EMPLOYEE BENEFITS LAW
INFORMATION MEMO
APRIL 7, 2021

Federal Agencies Explain New Mental Health Parity Requirements for Health Plans

On April 2, 2021, the three federal Departments that regulate health plans and health insurance (Labor, Treasury, and Health and Human Services) published guidance on the recently enacted changes to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The new guidance, which is in the form of "frequently asked questions" or FAQs (the Agency Guidance), explains the significant new requirements under MHPAEA enacted last December in the Consolidated Appropriations Act of 2021 (the Appropriations Act). Under the Appropriations Act, health plans and health insurers covered by MHPAEA must perform and document comparative analyses of the "non-quantitative treatment limitations" (NQTLs) under the plan and furnish such analyses to the Departments upon request.

Background – The Mental Health Parity and Addiction Equity Act

The MHPAEA requires parity between a covered health plan's benefits for mental health and substance use disorder (SUD) services on the one hand, and the benefits for medical and surgical services on the other, in three different categories of plan design features:

- annual and lifetime limits;
- financial requirements such as coinsurance and copays; and
- treatment limitations.

The last of these categories – treatment limitations – includes both "quantitative" treatment limitations (like limits on the number of covered visits to a provider) and non-quantitative treatment limitations. NQTLs include such things as "medical necessity" and pre-authorization requirements, exclusions of "experimental" treatments, network tier designs and "usual, customary and reasonable" standards. So, NQTLs are plan requirements that can limit a plan participant's access to coverage, but aren't expressed quantitatively, like covered visit limits.

Under MHPAEA, the "processes, strategies, evidentiary standards, or other factors" used by a health plan or policy in applying a non-quantitative limit to mental health/SUD benefits in each benefit classification must be comparable to, and not applied more stringently than, the factors used in applying the limit with respect to medical/surgical benefits in the same classification. (For purposes of MHPAEA, health plan benefits are divided into six broad classifications: (1) inpatient, in-network, (2) inpatient, out-of-network; (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care and (6) prescription drugs.)

This parity requirement as to NQTLs replaced an earlier rule under which permitted differences in NQTLs as between mental health/SUD benefits and medical/surgical benefits "to the extent that recognized clinically appropriate standards of care may permit a difference."

The Appropriations Act Amendment and the Agency Guidance

Accordingly, health plans and policies covered by MHPAEA are prohibited from developing or applying factors relating to NQTLs in ways that adversely affect the required parity between mental health/SUD and medical/surgical benefits. The Appropriations Act, signed into law on Dec. 27, 2020, specifically requires covered plans to perform and document "comparative analyses" of its non-quantitative treatment limitations which demonstrate the requisite parity between plan benefits in relation to these limits. The Appropriations Act also requires covered plans to make their comparative analyses available to the three Departments, or applicable state authorities, beginning 45 days after the enactment of the Appropriations Act – that is, beginning Feb. 11, 2021. In other words, the required analysis documentation could be demanded by federal or state agencies at any time, and the Agency Guidance confirms this.

The Agency Guidance[1] includes fairly detailed information on the new MHPAEA requirements and the requisite "comparative analyses" of NQTLs. The guidance includes the following recommendations and mandates:

- The analyses must be sufficiently specific, detailed and reasoned to demonstrate the required parity; general statements of compliance and conclusory references to broadly stated processes, evidentiary standards or other factors will not be enough.
- Covered plans are urged to use the Department of Labor's MHPAEA Self-Compliance Tool[2] in developing their parity analyses. (The Self-Compliance Tool is a detailed guidance document on MHPAEA that includes examples, self-audit questions and "compliance tips". The FAQs state that if plans use the Self-Compliance Tool, they "should be in a strong position to comply with the [CAA's] requirement to submit comparative analyses upon request."
- A compliant analysis must include, at minimum, nine specific components (listed in the Agency Guidance), including: identification of the specific mental health/SUD and medical/surgical benefits that are compared; identification and explanation of the factors relied on in the design or application of each NQTL, including what weight was given to each such factor; and an explanation of any variations in the application of a guideline or standard as between mental health/SUD benefits and medical/surgical benefits.
- If the federal agencies determine that a health plan's parity analyses are insufficient or non-compliant, the plan will be required to notify all plan participants and enrollees of the non-compliance, and the applicable authorities of the state where the plan is located will also be notified.
- Besides federal and state regulatory authorities, participants in ERISA-covered health plans can also request copies of the plan's comparative analyses of its NQTLs. In addition, if a participant's benefit claim is denied and the MHPAEA analysis is relevant, it would have to be furnished to the participant in connection with their right to appeal the claim denial.

What Covered Plans Must Do

Since the federal and state agencies could demand the required parity analyses at any time, group health plans covered by MHPAEA should immediately review their comparative analyses in light of the

1 The Agency Guidance can be found here.

2 The Self-Compliance Tool can be found here here.

detailed provisions of the Agency Guidance. Note that MHPAEA covers all health plans (insured or self-insured, and whether sponsored by private or governmental employers) and health insurance policies that provide mental health or substance abuse disorder treatments as well as medical or surgical benefits. (There is an exception for small self-insured plans, with 50 or fewer covered employees.)

The Agency Guidance also states note that, in the near term, the Department of Labor expects to focus its enforcement efforts on:

- prior authorization requirements,
- concurrent review requirements,
- standards for provider admission to participate in a network (including reimbursement rates) and
- out-of-network reimbursement rates.

If you have any questions, please contact Robert Patterson, any attorney in our Employee Benefits and Executive Compensation practice or the attorney at the firm with whom you are regularly in contact.