AssuredPartners

Mental Health Parity Guide

October 2024

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Introduction to Mental Health Parity Rules

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans offering mental health (MH) or substance use disorder (SUD) benefits to provide such benefits "in parity" with (equal to or better than) the medical/surgical coverage available under the group health plan. MHPAEA does not require group health plans to provide MH or SUD benefits, but if they do offer such benefits beyond what is considered preventive under the Affordable Care Act (ACA), the parity requirements apply.

Group Health Plans Subject to MHPAEA Requirements

MHPAEA applies to group health plans, but not excepted benefits or retiree-only plans. The rules apply to both fully-insured and self-funded plans, and there is no exception for church plans. There is an exception for small employers (generally <50 employees) offering grandmothered, grandfathered or level-funded/self-funded plans, but most small employers with fully-insured plans will need to comply with MHPAEA – see more below. NOTE: There was originally an option for non-federal government entities offering a self-funded plan to opt-out, but this opt-out option was removed by legislation passed late in 2022.

For purposes of compliance with the parity rules, the term "group health plan" includes not only a major medical plan offering, but other benefits providing MH/SUD benefits as well. For example, telehealth benefits, carve-out prescription drug benefits, employee assistance programs (EAPs) not qualifying as excepted benefits, etc. If an employer or organization has multiple arrangements by which it provides health care benefits, and any participant can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, such combination of arrangements is treated as a single group health plan subject to the parity requirements.

For fully-insured plans, the insurance carriers are primarily responsible for compliance with MHPAEA. For self-funded plans, while the employer likely relies heavily on a third-part administrator (TPA) and other service providers to design and administer the group health plan, the employer is primarily responsible for complying with MHPAEA, so the employer must take care to choose competent service providers.

Small Employer Exception

Small employers are generally exempt from MHPAEA. For this purpose, a small employer is defined as an employer who employed not more than 50 employees on business days during the previous calendar year. Non-federal governmental employers with fewer than 100 employees are also exempt. However, the Affordable Care Act (ACA) requires coverage for MH/SUD benefits as an essential health benefit for small fully-insured group health plans, and employers subject to the ACA's essential health benefit rules are required to provide these benefits in a manner that complies with MHPAEA. Consequently, small fully-insured employers will generally be required to offer MH/SUD benefits in parity with other benefits offered by the plan.

Significant Increase in Cost

Employers who experienced an increased cost attributable to the MH/SUD benefits of at least 2% in the first year MH/SUD benefits are offered, or any subsequent year's cost increase of 1% or more, may be able to avoid MHPAEA requirements for one year. It is very rare for a plan to take advantage of the cost exception. An employer/plan sponsor must follow detailed financial analysis rules and have their compliance certified by an actuary to take advantage of this exemption. Furthermore, the cost exception applies for only one plan year. If the plan continues to offer MH/SUD benefits, the plan would need to meet the parity rules for the next plan year.

General Parity Rules

If a group health plan provides medical/surgical benefits and MH/SUD benefits beyond preventive care as required by the ACA, the plan's MH/SUD benefits are subject to the following parity requirements (as compared to the plan's medical/surgical benefits):

- Same or more generous annual/lifetime limits;
- Equal financial requirements and quantitative treatment limitations; and
- Equal treatment for non-quantitative treatment limitations.

The definitions of medical/surgical, MH, and SUD benefits for this purpose should be defined under the terms of the plan in accordance with the most current version of the International Classification of Diseases (ICD), and for MH/SUD benefits, the Diagnostic and Statistical Manual of Mental Disorders (DSM). If the condition or procedure is not clearly addressed by the ICD or DSM, then applicable federal and state law may be used to define the benefit as medical/surgical, MH or SUD.

The parity rules must be followed for any MH/SUD benefits provided by the plan. In addition, beginning in 2026, plans must provide meaningful benefits for any MH/SUD conditions or disorders covered by the plan. Guidance indicates that an exclusion of all benefits for a particular condition or disorder would be permitted, although such exclusions may run afoul of other requirements (e.g., state insurance mandates, Americans with Disabilities Act prohibitions on discriminating against disabilities, §1557 nondiscrimination rules).

