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New law requires health plans to demonstrate compliance with the parity requirements between mental health and medical benefits

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Beginning February 10, 2021, the Department of Labor (DOL), Internal Revenue Service (IRS), and/or Department of Health & Human Services (HHS) (collectively, the Departments) may request employer-sponsored group health plans to provide evidence that their plans apply limitations on mental health and substance use disorder (MH/SUD) benefits in parity with those they apply to medical/surgical (M/S) benefits. Upon request, group health plans will need to have and readily produce comparative analyses showing that the plans comply with the parity requirements, as well as other requested information. The Departments will publish reports of their investigations, identifying those plans out of compliance with the parity requirements. Sponsors and plan administrators of group health plans need to take immediate action to prepare for the Departments' inquiries. They may also need to make changes to their plan design and agreements with their plan vendors. Below is a more detailed summary of the new mental health parity initiative that the Consolidated Appropriations Act, 2021 (CAA) jumpstarted.

A bit of history

After the 1996 Mental Health Parity Act made the first step toward protecting benefits for individuals with mental health and substance use disorder conditions, Congress enacted the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA imposed stricter parity requirements between MH/SUD and M/S benefits. It prohibited plans and issuers from imposing financial and treatment limitations (quantitative limitations) on the MH/SUD benefits more restrictive than the predominant limitations applied to substantially all M/S benefits in each classification of benefits. In 2013, the Department issued regulations under the MHPAEA identifying six classifications of benefits, including in-network and out-of-network inpatient and outpatient care, emergency services, and prescription drugs, that must separately meet the parity tests. The regulations permitted certain sub-classifications, such as network tiers, office visits, and other outpatient care, that may be tested separately for parity.

In addition to prescribing parity among the limitations that can be measured in amounts, days, or visits (i.e., "quantitative treatment limitations"), the MHPAEA mandated parity in other limitations that relate to medical management, licensing of providers, determination of medical

necessity or categorizing treatments as experimental or investigational, among others. These limitations are known as "nonquantitative treatment limitations" or "NQTLs." A plan may not impose NQTLs on mental health benefits unless, in applying these limitations to MH/SUD benefits, the plan uses processes, strategies, evidentiary standards, or other factors that are comparable to and applied no more stringently than those applied to M/S benefits. As with the quantitative limitations, parity in NQTLs applies separately to each classification of benefits. Health plans must establish parity both in the written terms of the plan and in operation.

For the most part, compliance with the quantitative treatment limitation requirements has been straightforward. However, adequate compliance with the MHPAEA's NQTL requirements has been elusive, in part due to a lack of clear guidance from regulators on how plan sponsors and administrators can take steps to ensure compliance. Since the issuance of the regulations, the Departments published subregulatory guidance that emphasized the importance of compliance with the parity requirements. The Departments FAQs on mental parity and other compliance resources (including a self-compliance tool for health plans) can be found here. Recognizing the difficulty health plan experience complying with NQTL requirements, the Department has recently focused its subregulatory guidance on NQTLs. In 2016, the Departments issued a fact sheet that identified some warning signs and red flags in plan designs that might signal potential violations of the parity requirements. More guidance and compliance tools became available as part of a broader mental health reform implemented by the 21st Century Cures Act.

The CAA is a culmination of the parity initiatives

As a natural continuation and evolution of the government's efforts to facilitate parity in mental health care, Division BB, Title II, Section 203 of the CAA, *Strengthening Parity in Mental Health and Substance Use Disorder Benefits*, added several new measures to the MHPAEA parity mandates.

Agency investigations of compliance

Most important for sponsors of group health plans, the CAA requires health plans that impose NQTLs on mental health and substance use disorder benefits to perform a comparative analysis of the design and application of NQTLs to MH/SUD benefits and M/S benefits. The Departments (DOL, IRS, or HHS, depending on whether the plan is insured, self-insured, and/or subject to ERISA) may request a plan to provide these comparative analyses and additional information. The Departments must examine at least 20 comparative analyses per year. A request for information may come at each Department's discretion in response to a complaint or obtaining other evidence of potential noncompliance or in other instances as a Department's Secretary may determine.

