COMPLIANCE OVERVIEW

Mental Health Parity—Compliance FAQs

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan's medical and surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. In general, if a health plan provides MH/SUD benefits, MHPAEA requires the plan to:

- Offer the same access to care and patient costs for MH/SUD benefits as those that apply to medical/surgical benefits;
- Treat MH/SUD coverage and medical/surgical coverage equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review; and
- Contain a single combined deductible for MH/SUD coverage and medical/surgical coverage.

The Departments of Labor, the Treasury, and Health and Human Services (Departments) have issued frequently asked questions (FAQs) on MHPAEA compliance. This Compliance Overview includes select FAQs on MHPAEA's requirements.

LINKS AND RESOURCES

- Final rule on MHPAEA
- Department of Labor (DOL) webpage on MHPAEA compliance, including links to frequently asked questions (FAQs)
- DOL's Fact Sheet on MHPAEA
- Final FAQs on MHPAEA and the 21st Century Cures Act

Parity Requirements

- The financial requirements applicable to MH/SUD benefits can be no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- A plan's treatment limits for MH/SUD benefits must also comply with MHPAEA's parity requirements.

Disclosures

- Plans and issuers must disclosure the criteria for medical necessity determinations for MH/SUD benefits to a plan participant or participating provider upon request.
- If a plan is subject to ERISA, it must provide certain information on MH/SUD coverage within 30 days of a participant's request.

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MHPAEA—General Compliance FAQs

Q1: What protections does MHPAEA provide for participants and beneficiaries?

The Mental Health Parity Act of 1996 (MHPA) required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. MHPAEA expanded those provisions to include substance use disorder benefits. Thus, under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.

MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to MH/SUD benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

Q2: Can group health plans still apply financial requirements and treatment limitations, such as copays or visit limits on MH/SUD benefits?

Generally, yes. Group health plans and issuers may still apply financial requirements and treatment limitations with respect to MH/SUD benefits; however, they must do so in accordance with the requirements under MHPAEA.

There is a test for determining whether a financial requirement or treatment limitation for MH/SUD benefits is permissible. The general rule is that a plan may not impose a financial requirement or quantitative treatment limitation applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative limitation of that type applied to substantially all medical/surgical benefits in the same classification. How to apply this test is discussed in more detail in the following FAQs.

Q3: What is a financial requirement or quantitative treatment limitation?

The most common types of financial requirements include deductibles, copays, coinsurance and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits (for example, number of treatments, visits or days of coverage). These are just examples; therefore, you could find a type of financial requirement and quantitative treatment limitations that is not specifically listed here.

Q4: The test for determining parity refers to levels of types of financial requirements or treatment limitations. What is a level of a type of financial requirement or treatment limitation?

The level of a type of financial requirement or treatment limitation refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent, different levels of copays include $15 and $20, or different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

Q5: How can I determine if a financial requirement or quantitative treatment limitation applicable to MH/SUD benefits is permissible?

To determine if a quantitative financial requirement (such as a copay) or quantitative treatment limitation (such as a visit limit) is permissible, the parity analysis must be applied for that type of financial requirement or treatment limitation within a coverage unit for each of the six classifications of benefits separately. A coverage unit refers to the way in which

a plan groups individuals for purposes of determining benefits, or premiums or contributions (for example, self-only, family or employee plus spouse). Under MHPAEA, the six classifications of benefits are:

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.

If a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification (for example, if a copay applies to substantially all medical/surgical benefits), then it may be permissible for that requirement or limitation (the copay) to apply to MH/SUD benefits in the same classification. In some circumstances, plans can subdivide certain classifications to account for multiple network tiers, among other things.

Generally, a financial requirement or treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits for the same classification and coverage unit. This two-thirds calculation is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid for the year (or portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on MH/SUD benefits within that classification. There is a detailed test for determining the predominant level, which is discussed in the next FAQ. If, for example, for self-only coverage a $10 copay is the predominant level of copay that applies to substantially all inpatient in-network medical/surgical benefits, that is the most restrictive copay that can apply to inpatient in-network MH/SUD benefits. With respect to the prescription drug classification, there is a special rule for multi-tiered prescription drug benefits.