Meaningful Benefits

Final rules released in 2024 clarify that beginning with 2026 plan years, if a plan provides any benefits for a specific MH/SUD condition or disorder, the plan must provide "meaningful benefits" for that condition or disorder in every classification in which medical/surgical benefits are provided. To satisfy this requirement, a plan must provide core treatment (or if there is no core treatment, at least some benefits) for that specific condition or disorder in each classification in which the plan provides benefits for a core treatment for medical conditions or surgical procedures. "Core treatment" is defined as *"a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice."* Examples in the final regulations address how this new requirement may apply for autism spectrum disorder (ASD), eating disorders, and opioid use disorders.

Annual & Lifetime Limits

In general, under MHPAEA, a group health plan may impose lifetime or annual maximum limits on MH/SUD benefits only if the group health plan imposes lifetime or annual limits on more than 1/3 of all medical/surgical benefits. The ACA prohibits lifetime or annual dollar limits for any essential health benefits covered by the group health plan. Many MH/SUD benefits are essential health benefits as set forth in the applicable state benchmark plan, in which case the plan cannot impose a lifetime or annual dollar limit on such benefits under the ACA rules. In addition, even for MH/SUD benefits that may not be essential health benefits, it is unlikely that a plan will impose lifetime or annual limits on enough medical/surgical benefits to allow for such limits to apply to MH/SUD benefits. Therefore, the ACA restriction on lifetime and annual maximum for essential health benefits makes the parity rule limits on lifetime or annual maximums largely irrelevant. In almost all cases, a group health plan will not be able to impose lifetime or annual dollar limits on any MH/SUD benefits.

Financial Requirements & Treatment Limitations

The parity of any financial requirements, quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) is determined on a classification-by-classification basis, as seen in the table below. Plans must provide MH/SUD benefits in parity in all classifications where medical/surgical benefits are available.

MHPAEA – Permitted Classifications	
Inpatient, in-network	Inpatient, out-of-network
Outpatient, in-network*	Outpatient, out-of-network*
Emergency care	Prescription drugs

**Outpatient services may be sub-classified into (a) office visits and (b) all other outpatient items and services but plans generally cannot further sub-classify generalists and specialists.*

Multiple providers for in-network tiers may be used as a further sub-classification so long as the tiering is not based on whether a provider is a provider of medical/surgical or MH/SUD services.

Additional Classification Clarifications

Tiers of Coverage

If a plan applies different financial requirements or treatment limitations to different tiers of coverage (e.g., single or family), then that financial requirement or treatment limitation must be reviewed separately for each coverage unit to determine the predominant level of that requirement or treatment limitation.

Prescription Drug Coverage

A plan is permitted to apply different financial requirements to different tiers of prescription drug benefits based on certain reasonable factors (e.g., generic versus brand name and mail order versus pharmacy pick-up) so long as the difference is not tied to whether a drug is generally prescribed with respect to medical/surgical benefits or with respect to MH/SUD benefits.

Network Requirements.

If the plan does not contract with a network of providers, all benefits are out-of-network. If the plan provides coverage for out-of-network providers for medical/surgical benefits, then coverage must also be provided for out-of-network MH/SUD benefits.

Cumulative Requirements and Limitations

No separate cumulative financial requirement or QTL may apply to MH/SUD benefits, even if the limits are equal to those imposed on medical/surgical benefits. In other words, separate but equal is not allowed (e.g., deductibles, out-of-pocket maximums, visit limits for MH/SUD benefits that accumulate separately from those for medical/surgical benefits in the same classification are not permitted).

Intermediate Benefits

Coverage must be available for intermediate MH/SUD benefits such as residential treatment, partial

hospitalization, and intensive outpatient treatment in the same way that it is covered for medical/surgical benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well.

Scope of Benefits

Scope of benefits has not been defined in detail, but restrictions based on geographic location, facility type, provider specialty or other criteria limiting scope or duration must also comply with the parity rules.

Financial Requirements & Quantitative Treatment Limitations (QTLs)

