Mental Health Parity Laws and Health Plan Compliance August 2022

Introduction and Background.

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), requires health plans and insurers that offer mental health and/or substance use disorder (MH/SUD) benefits, to provide full parity with medical/surgical (med/surg) benefits. Plans must ensure that their plans include the same or less restrictive financial requirements and treatment limitations on MH/SUD benefits than are placed on the majority of med/surg benefits.

The Affordable Care Act (ACA) amended the MHPAEA in 2010 to extend mental health parity to one of HHS' 10 essential health benefits (EHB) categories. EHBs apply to non-grandfathered individual and small group coverage.

> The 2021 Consolidated Appropriations Act (CAA) included a requirement that health plans and insurers conduct and document an analysis comparing treatment limits that apply to MH/SUD services to the limits for med/surg services. The CAA also required that plans develop compliance materials that include staff training and information about periodic reviews. The periodic review would compare denials of MH/SUD claims to that of med/surg claims. This information must be supplied to the Departments of Labor (DOL) and Health and Human Services (HHS) if requested. DOL and HHS prioritized the ongoing enforcement of MHPAEA parity compliance as a result of their report findings that most if not all plans fail to comply with the MHPAEA. (2022 MHPAEA Report)

The Cures-Act of 2021 also amended the MHPAEA by requiring that DOL, HHS and the Treasury Department issue compliance guidelines and to document, each year, the enforcement of mental health parity.

Which health plans must comply with MH/SUD parity?

Most employer-sponsored health plans, including private-sector plans and those covering state and local government employees**.

- **Self-insured state and local government plan sponsors (non-federal state and local government employees), regulated by the HHS and the Centers for Medicare and Medicaid Services (CMS) currently have the ability to opt out of MH/SUD parity compliance each year by filing an annual election notice with HHS and CMS.

    - U.S. Senate bill 4170, introduced by Senators Cassidy and Murphy includes a provision that would eliminate the ability of state and local plans to opt out of MH/SUD parity. Hopefully this provision is included in any mental health package(s) that are passed by Congress this year.

Both grandfathered and non-grandfathered group health plans and group health insurance plans.

Non-grandfathered individual and small group market plans, that must cover certain essential health benefits (EHBs) such as MH/SUD benefits, as required under the ACA.

Medicaid alternative benefit plans (ABPs).

Certain CHIP (Children's Health Insurance Program) plans.

Which Plans Are Not Required to Provide Parity?

Plans that do not provide MH or SUD benefits.

Self-insured, non-federal governmental health plans that have obtained a waiver from HHS/CMS.

Self-insured non-federal governmental plans that have 50 or fewer employees.

Medicare.

Retiree-only group health plans.

Self-insured small group private sector health plans with more than two but fewer than 50 enrollees.

Excepted benefit plans (e.g., dental, vision, hearing coverage).

Group health plans that meet federal law requirements for an increased cost exemption.

Which Agencies Enforce MH/SUD parity?

HHS has primary enforcement authority over non-federal government health plans, such as those sponsored by state and local government employers.

HHS regulates issuers in states that have notified HHS/CMS that they do not have the authority to enforce or are not otherwise enforcing MHPAEA.

In all other States, the State is directly enforcing MHPAEA with respect to health insurance plans.

Comparing MH/SUD Benefits to Med/Surg Benefits.

Plans that are required to comply with the parity provisions must provide MH/SUD benefits that are comparable to, or less restrictive than, those for med/surg benefits in terms of both quantitative and nonquantitative treatment limits.

What are Quantitative and Non-Quantitative Treatment Limits?

These treatment limits are, generally, indications of either the financial or treatment limits/terms of the MH/SUD benefit. The regulations re quantitative or non-quantitative treatment limits in measuring mental health parity.

1) Quantitative treatment limits (QTLs). QTLs for MH/SUD benefits when compared to med/surg benefits including financial measures of the:

Amount of money the patient is required to pay for treatment and services such as:

- deductibles,
- copayments,
- coinsurance,
- and out-of-pocket maximums
- other costs.

A financial requirement QTL must apply to substantially all med/surg benefits in six (6) classifications of benefits. A QTL must also apply to at least two the med/surg benefits in the classification based on the dollar amount of plan payments for member's coverage expected to be paid for the plan year within the classification.

2) Non-quantitative treatment limits (NQTLs). NQTLs for MH/SUD benefits refer to limitations on the scope and duration of covered benefits not expressed numerically, such as the:

Treatment limits on the amount of care that will be covered when compared to med/surg care such as:

- On an annual basis,
- Per episode of care
- Days of care
- Length of stay
- Number of visits) compared to med/surg benefits.

Examples of NQTLs for MH/SUD and med/surg benefit parity comparisons include:

Prior-authorization requirements.

Medical-management standards that limit or exclude coverage based on medical necessity or appropriateness.

Prescription drug formulary or network tier design.

Fail-first or step therapy protocols.

Exclusions/denials for failure to complete a course of treatment.

Restrictions based on location, facility type, or provider specialty.

Methods to determine provider reimbursement rates and standards for provider participation in the network.

Testing for MHPAEA compliance.

Plans must analyze QTL and NQTL parity compliance within each of the following six benefit categories:

1) inpatient, in-network;

2) inpatient, out-of-network;

3) outpatient, in-network;

4) outpatient, out-of-network;

5) prescription drugs; and,

6) emergency care.

If a plan provides a med/surg benefit in any of the above 6 categories, it must provide the same level benefit in all classifications for MH/SUD as well. Within each classification, parity must be determined for each coverage unit (e.g., employee-only coverage, employee plus one, family).

MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to MH/SUD benefits;

The above six classifications are the only ones those federal regulators permit to determine the predominant financial requirements or QTLs that apply to substantially all med/surg benefits. A plan or insurer may not use a separate sub-classification under these classifications for generalists and specialists.

Parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD that are not essential health benefits.

NQTL Comparability Test.

NQTL Comparability tests must be based on the framework of the six QTL categories above and must examine:

Prior authorization requirements for in-network and out-of-network inpatient services;

Concurrent review requirements for in-network and out-of-network inpatient and outpatient care;

Standards for provider admission to participate in a network, including reimbursement rates; and,

Out-of-network reimbursement rates (plan's method for determining usual, customary, and reasonable charges).

Preparing for Comparative Analysis of MH/SUD parity.

If plans/vendors/insurers cannot or unable to supply a comparative parity analysis, plan sponsors and unions should conduct their own analysis. Plans will want to review the four types of NQTLs above as these seem to be the current focus of the DOL and HHS enforcement efforts:

Consumer Information Rights and Appeals.

Health plans and insurance companies must, upon request, provide consumers with the criteria used to decide if a MH/SUD service is medically necessary. If a plan denies payment for a MH/SUD service it must provide the consumer with a written explanation as to why the claim or treatment was denied. Consumers also have the right to appeal a denied treatment or claim.

MHPAEA Resources to Share with Members.

Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits | SAMHSA Publications and Digital Products

Understanding Parity: A Guide to Resources for Families and Caregivers | SAMHSA Publications and Digital Products

2022 MHPAEA Report to Congress (dol.gov)

For more information or questions regarding mental health and substance use disorder parity and how it impacts your members' plans, please contact NEA's Collective Bargaining and Member Advocacy Department and Cynthia Blankenship at cblankenship@nea.org.