Mental Health Parity :
What Group Health Plan Sponsors Need to Know

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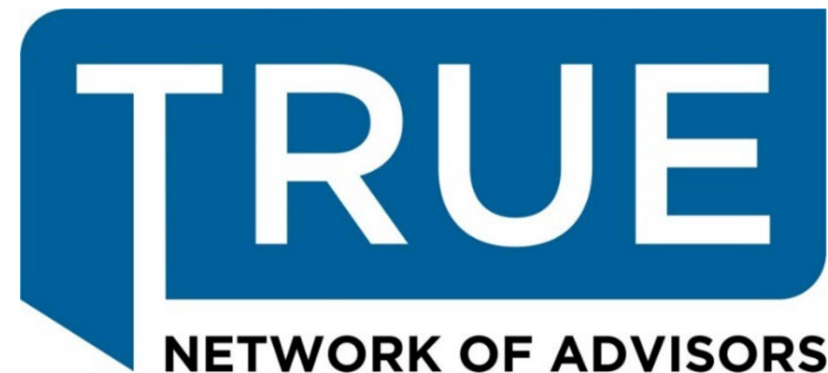

AGENDA

- Mental Health Parity Acronyms and Overview
- Financial Requirements and Quantitative Treatment Limitations (QTLs)
- Nonquantitative Treatment Limitations (NQTLs)
- NQTL Comparative Analyses
- New Requirements from 2024 Final Regulations
- Enforcement and Practical Advice

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Mental Health Parity (MHP) Acronyms

- **MHPA**
  Mental Health Parity Act (1996)
- **MHP**
  General acronym used to described all Mental Health Parity laws
- **MH/SUD**
  Mental Health and Substance Use Disorder
- **HHS**
  Department of Health and Human Services
- **MHPAEA**
  Mental Health Parity and Addiction Equity Act (2008)
- **QTL**
  Quantitative Treatment Limitation
- **M/S**
  Medical and Surgical
- **CMS**
  Centers for Medicare and Medicaid Services (part of HHS)
- **CAA**
  Consolidated Appropriations Act, 2021
- **NQTL**
  Nonquantitative Treatment Limitation
- **DOL**
  Department of Labor

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New MHP Definitions Effective 1/1/2025

- **Processes**
  Actions, steps, or procedures that a plan or issuer 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 plan or issuer considered or relied upon in designing or applying a factor with respect to an NQTL
- **Factors**
  All information, including processes and strategies (but not evidentiary standards), that a plan or issuer considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan or coverage

Revised definitions for the following:

- M/S Benefits
- MH Benefits
- SUD Benefits

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What Plans are Subject to MHP Laws?

- Generally applies to "group health plans"
- Does not apply to "excepted benefits"
  (*e.g.*, most health FSAs, dental, vision, etc.)
- No exemption for church plans
  Governmental plan opt-out expired at end of 2022
- Exclusion for retiree-only plans and "small" employers
  Small generally means employer had 50 or fewer employees on business days during preceding calendar year

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MHP Overview

- Under the MHPAEA, group health plans must ensure that any limitations placed on MH/SUD benefits are no more restrictive than those placed on M/S benefits
- Three mandates – Ensure parity as to:

1. Annual or lifetime limits – Generally rendered moot due to ACA's prohibition on annual or lifetime limits for essential health benefits
2. Financial requirements (*e.g.*, deductibles, copay/ coinsurance, OOPMs) and QTLs (*e.g.*, number of treatments, visits, or days of coverage); and
3. NQTLs (*e.g.*, prior authorization, prescription drug formulary design, network composition, or fail-first protocols)

Six Classifications

Six classifications (and several permitted "sub-classifications"):

1. Inpatient, in-network;*
2. Inpatient, out-of-network;
3. Outpatient, in-network;*
   - Office visits
   - All other items/services
4. Outpatient, out-of-network;
   - Office visits
   - All other items/services
5. Emergency care;
6. Prescription drugs.

*Some plans have multiple "tiers" of in-network providers (e.g., regular vs. preferred in-network providers). In such case, sub-classifications for each tier generally are permissible.

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Six Classifications

If a plan or insurer provides MH/SUD benefits in any of the six classifications described in the MHPAEA final regulations, then MH/SUD benefits* must be provided in every classification in which M/S benefits are provided

1. Inpatient, in-network;
2. Inpatient, out-of-network;
3. Outpatient, in-network;
   - Office visits
   - All other items/services
4. Outpatient, out-of-network;
   - Office visits
   - All other items/services
5. Emergency care;
6. Prescription drugs.

*Expanded Requirement under 2024 Regulations:

For plan years beginning on or after January 1, 2026, plans that offer any benefits for a MH/SUD conditions in any classification must provide "meaningful benefits" for that condition in every classification in which M/S benefits are provided

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Six Classifications

Meaningful Benefits:

- To be "meaningful," plan must cover "core treatment" for the condition in each classification in which plan covers a "core treatment" for one or more M/S conditions
- "Core treatment" means a standard treatment or course of treatment, therapy, service or intervention indicated by generally recognized standards of current medical practice
  - Regulations provide examples specifying that coverage of ABA therapy is a "core treatment" for ASD and nutritional counseling is a "core treatment" for eating disorders

1. Inpatient, in-network;
2. Inpatient, out-of-network;
3. Outpatient, in-network;
   - Office visits
   - All other items/services
4. Outpatient, out-of-network;
   - Office visits
   - All other items/services
5. Emergency care;
6. Prescription drugs.