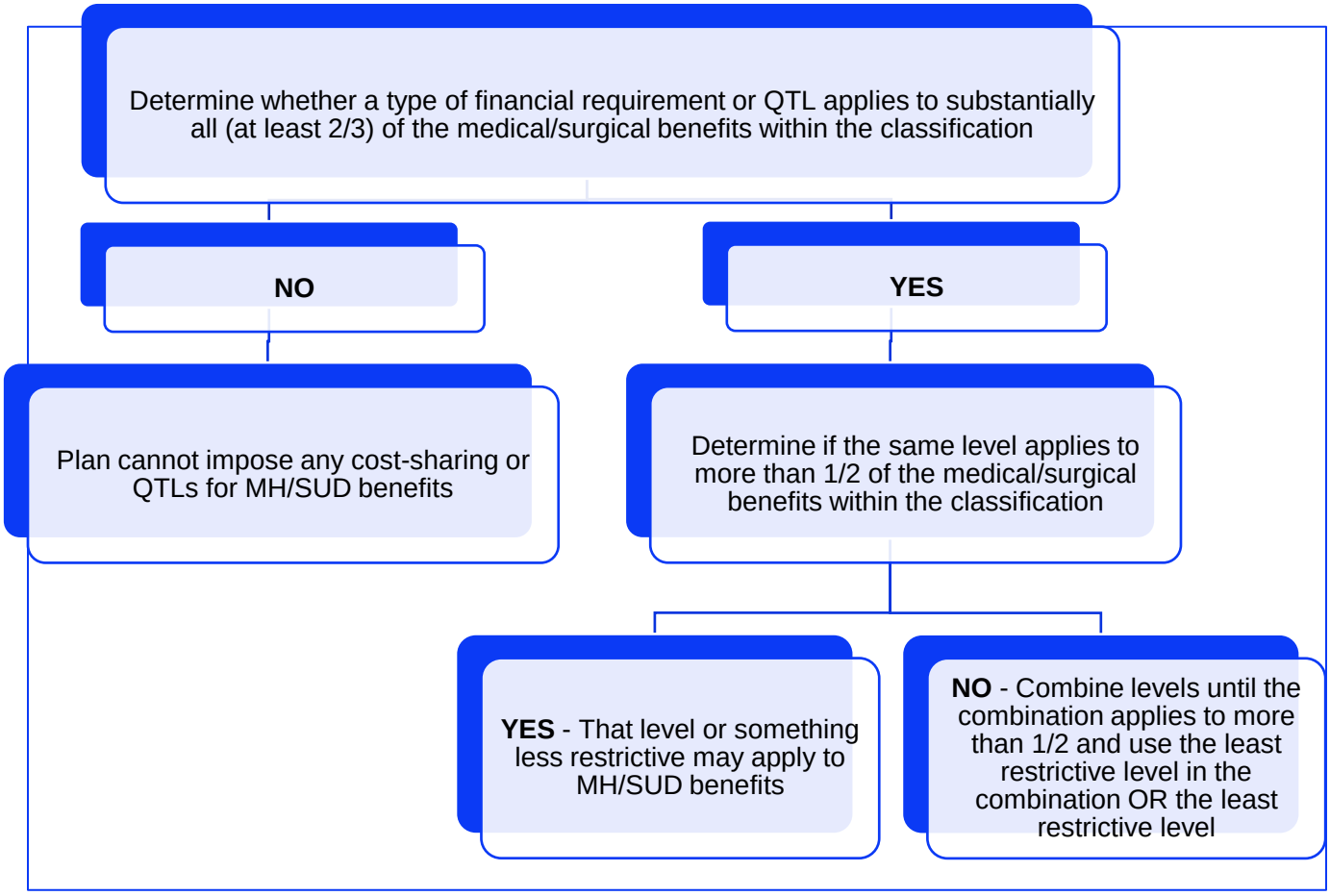
A group health plan must ensure that the financial requirements and QTLs are no more restrictive for MH/SUD benefits than the predominant financial requirements and treatment limitations that apply for substantially all (i.e., 2/3) of the medical/surgical benefits. For this purpose, financial requirements include deductibles, copays, coinsurance and out-of-pocket expenses, but exclude annual and lifetime limits. QTLs include limits on the frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of treatment.

Substantially-All Test

The substantially-all test determines whether and what type of financial requirements or QTLs can apply to MH/SUD benefits within a classification.

- If there is no type of financial requirement or QTL that meets the 2/3 (“substantially all”) threshold, then the plan cannot apply any financial requirement or QTL for MH/SUD benefits within that classification; all MH/SUD benefits within that classification must be covered at 100%.
    - The calculation of whether a financial requirement or QTL applies to at least 2/3 of the medical/surgical benefits within a classification is based on the dollar amount of plan payments expected to be paid for the plan year within the classification.
    - Benefits expressed as a zero-level type of financial requirement (e.g., $0 copay) are treated as benefits not subject to that type of financial requirement.
- If a type of financial requirement or QTL meets the 2/3 threshold, then the predominance test determines the maximum level of that type of financial requirement or QTL that can apply to MH/SUD benefits within a classification or sub-classification.
    - The predominance test is used to determine if the same level of financial requirement or QTL applies to more than ½ of medical/surgical benefits within a classification. If no level applies to more than ½ of medical/surgical benefits, then levels should be combined until the combination applies to more than ½ of medical/surgical benefits. Either the least restrictive level from that combination, or the least restrictive level in general, may then be applied to MH/SUD benefits.

