/SUD services.

Restrictions on coverage based on type of facility. Coverage restrictions based on facility type are NQTLs. Accordingly, in evaluating an exclusion or other limitation on MH/SUD benefits based on the type of facility, a plan must be able to demonstrate that the exclusion or limitation is based on comparable factors and applied no more stringently than those applied to medical/surgical conditions and justify the disparate treatment to comply with MHPAEA. For example, a plan that covers inpatient, out-of-network treatment outside of a hospital for medical/surgical conditions if prior authorization is obtained, but excludes inpatient, out-of-network treatment of eating disorders in a residential treatment center in all instances would not comply with MHPAEA because the restrictions imposed on residential treatment for eating disorders are more stringent.

Provider Directories. ERISA requires an SPD for a plan that utilizes a provider network to include a list of providers that is “up-to-date, accurate, and complete (using reasonable efforts).” This list can be provided as a separate document that accompanies the SPD. The guidance notes that a network provider list that has not been updated in at least three years and contains inaccurate information is not permissible.

The list can also be provided electronically, for example via hyperlink, if the DOL’s electronic disclosure safe harbor requirements are met. A summary of material modifications (SMM) for provider network changes is required to be furnished no later than 210 days after the close of the plan year when the change is made. Rules governing the summary of benefits and coverage also require an internet address or other contact information for obtaining a list of in-network providers. (See our [February 14, 2017 For Your Information](#) for more on SBC rules.)

Related Physical Health Conditions

An acute condition affecting physical health sometimes arises as a complication of an MH/SUD condition. Whether the physical health condition is subject to MHPAEA requirements depends on how the terms of the plan describe the condition. If the plan defines it as an MH/SUD condition, benefits for care provided for the diagnosis, cure, mitigation, treatment, or prevention must comply with parity rules. For example, if the plan defines all lacerations as a medical condition, treatment for lacerations is not subject to parity requirements even if the participant has a mental health condition or substance use disorder. However, if the plan — or state law, in the case of an insured plan — defines the specific physical health condition as part of an MH/SUD condition, the benefits for treatment of the physical health condition must comply with MHPAEA.

Comment. Plan sponsors might want to review plan language for clarity on whether particular conditions are described as MH/SUD conditions.

Revised Disclosure Template

The disclosure template is designed to help participants and beneficiaries request information on any limitations that may affect their MH/SUD benefits, with the idea of enabling them to evaluate parity. The draft form, which participants and beneficiaries can use to request information from plans even though it has not yet been finalized, gives the plan 30 days to respond, and solicits the following information:

- Specific plan language on the treatment limitation and identification of all MH/SUD conditions as well as relevant medical/surgical conditions to which it applies
- Factors used to develop the limitation and the evidentiary standards used to evaluate those factors. The notice includes examples of some relevant factors and their evidentiary standards: excessive utilization (e.g., two

standard deviations above average utilization per episode of care), recent cost escalation (e.g., a 10% or more cost increase per year for two years); high variability in cost per episode of care (e.g., episodes of outpatient care being two standard deviations higher than average 20% or more of the time in a 12-month period); and safety and efficacy of treatment modality (e.g., two random clinical trials required to establish a treatment as not experimental or investigative)

Note the Quick Turn Around!

Plans must respond to disclosure requests within 30 days of the plan's receipt of the request. Failure to comply with a disclosure request within this timeframe may result in a penalty of \$110 per day.

- Identification of the methods and analysis used in developing the limitation
- Any evidence and documentation to show the limitation is applied no more stringently to MH/SUD conditions than to medical/surgical conditions — either under the plan terms or in practice

Self-Compliance Tool

The self-compliance tool, which DOL intends to update every two years to reflect any additional MHPAEA guidance, is designed to assist plan sponsors in determining whether their plans comply with MHPAEA requirements. Plan sponsors can use the tool to review plan terms and policies and to monitor those of vendors and/or carriers to confirm MHPAEA compliance.