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Financial Requirements and Quantitative Treatment Limitations (QTLs)

- "Financial requirements" include deductibles, copays, coinsurance, and out-of-pocket maximums (OOPMs)
- "QTLs" include limits on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or "other similar limits on the scope or duration of treatment"
  - A permanent exclusion of all benefits for a particular condition or disorder is not a "treatment limitation"
- If a financial requirement or QTL:
  - DOES NOT apply to "substantially all" of the M/S benefits in a given classification, then it cannot be applied to MH/SUD benefits in that classification
  - DOES apply to "substantially all" of the M/S benefits in a given classification, then the financial requirement or QTL may also be applied to MH/SUD benefits in that classification, but only if the "level" of that financial requirement or QTL is no more restrictive than the "predominant level" of that financial requirement or QTL when it is applied to M/S benefits

Financial Requirements and QTLs: Substantially All

- A financial requirement or QTL applies to "substantially all" of the M/S benefits in a classification (or sub-classification) if it applies to at least 2/3 of all M/S benefits in that classification (or sub-classification)
- Whether it applies to at least 2/3 of all M/S benefits is determined "based on the dollar amount of all plan payments for the M/S benefits in the classification" that are "expected to be paid under the plan for the plan year"

Financial Requirements and QTLs: Predominant Level

- Level = Magnitude of the financial requirement QTL
  - For example, if a plan has $25 and $50 copays, the "levels" for the copays are $25 and $50
- Is there a single level that applies to more than ½ of M/S benefits?
  - If yes, then use that level for MH/SUD benefits
  - If no, then aggregate the levels (starting with the highest level and moving down) until you get above 50%
    - Level that can be applied to MH/SUD = the lowest of the aggregated levels
- If a plan applies different financial requirements or QTLs to different "coverage units" (*aka*, tiers) (*e.g.*, employee-only, employee+1, family, etc.), then the "predominant level" analysis must be applied separately for each coverage unit

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Financial Requirements and QTLs: Special Considerations

- Must use enough data to perform the analysis consistent with the applicable Actuarial Standards of Practice. If plan-specific data is insufficient, then the plan should use reasonable data from other similarly structured plans with similar demographics
- No separate cumulative financial requirements or QTLs (*e.g.*, deductibles and OOPMs) are permitted on MH/SUD benefits
- Special Rule for multi-tiered prescription drug benefits

Nonquantitative Treatment Limitations (NQTLs)

- NQTL = Non-numeric limit on the scope or duration of benefits
- Examples:

Medical management standards limiting benefits based on medical necessity, appropriateness, or whether treatment is experimental or investigative Note: Medical management standards are implemented by processes such as prior auth., concurrent review, retrospective review, case management, and utilization review
Rx formulary design
Network tier design
Standards for provider admission to participate in a network
Methods for determining out-of-network rates (e.g., UCR)
Fail-first (aka, step-therapy) protocols
Exclusions based on failure to complete a course of treatment
Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits

NQTLs : Generally

- Plans may not impose an NQTL on MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all M/S benefits in the same classification
- Cannot have separate NQTLs that are applicable only to MH/SUD benefits
  - But not required to have the exact same NQTLs for MH/SUD and M/S benefits, because application of the "comparable processes" rule can have disparate results

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NQTLs : New Rules (1/1/2026)

1. Design and Application Requirement:
   - The processes , strategies, evidentiary standards, or other factors ("Processes") used in designing and applying an NQTL to MH/SUD benefits within a classification must be comparable to, and applied no more stringently than, the Processes used in designing and applying the NQTL to M/S benefits in the same classification
2. Relevant Date Requirement
   - Must collect and assess "relevant data" that is reasonably designed to evaluate an NQTL's effect on relevant outcomes related to accessing MH/SUD and M/S benefits (*e.g.* , number and percentage of claims denials, or for network composition, in-network and OON utilization rates)
   - If relevant data shows NQTL contributes to material differences in access to MH/SUD benefits vs. M/S benefits, plan sponsor must take action to address, and document the actions taken
3. Special emphasis on NQTLs related to network composition

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NQTLs : Comparative Analysis

- Consolidated Appropriates Act, 2021 (CAA) added the requirement for plans to perform and document a “comparative analyses of the design and application” of NQTLs on MH/SUD benefits vs. M/S benefit – Originally effective beginning February 10, 2021
- Analyses must be available to agencies upon request, and agencies must request at least 20 per year

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Comparative Analysis

Six Steps

1. Description of NQTLs:
   - Identify each NQTL, including the specific terms of the plan, policies, or other documents describing the NQTL
   - Identify all MH/SUD and M/S benefits to which the NQTL applies
   - Describe which benefits are included in which classifications

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Comparative Analysis
Six Steps