The following analysis should be performed within each classification or sub-classification:



Substantially-All Test Examples for Financial Requirements & QTLs

Example 1:

For outpatient, in-network coverage other than office visits, the plan imposes a mix of copays and coinsurance for medical/surgical benefits. Neither copays nor coinsurance apply to at least 2/3 of the medical/surgical benefits within this classification (i.e., neither applies to substantially all medical/surgical benefits), therefore the plan cannot impose a copay or coinsurance on MH/SUD benefits within this classification.

Example 2:

For outpatient, in-network office visits, the plan imposes a copay for at least 2/3 of the medical/surgical benefits. The copay is $25 for general office visits and $45 for specialist office visits. The $25 copay applies to more than 1/2 of the outpatient, in-network office visits, so a copay of $25 or less may apply to MH/SUD benefits in this classification.

Example 3:

For outpatient, in-network office visits, the plan imposes a copay for at least 2/3 of the medical/surgical benefits. The plan applies copays of $50, $25, $15 and $10 to different in-network office visits. No single copay amount applies to at least 1/2 of the medical/surgical outpatient, in-network office visits, but a combination of $50, $25 and $15 copays does. In this case, $15 would be the predominant level, so a copay of $15 or less may apply to MH/SUD benefits in this classification. Alternatively, a copay of $10 or less could be used since $10 is the least restrictive level.

Non-Quantitative Treatment Limitations (NQTLs)

A group health plan must ensure that the NQTLs are no more restrictive for MH/SUD benefits than the predominant NQTLs that apply for substantially all of the medical/surgical benefits. The regulations require that NQTL factors, standards, and processes be in parity both "as written" and "in operation." For this purpose, NQTLs are non-quantitative restrictions and exclusions on the scope or duration of care. Examples of NQTLs include:

- Medical management standards (e.g., prior authorization) limiting or excluding benefits based on medical necessity or appropriateness, or based on whether treatment is experimental/investigative;
- Formulary design for prescription drugs;
- Network tier design;
- Standards related to network composition, including but not limited to, admission standards, reimbursement rates, credentialing standards, and procedures for ensuring network adequacy;
- Plan methods for determining usual, customary and reasonable charges for out-of-network rates;
- Refusal to pay for high-cost therapy until it is shown that a lower-cost therapy is not effective (aka fail-first or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan.

Unlike the mathematical analysis used to determine compliance for financial requirements or QTLs, final rules released in 2024 suggest a 2-part test to determine compliance for NQTLs. NQTLs applied to MH/SUD benefits must meet both: (i) a design and application requirement; and (ii) a relevant data evaluation requirement.

Design and Application Requirement

A plan may not impose an NQTL for MH/SUD benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or

other factors used in designing and applying the limitation with respect to medical/surgical benefits. In addition, a plan cannot rely upon discriminatory (biased or not objective) factors or evidentiary standards to design or apply an NQTL for MH/SUD benefits.

DEFINITIONS

Processes = actions, steps, or procedures that a group health plan uses to apply an NQTL.

Strategies = practices, methods, or internal metrics that a plan considers, reviews, or uses to design an NQTL.

Evidentiary Standards = any evidence, sources, or standards that a group health plan considered or relied upon in designing or applying a factor with respect to an NQTL, including specific benchmarks or thresholds.

Factors = all information, including processes and strategies (but not evidentiary standards), that a group health plan considered or relied upon to design an NQTL, or to determine whether or how the NQTL applies to benefits under the plan or coverage.

Relevant Data Evaluation Requirement

The plan must collect and evaluate relevant data (e.g., number and percentage of claims denials, network utilization, network adequacy metrics, provider reimbursement rates) to assess the application of an NQTL and how it impacts access to MH/SUD benefits. If after examining relevant data it is discovered that there are material differences in access to MH/SUD benefits in comparison to medical/surgical benefits, the plan must take reasonable action as necessary to address any material differences in access. For example, within a classification, similar medical management techniques may apply to medical/surgical benefits and MH benefits; however, if after analyzing the percentage of claims denied, the data shows MH benefit claims being denied at a much larger percentage than medical/surgical benefits, the plan may need to make adjustments.