Q6: If as determined under MHPAEA, it is permissible for my plan to impose a copay on my inpatient, in-network MH/SUD benefits, is there any restriction on the amount of copay that can apply?

Yes. The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on MH/SUD benefits within that classification.

Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the requirement or limitation. If there is no single level that applies to more than one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the requirement or limitation in the classification. The least restrictive level within the combination is considered the predominant level. The determination of the portion of medical/surgical benefits in a classification subject to a financial requirement or treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

Q7: Can my plan impose a higher "specialist" financial requirement with respect to MH/SUD benefits?

A plan may not create sub-classifications for generalists and specialists to determine separate predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. However, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical specialist, then that level of that type of financial requirement can be applied for MH/SUD benefits within that classification.

On the other hand, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical generalist, then the level of that financial requirement charged for MH/SUD benefits within that classification cannot be higher than the level of that financial requirement for "generalist" medical/surgical benefits.

Q8: What are nonquantitative treatment limitations (NQTLs)?

NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies 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 or coverage.

This is an illustrative, non-exhaustive list.

Q9: How does MHPAEA provide for parity with respect to NQTLs?

Under MHPAEA, a plan may not impose a NQTL with respect to MH/SUD benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to MH/SUD benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Q10: My mental health benefits were denied. What information am I entitled to receive from my plan under MHPAEA?

Under MHPAEA, the criteria for medical necessity determinations made under a group health plan (or health insurance coverage offered in connection with the plan) with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary or contracting provider upon request. In addition, under the Employee Retirement Income Security Act (ERISA), documents with information on the medical necessity criteria for both medical/surgical benefits and MH/SUD benefits are plan documents, and copies must be furnished within 30 days of your request.

Additionally, the individual (or a provider or other individual acting as a patient's authorized representative) may request these documents consistent with the DOL claims procedure regulation (and, if the plan is a non-grandfathered health plan, the external review requirements added by the Affordable Care Act would apply).

Q11: I am a participant in a group health plan that provides treatment for anorexia as a mental health benefit. In accordance with the plan terms, my provider, on my behalf, requested prior authorization for a 30-day inpatient stay to treat my anorexia. The request was denied based on the plan's determination that a 30-day inpatient stay is not medically necessary under the plan terms.
I then requested from the plan administrator a copy of its medical necessity criteria for both medical/surgical and MH/SUD benefits (including anorexia), as well as any information regarding the processes, strategies, evidentiary standards, or other factors used in developing the medical necessity criteria and in applying them. May the plan administrator deny me this information based on an assertion that the information is "proprietary" and/or has "commercial value"?

No. The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, regardless of any assertions as to the proprietary nature or commercial value of the information.

Whether a plan that is subject to ERISA can refuse to provide "instruments under which the plan is established or operated" on the basis that the information is "proprietary" was specifically addressed in the DOL's Advisory Opinion 96-14A. The Advisory Opinion rejected that basis for refusal. In that Advisory Opinion, the DOL stated that any documents or instruments that specify formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan (in that case, a schedule of a plan's usual and customary fees) would constitute "instruments under which the plan is established or operated," and must be provided, notwithstanding that the plan asserted that such fee schedules are of a "proprietary" nature. Such information must be disclosed, even in cases where the source of the information is a third-party commercial vendor.

Q12: Can my plan, upon request, provide a summary description of the medical necessity criteria for both MH/SUD benefits and medical/surgical benefits that is written to be understandable for a layperson?

Yes. Although not required to do so, group health plans and issuers can provide a document that provides a description of the medical necessity criteria in layperson's terms. However, providing such a summary document is not a substitute for providing the actual underlying medical necessity criteria, if such documents are requested.