In addition to the documented comparative analyses, the Secretary may request:

- The terms of the plan containing the NQTL and MH/SUD and M/S benefits to which the limits apply;
- Factors used to determine that the NQTL will apply to the benefits;
- Evidentiary standards and other sources and evidence used to identify the factors described above;
- Comparative analyses demonstrating that processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits are comparable and applied no more stringently than those used in applying the NQTLs to medical/surgical benefits; and
- Disclosure of the specific findings and conclusions that indicate the plan is in compliance with the NQTL parity requirements.

If the Secretary determines upon its review of the comparative analyses that a plan is not in compliance with the parity requirements, the plan must take corrective action and within 45 days of the initial finding present another comparative analysis showing the plan's compliance with those requirements. If the Secretary still finds that the plan is out of compliance, within seven days, it will notify all individuals enrolled in the plan of its findings.

The Secretary must also submit a detailed annual report to Congress regarding its investigations. The first report is due by December 27, 2021, and subsequent reports are due by each October 1. The report will identify each plan that the Secretary found not to be in compliance with the MHPAEA parity requirements. In addition, the report will contain a summary of all comparative analyses reviewed, specified information requested by the Secretary, the Secretary's conclusions for each plan regarding the plan's compliance or noncompliance, the actions that the Secretary specified for each plan to achieve compliance, and other information. Although information about the Departments' investigations and findings of noncompliance will be reported to Congress and plan enrollees (where noncompliance is found), the communications between the Departments and the plans will not be subject to public FOIA disclosures.

Compliance guidance

Although group health plans face immediate compliance challenges, the Departments have more time to issue additional guidance to help plans achieve compliance with the mental health parity requirements. The CAA directs the Departments to issue and finalize additional regulations and guidance on MHPAEA compliance by June 27, 2022. The Department must provide stakeholders at least 60 days after the issuance of any proposed guidance to submit comments.

The Departments, in consultations with the Inspectors General of each of the three departments, must also develop a "compliance program guidance document" (Guidance Document) that it will update every two years. The Guidance Document must contain illustrative examples of previous findings of compliance and noncompliance with the parity requirements. These examples will contain no protected health information. Where noncompliance involves NQTLs, the examples will include detailed explanations of the criteria involved in approving MH/SUD and M/S benefits. To ensure access to additional information, the Departments will enter into information-sharing agreements with the Inspectors General of the Departments and seek to enter into similar agreements with the States.

The Guidance Document will provide recommendations to plans that encourage the establishment of internal controls to monitor adherence to the applicable statutes, regulations, and other guidance. In issuing additional guidance, the Departments must also assist plans with the required disclosures regarding the NQTLs and the factors that the plan uses in applying those limitations to MH/SUD and M/S benefits.

Guidance will also provide a process for plan participants, beneficiaries, their representatives, and service providers for filing complaints regarding instances of noncompliance. Those would be the triggers for the Departments to initiate an investigation of the plan compliance with the mental health parity requirements.

Plan sponsor takeaways

Plan sponsors and administrators have a limited time to shift into full compliance gear under the CAA mandates. In that regard, sponsors and administrators should consider taking the following steps:

- Conduct an initial review of quantitative treatment limitations to determine whether any parity compliance issues are apparent on the face of the plan design.
- Sponsors and administrators with fully-insured health plans should reach out to their insurance carriers and request a copy of the most recent quantitative and NQTL comparative analyses.
- Sponsors and administrators with self-insured health plans should work with their third-party administrators to conduct comparative analyses. Particular care should be given to administrative structures that include separate (or "carve-out") pharmacy benefit and/or mental health and substance abuse providers. Where carve-out vendors exist, there is likely to be very little coordination between the vendors regarding parity compliance.
- If the comparative analyses indicate that adjustments are necessary, sponsors and administrators should take further steps to bring the plans into compliance. These corrective efforts should be thoroughly documented.

Given the new compliance mandate under the CAA, sponsors and administrators are now "on-the-clock" to bring their plans into compliance. The rules are complex and will require full collaboration with group health plan vendors. Of course, sponsors and administrators should seek assistance from benefits counsel when conducting and reviewing mental health parity comparative analyses.

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