Specific to network composition, the plan must collect and evaluate relevant data to assess the aggregate impact of NQTLs on access to benefits. The rules suggest certain actions that could be taken if material differences in access are discovered related to network composition (e.g., recruit and encourage more network participation, expand telehealth, assist plan participants in finding in-network care, keep provider directories current).

Earlier regulations included a broad exception for variation in access to coverage to the extent that recognized clinically appropriate standards of care permitted a difference. This exception was removed in the final rules issued in 2024, but the agencies suggest that such differences would not be deemed a material difference in access clearly requiring reasonable action.

Tip: Obtaining Relevant Data

There is no defined time frame or specific list of the types of data that must be collected and analyzed. There is some flexibility to collect and analyze the appropriate data as determined by the employer to examine compliance with MHPAEA and to meet the content requirements of the comparative analysis. That being the case, it seems likely that such efforts will be required on an ongoing basis (e.g., at least every 1-3 years) to address changes in plan design and claims processes and to ensure that relevant data is considered. Notably, while plan design may not change year to year, service providers administering benefits on behalf of a plan likely review their standards and practices annually, in which case additional analysis may be required to incorporate any changes.

For new NQTLs, or for NQTLs for which there is no relevant data, there is the ability to justify and explain this position in the written comparative analysis, but employers are expected to collect and analyze relevant data as soon as it becomes available.

The final rules released in 2024 recognize that many employers have struggled to obtain the relevant data from service providers (e.g., TPAs, PBMs) necessary to analyze compliance with MHPAEA and to prepare a comprehensive comparative analysis. The agencies recommend that employers who continue to struggle to get relevant data from their service providers should contact the agencies (e.g., the Department of Labor (DOL)).

Disclosures

Plan information and claim adjudication disclosures related to MH/SUD coverage are subject to existing ERISA requirements and other disclosure rules such as inclusion in a summary of benefits and coverage (SBC). If the plan is not subject to ERISA, the reason for the claim denial must be provided upon the request of a participant or beneficiary within a reasonable time and manner.

Claims Processing

The criteria for medical necessity determinations made under the plan with respect to MH/SUD benefits shall be made available by the plan administrator or carrier to any current or potential participant, beneficiary, or contracting provider upon request. In addition, the reason for any denial under the plan of reimbursement or payment for services with respect to MH/SUD benefits must be made available by the plan administrator or carrier to the participant or beneficiary. This will generally be handled by the carrier for a fully-insured plan and by the TPA for a self-funded plan.

Comparative Analysis

Group health plan sponsors are required to prepare a written comparative analysis documenting compliance for any NQTLs imposed on MH/SUD benefits. The analysis does not need to be submitted annually (or otherwise), but instead must be completed and kept up-to-date in the employer's files and provided if requested (e.g. must be provided within 10 days if requested by a federal or state agency, or within 30 days if requested by ERISA plan participants). NOTE: A thorough, compliant comparative analysis cannot be quickly pulled together within the required timeframe to comply with a request from an agency or plan participant, so it is necessary for employers to complete it and have it ready and on file prior to any request.

Final rules issued in 2024 clarified the content requirements for the comparative analysis, providing much more detail about what is expected to be evaluated and included in the written analysis, and then also require plans to include an evaluation of relevant data beginning in 2026. There are 6 specific content requirements that must be addressed for each NQTL imposed on any MH/SUD benefit. The table below illustrates the comparative analysis content requirements (#5 - analyzing relevant data and actions taken to address any material differences is not required until 2026).

Comparative Analysis Content Requirements
1. Description of the NQTL, which benefits are subject to the NQTL, and which benefits are in which classification
2. List and definitions for any factors and evidentiary standards used to design or apply the NQTL
3. Description of how factors are used in the design and application of the NQTL
4. Demonstration of comparability and stringency of the NQTL, as written
5. Demonstration of comparability and stringency of the NQTL, in operation, including any material differences in access and reasonable action taken to address the material differences
6. Findings and conclusions, including the date the analysis was completed and the title and credentials of persons involved in preparing the comparative analysis

In addition to the above content requirements for the comparative analysis, a list of all NQTLS must be available upon request and automatically provided to any named fiduciaries providing certification as described below.