Q13: Are there plans that are exempt from MHPAEA?

Yes. While MHPAEA applies to most employment-based group health coverage, there are a few important exceptions. Specifically, MHPAEA does not apply to small employers who have fewer than 51 employees. There is also an increased cost exception available to plans that follow guidance issued by the Departments. Additionally, plans for state and local government employees that are self-insured may opt out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees). Finally, MHPAEA does not apply to retiree-only plans.

Q14: Who enforces MHPAEA?

The Departments, as well as the states, all have important roles with respect to MHPAEA's implementation. The Departments are working with plans, issuers, and their service providers to help them understand and comply with MHPAEA, and to ensure participants and beneficiaries receive the benefits they are entitled to under the law. Employees with questions about MHPAEA, including complaints about compliance by their employment-based group health plans, can contact the DOL at www.askebsa.dol.gov or 866-444-3272. The DOL will work with the other federal departments and the states, as appropriate, to ensure MHPAEA violations are corrected.

Q15: Does MHPAEA apply to any benefits a plan may offer for Medication Assisted Treatment for opioid use disorder?

Yes. Medication Assisted Treatment (MAT) is any treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment in combination with behavioral health services. The Departments' final regulations implementing MHPAEA define "substance use disorder benefits" as benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage, and in accordance with applicable federal and state law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Opioid use disorder is a type of substance use disorder and MAT is a "substance use disorder benefit" within the meaning of the term as defined by MHPAEA.

Group health plans and issuers that offer MAT benefits must do so in accordance with the requirements of MHPAEA and, accordingly, any financial requirements and treatment limitations may not be more restrictive than the predominant financial requirements and quantitative treatment limitations that apply to substantially all medical and surgical benefits in a classification. In addition, the special rule for multi-tiered prescription drug benefits also applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA.

Q16: Does MHPAEA apply to any benefits a plan or issuer may offer for treatment of an eating disorder?

Yes. The Departments' regulations implementing MHPAEA define "mental health benefits" as benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and

in accordance with applicable Federal and State law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Eating disorders are mental health conditions and therefore treatment of an eating disorder is a "mental health benefit" within the meaning of that term as defined by MHPAEA.

Affordable Care Act—Impact on MHPAEA

Q17: What was the effect of the ACA on MHPAEA?

The ACA provides that MH/SUD services are one of 10 essential health benefit (EHB) categories. Under the EHB rule, non-grandfathered health plans in the individual and small group markets are required to comply with the requirements of the parity regulations to satisfy the requirement to provide EHBs. In addition, Section 1563 of the ACA extends the protections of MHPAEA to the entire individual market, both with respect to grandfathered and non-grandfathered coverage. Therefore:

- *For non-grandfathered individual market coverage*: For policy years beginning on or after Jan. 1, 2014, all non-grandfathered individual market coverage that is not otherwise subject to the U.S. Department of Health and Human Services (HHS) transitional policy must include coverage for MH/SUD benefits, and that coverage must comply with the federal parity requirements set forth in the interim final regulations issued in February 2010. The final regulations apply for policy years beginning on or after July 1, 2014.
- *For grandfathered individual market coverage*: Grandfathered individual health insurance coverage is not subject to the EHB requirements, and therefore is not required to cover MH/SUD benefits. However, to the extent that MH/SUD benefits are covered under the policy, coverage must comply with the federal parity requirements set forth in final regulations for policy years beginning on or after July 1, 2014.
- *For non-grandfathered small group market coverage*: For plan years beginning on or after Jan. 1, 2014, all non-grandfathered small group market coverage that is not otherwise subject to the HHS transitional policy must include coverage for MH/SUD benefits, and that coverage must comply with the federal parity requirements set forth in the interim final regulations issued in February 2010. The final regulations apply for plan years beginning on or after July 1, 2014.

Grandfathered small group market coverage is not required to comply with either the EHB provisions or MHPAEA.

Source: Departments of Labor, the Treasury, and Health and Human Services