The section on NQTLs is the most detailed — for example, the tool solicits the factors considered in the design of the plan's NQTL as well as the processes, strategies, and evidentiary standards used to define those factors. It features several helpful compliance tips, including the need to:

- Look for parity compliance both in plan terms as well as operation
- Identify specific information to substantiate how factors are used to apply a specific NQTL and determine whether any factors were given more weight than others, and the reasons(s) for doing so
- Analyze multiple components of a benefit separately (e.g., outpatient services and prescription drugs for treating a specific condition) and understand how requirements are implemented, who makes the decisions, and the qualifications of the decision maker(s)
- Ensure measures to evaluate comparable application if different entities conduct utilization review for MH/SUD and medical/surgical benefits, respectively
- Determine whether there are exception processes available and when they may be applied
- Review average denial rates, appeal overturn rates and assess parity, which may be a warning sign, though not determinative of compliance
- Focus on underlying processes and strategies — rather than results
- Document the parity analysis

The tool also offers useful compliance tips for responding to disclosures, explaining that:

- The reason for the denial must include the applicable medical necessity criteria
- Plans cannot refuse to disclose information necessary for the parity analysis on the basis that it is proprietary or has commercial value
- Plans can provide summary descriptions of the medical necessity criteria in layperson terms
- Vendors and carve-out providers should document the necessary information to the plan to ensure parity compliance

Focus on Enforcement

The guidance suggests that, a decade after MHPAEA's enactment, enforcement is now a stronger priority than ever.

Agency Statistics

As part of its 2017 fiscal year enforcement efforts, DOL's Employee Benefits Security Administration's (EBSA) reviewed 187 plans for MHPAEA compliance and identified 92 MHPAEA violations. Of these violations, 48.91% involved NQTLs. The rest involved financial limits and quantitative treatment limits (28.26%), cumulative financial requirements/treatment limitations (8.7%), annual and lifetime dollar limits (8.7%), and benefits in all classifications (5.43%). Additionally, EBSA answered over 127 public inquiries in 2017 relating to MHPAEA.

EBSA often identifies plans for MHPAEA compliance reviews after receiving participant complaints indicating systemic problems that may adversely affect other participants and beneficiaries. To achieve maximum impact, EBSA investigators seek global correction by working with plan service providers to find improperly denied claims and thereby correct the problem for other plans as well.

DOL identified the following examples of corrective actions taken following MHPAEA enforcement efforts in 2017:

- Removal of an improper annual day limit for residential SUD treatment
- Elimination of higher copayments for MH/SUD benefits than for medical/surgical benefits
- Addition of coverage for out-of-network MH/SUD services where such coverage was available for medical/surgical benefits
- Elimination of more stringent precertification requirements for MH/SUD benefits
- Repayment of improperly denied claims for post-traumatic stress disorder
- Elimination of an overly restrictive benefit requirement where a participant had to show that an MH/SUD condition adversely affected more than one area of daily living but there was no similar requirement for medical/surgical conditions

HHS, which enforces parity requirements on non-federal governmental plans, highlighted a "one-stop" [government website](#) that specifically focuses on parity. Since the beginning of 2016, HHS has completed five MHPAEA investigations of non-federal governmental plans.

Report to Congress

In its report to Congress, DOL emphasized that MHPAEA enforcement continues to be a priority for 2018. It highlighted future enforcement efforts including establishment of a task force to target areas where parity issues may affect access to treatment for opioid addiction and the formation of teams to evaluate NQTLs imposed by large behavioral health providers and issuers.

Comment. DOL also recommended that Congress grant it enforcement authority over health insurers in connection with parity violations. In the absence of that authority, enforcement action against health insurers for MHPAEA violations is done via private litigation where participants and beneficiaries seek coverage for treatment related to MH/SUD issues.

The report recommended that Congress provide DOL with authority to levy monetary penalties on insurers and funders for parity violations. DOL believes that having the authority to impose civil monetary penalties — as it does in connection with other laws governing group health plans — would lead to “more meaningful incentives and penalties for noncompliance.”

In Closing

The departments appear focused both on compliance assistance as well as enforcement. Using DOL’s self-compliance tool as a guide, now is a good time to work with advisors in evaluating parity compliance — paying close attention to areas like exclusions for experimental or investigative treatments, formulary design, step-therapy protocols or fail-first policies, network access, provider lists, and reimbursement rules. Plans should also reach out to vendors, such as those providing MH/SUD or prescription drug carve-out benefits, to confirm compliance with parity rules. They should also ensure processes are in place to respond in short order to disclosure requests.

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