Fiduciary Certification

To further enforce awareness and compliance with MHPAEA requirements, for plans subject to ERISA, the final rules require that the comparative analysis include a certification by one or more named fiduciaries (e.g., the employer as plan sponsor). The fiduciaries must certify that they *"engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis…and have satisfied their duty to monitor those service providers…"* In other words, plan fiduciaries do not have to certify full compliance with MHPAEA, but instead must certify and take responsibility for due diligence in selecting and monitoring a service provider that can provide what is needed to comply with MHPAEA.

To be able to sign off on the required fiduciary certification, when selecting service providers to assist, the employer may want to solicit bids from multiple service providers to best assess the provider's qualifications, the quality of the services offered, and the reasonableness of the fees charged. In addition, once the comparative analysis is prepared, the employer is expected to review it, ask questions where appropriate, and develop a general understanding of the findings and conclusions.

Non-Compliance

For plans that fail to provide a complete and thorough comparative analysis and then fail to correct any insufficiencies within the timeframe required by the applicable agency, the agencies may direct the plan not to impose any NQTL that cannot be adequately shown to be in parity with medical/surgical benefits. In addition, the plan (or sponsoring employer) may be listed in the agencies' enforcement report to Congress and may have to notify plan participants with something similar to the following:

> "Attention! The [Department of Labor/Department of Health and Human Services/Department of the Treasury] has determined that [insert the name of group health plan or health insurance issuer] is not in compliance with the Mental Health Parity and Addiction Equity Act."

The notice would need to include a summary of the agency's finding of non-compliance and information about how participants can obtain a copy, information for where to direct any questions or complaints, and contact information for the applicable agency. The notice would also be required to include a summary of any changes the plan has made as part of its corrective action plan, including an explanation of any opportunity for a participant to have a claim for benefits newly submitted or reprocessed.

In addition to the potential consequences discussed above for failure to provide a complete comparative analysis when requested by a federal or state agency, for ERISA plans, there is risk of civil penalties for failure to provide the analysis within 30 days of request by a plan participant or beneficiary.

Enforcement Efforts & Non-Compliance

Over time, the focus of the agency has changed as different compliance issues are identified, and as others are addressed and generally brought into compliance. The agency has indicated a desire to focus current efforts on the enforcement of: (i) prior authorization requirements for in-network and out-of-network inpatient services; (ii) concurrent review for in-network and out-of-network inpatient and outpatient services; (iii) standards for provider admission to participate in a network, including reimbursement rates; and (iv) out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

In addition to audits, the comparative analysis provides another tool to help with enforcement. Keep in mind, the purpose of the comparative analysis is to provide further visibility into whether plans are compliant with MHPAEA. Whether the analysis is determined to be sufficient or not, if an agency audit determines that any financial requirements or treatment limitations do not comply with the parity requirements, the plan may be required to take corrective action (e.g., reprocess claims and refund participants when applicable). In addition, non-compliant plans could be subject to a penalty of up to $100/day per affected individual, and if disclosures are not provided as required, general ERISA penalties could apply (e.g., up to $110 per day that the failure persists).

Summary

MHPAEA requirements, including the requirements for plan design and administration as well as the written comparative analysis, can be complex to navigate and implement. Most employers do not have the expertise needed to design a group health plan as required, are not directly involved in claims processing, and do not have access to the level of information needed to prepare a sufficient comparative analysis. Therefore, employers must rely heavily on carriers, TPAs and other service providers to offer a compliant plan design, to properly administer claims, and to evaluate and document compliance in a detailed comparative analysis.

For fully-insured plans, the carrier is directly responsible for compliance and will generally only offer plans that comply with MHPAEA (or will face direct consequences for failure to comply). The carrier will also prepare a written comparative analysis, but it would be appropriate for the employer to request a copy, and for ERISA plans, the employer may need to sign off on a fiduciary certification.

For self-funded plans, while service providers may be co-fiduciaries under ERISA rules, the employer is primarily responsible for compliance and will need to take efforts to ensure that TPAs, PBMs and other service providers involved in designing and administering the plan on the employer's behalf are competent and willing to comply with MHPAEA requirements and to prepare a comparative analysis on behalf of the plan, or at least provide the data needed for another vendor to prepare the comparative analysis. If the TPA will not prepare the comparative analysis, the employer may need to engage another vendor to help collect and analyze plan design and claims data and prepare the comparative analysis.

Resources

DOL Resource Site - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity

The DOL Self-Compliance Tool (must be updated every 2 years) can be found here - https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

Appendix A – MHPAEA Evolution