2. Factors and Evidentiary Standards:

- Identify and define every factor and evidentiary standard considered or relied upon, and the sources from which each evidentiary standard was derived, in determining which benefits are subject to the NQTL
- Include a definition and detailed description of each factor and a description, and the source, of each evidentiary standard used to design or apply each factor
  - Beginning in 2026, include a description of any steps taken to correct, cure, or supplement any "biased" information, evidence, sources, or standards

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Comparative Analysis
Six Steps

3. Use of Factors in Design and Application of NQTLs:

- Describe how each factor is used in the design or application of the NQTL, including a detailed explanation of how each factor is used to determine which benefits are subject to the NQTL
- Explain the evidentiary standards considered or relied upon in designing or applying the NQTL
- If application of the factor depends on decisions made in administering benefits, the nature and timing of the decisions, and qualifications of the decision-maker
- If more than one factor is used, explain how the factors relate to each other, the order of application, and whether and how factors are given more weight
- Identify any variation in how a factor is used when applying an NQTL to MH/SUD vs. M/S benefits

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Comparative Analysis Six Steps

4. Comparability "As Written":

- Evaluation of whether, in any classification, as written, the factors used in designing and applying NQTLs to MH/SUD benefits are comparable to and applied no more stringently than the factors used for M/S benefits
  - Including (a) documentation of each factor, including quant. data, calculations, or other analyses, and (b) plan records documenting the consideration and application of all factors and evidentiary standards, and results of their application
- Comparison of how NQTLs, as written, are designed and applied to MH/SUD and M/S benefits, including the specific provision of such items as forms, checklists, and procedure manuals
- Documentation demonstrating how the factors are comparably applied
- Explanation of the reasons for deviations or variations in applying the factors and how the plan established the deviations or variations

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Comparative Analysis Six Steps

5. Comparability "In Operation":

- **Evaluation of whether, in any classification, in operation, the factors used in designing and applying NQTLs to MH/SUD benefits are comparable to and applied no more stringently than the factors used for M/S benefits**
- **Comprehensive explanation of how plan conducts such an evaluation, including —**
  - Methodology and underlying data used;
  - Sample period, inputs used in calculations, definition of terms used, and other criteria;
  - If relevant data is temporarily unavailable, a detailed explanation of why it is unavailable, and when and how it will be available, collected, and analyzed;
  - If plan's position is that no data exists, reasonable justification for such position;
  - Identification of the data collected and evaluated;
  - Documentation of the outcomes resulting from application of NQTLs to MH/SUD vs. M/S benefits; and
  - Detailed explanation of any material differences in access demonstrated by the outcomes, including (a) extent to which differences are not attributable to NQTL comparability differences or are attributable to generally recognized independent professional medical standards or measures designed to prevent fraud and abuse, and (b) actions taken by the plan to address any material differences

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Comparative Analysis
Six Steps

6. Findings and Conclusions:

- Plan's findings and conclusions regarding comparability and stringency of NQTLs as written and in operation, including any findings indicating that plan might not be in compliance and any actions taken, or that will be taken, to address noncompliance
- Citations to any additional info not otherwise included in comparative analysis that supports findings and conclusions
- Date the analysis is completed, and title and credentials of persons who prepared analysis
- Assessment of the qualifications of each expert used in preparing the analysis
- Fiduciary certification

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Fiduciary Certification (1/1/2025)

- For ERISA plans, one or more plan fiduciaries must certify in writing that they believe a "prudent process" was used to select one or more "qualified service providers" to perform and document the comparative analysis, and they satisfied their duty to monitor the service provider(s)
  - Fiduciary must review comparative analysis and should ask questions, discuss with service providers, understand findings and conclusions, ensure service provider "provides assurance that, to the best of its ability, the NQTL and comparative analysis complies with the requirements of MHPAEA"
- DOL attorney said there is flexibility on who constitutes "qualified service provider"
- Unclear how employers with fully-insured plans will address this

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Liability and Enforcement

- If DOL request comparative analysis, the plan must provide it within 10 business days of receipt of the request
  - If determined to be insufficient, plan has 10 business days to provide the required additional information requested
- Initial determination of noncompliance – Plan has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses
- Final determination of noncompliance – Plan must notify all participants and beneficiaries of its noncompliance within 7 business days
- DOL could refer violators to the IRS, and IRS has power to assess excise taxes of up to $100 per day for violations
- For ERISA-covered plans, final 2024 regulations clarify that comparative analyses subject to ERISA § 104(b)(4), which means they must be provided to participants and beneficiaries within 30 days of written request, or be subject to penalty of up to a $110 per day for not providing

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Practical Considerations

- Could 2024 regulations be overturned?
  - Possibility that Trump administration could repeal
  - Possible that federal court could overturn
- Employers should start by asking TPAs or other applicable vendors for updated comparative analyses
- Tough for anyone to know what data will be required at this point – Agencies need to issue further guidance
  - Note that no good faith relief is available yet
- Cost to do work – DOL estimates employer cost at $50K –$150K per plan
  - Many vendors have started doing this work for significantly less. Attorneys (including our firm) do this work, likely for less depending on circumstances

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