Client Alert: A Practitioners' Guide to MHPAEA

Focus on Mental Health Parity

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Most employers that sponsor group health plans must ensure that their plans comply with, or are exempt from, the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA). Conceptually, parity is simple. Insurance coverage for mental health and substance use disorder (MH/SUD) care should be no more restrictive than insurance coverage for any other medical condition. However, the Federal Parity Law is very complex, and implementation of the law can be challenging.

In this alert, we provide an overview of the MHPAEA and highlight action items for plan sponsors to maintain compliance. Any questions should be directed to Rebecca Alperin.

WHAT EMPLOYERS NEED TO KNOW

MHPAEA audits are a top priority of the Biden Administration and group health plans and insurance carriers that offer both medical/surgical and MH/SUD benefits are required to evaluate and demonstrate parity. The Administration has also proposed that ERISA be amended to allow participants and beneficiaries to recover losses due to parity violations through private rights of action. Although compliance obligations for fully-insured plans generally are the responsibility of the insurer and the responsibility of the employer/plan sponsor for self-funded plans, employers that sponsor fully-insured plans may have liability if they direct the plan design, and/or influence its administration.

Accordingly, plan sponsors:

- Should review their MH/SUD benefits to determine where additional benefit offerings may be valuable and/or where unnecessary benefit restrictions may be removed. They should also ensure that impermissible exclusions are removed from coverage.
- Must ensure that thorough comparative analyses will be completed. This involves collecting information about processes applicable to medical/surgical benefits as well, to show that MH/SUD benefits are not being provided in writing or operation in a more restrictive manner than medical/surgical benefits.
- Should consider any amendments to service provider contracts necessary to help ensure all relevant parties are aware of and engaged in compliance-related activities.
- Use the Department of Labor's (DOL) online self-compliance tool to assess whether employer sponsored plans are in compliance with the federal mental health requirements.

MHPAEA KEY PROVISIONS

Unless an exception applies, if an employer's plan offers MH/SUD coverage, parity is required generally as follows:

- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., deductibles and co-payments), and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits.
- Health insurance policies must offer benefits for mental health care in the same service categories that are covered for medical and surgical benefits. For example, if the plan offers coverage for inpatient care for physical illness, it must offer inpatient care for treatment of MH/SUB conditions. The same would be true for outpatient, emergency and prescription medications.
- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits.
- Prior authorization requirements for MH/SUD services must be comparable to or less restrictive than those for medical/surgical benefits.
- If a group health plan or health insurance coverage includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for out-of-network medical/surgical benefits, it must provide for out-of-network MH/SUD benefits.
- Standards for medical necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

MHPAEA EXCEPTIONS

Except as noted below, MHPAEA requirements do not apply to:

- Fully-insured large group health plans and health insurance issuers that do not include MH/SUD benefits in their benefit packages.
- Self-funded small private employers and non-Federal governmental plans that have 50 or fewer employees.
- Group health plans and health insurance issuers that incur an increased cost of at least one percent in a plan or policy year as a result of providing MH/SUD coverage. Note that applicability of this exemption must be reassessed annually.

Note, these exceptions do not apply to plans in the individual and small group markets that are required by Affordable Care Act regulations to provide essential health benefits.

WHAT RIGHTS DO EMPLOYEES HAVE

- Employees have the right to request from their health plan information about the MH/SUD benefits it offers. This includes criteria the plan uses to decide if a service or treatment is medically necessary;
- If a plan denies payment for MH/SUD services, the plan must provide the employee with a written explanation of the reason for the denial and must provide more information upon request;
- If a health plan denies a claim, the employee has the right to appeal the denied claim.

WHO ENFORCES MHPAEA

The Department of Labor's Employee Benefits Security Administration is responsible for enforcing MHPAEA for private employer plans; however, it does not currently have independent authority to assess civil penalties specific to parity. It can refer cases to Treasury, which can

assess a $100 a day penalty per affected individual for violations. Finally, the Centers for Medicare & Medicaid Services has enforcement jurisdiction over MHPAEA in the individual and fully insured group markets in states where it has enforcement authority and over non-federal governmental group health plans, such as plans sponsored by state and local governments for their employees.

EXAMPLES OF MHPAEA VIOLATIONS

Department of Labor investigations often stem from participant complaints. Participants speak with DOL benefits advisors who first seek to obtain voluntary compliance from a plan. If that fails, the agency may open a formal investigation involving the plan and its service providers. The goal is to obtain broad correction, not just for the plan under investigation, but for other plans that contract with the service provider.

The most common errors uncovered during a formal investigation include:

- Insufficient Benefits – Not offering out-of-network providers or inpatient benefits to treat mental health or substance use disorders even though these benefits are available for medical/surgical benefits.
- Higher Financial Requirements – Charging higher copays to see mental health providers than those charged for medical/surgical providers.
- More Restrictive Quantitative Treatment Limitations (QTLs) – Imposing visit limits on mental health benefits that are more restrictive than those applied to medical/surgical visits.
- More Restrictive Non-Quantitative Treatment Limitations (NQTLs) – Imposing broad preauthorization requirements on all mental health and substance use disorder treatments, even though these same plans only required pre-authorization on a select few medical/surgical treatments. Requiring written treatment plans for mental health services while not requiring similar plans to receive medical/surgical treatment.
- Lower Annual Dollar Limits on Benefits – Imposing annual dollar limits on coverage of mental health benefits when such limitations are not imposed on medical/surgical benefits.
- Inadequate Disclosures – Not disclosing the criteria used for determining medical necessity and/or reasons for benefit denials.

APPLICABILITY OF STATE SPECIFIC LAWS

Most states have some form of MH/SUB coverage mandate that will apply to fully-insured employer plans and individual market policies. These requirements differ from state to state and could require insurers to cover specific services (i.e., applied behavioral analysis (ABA) for autism). These requirements might also set process rules that insurers must follow such as limits on use of prior authorization for a MH/SUB item or service.

For example, the Massachusetts Parity Law (*An Act Relative to Mental Health Parity*) applies, with some exceptions (i.e., self-funded private employer group plans), to health insurance policies issued or renewed in Massachusetts. The Massachusetts Parity Law mandates coverage for adults and children for 13 biologically-based mental health conditions, including schizophrenia, bipolar disorder, major depression, eating disorders, PTSD, and autism. This coverage must be provided on a non-discriminatory basis. Specifically, annual or lifetime service benefits (e.g., the number of outpatient visits or inpatients days) cannot be less than those imposed for physical illnesses. Likewise, co-payments and deductibles cannot be any higher. Moreover, and equally important, the plans must cover a full range of medically necessary inpatient, outpatient, and "intermediate" services for adults and children. Intermediate services include acute and other residential treatment, detoxification, partial hospitalization, crisis stabilization, and other services.

The Massachusetts Parity Law was further expanded by *An Act Addressing Barriers To Care For Mental Health*, which mandates coverage for (i) annual mental health wellness examinations with no patient cost-sharing, (ii) community-based acute treatment, intensive community-based acute treatment, and mental health acute treatment with no preauthorization required, (iii) services which integrate psychiatric and primary care, (iv) medically necessary emergency services programs, and (v) coverage for dependent persons over 26 years of age on a parent's insurance plan who are mentally or physically incapable of earning their own living due to disability.

If you have questions regarding the Mental Health Parity and Addiction Equity Act or Employee Benefits, please reach out to Rebecca F. Alperin.