JOURNAL of PENSION BENEFITS

Issues in Administration, Design, Funding, and Compliance
Volume 29 • Number 1 • Autumn 2021

Health & Welfare

Mental Health Parity After CAA: A Primer and Next Steps

This column explains the basic requirements for mental health benefits and explains the changes enacted as a part of the Consolidated Appropriations Act, as well as important recent guidance regarding enforcement of the new requirements.

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Congress takes "Mental Health Parity" seriously. Just this year it boosted enforcement and compliance in a big way through new requirements under the Consolidated Appropriations Act, 2021 (CAA) [P.L. 116-260] The United States Department of Labor (DOL) already has begun enforcement of these new provisions that only recently took effect in February of this year. But just what is "Mental Health Parity"? This column provides a basic explanation of the Mental Health Parity Act of 1996 (yes, you read that right, 1996), as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act, as well as the recent changes made by the CAA.

History of Mental Health Parity Law

Mental Health Parity requirements for health plans were first enacted at the federal level in 1996. [29 U.S.S.C. § 1185a] That law only applied to large employer-sponsored health plans with over 50 employees and required plans to set comparable dollar limits on mental health benefits (as compared to medical or surgical benefits). But there were a number of exceptions and dollar limits only tell half the story.

Congress strengthened the law in 2008 with passage of the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA). [P.L. 110-343] MHPAEA added new requirements: (1) financial limits (*e.g.*, copays and deductibles) and "quantitative limits" (*e.g.*, a limit on the total number of visits) could not be stricter than those applied to medical benefits other than mental health benefits; (2) new "nonquantitative" parity requirements (*e.g.*, geographical limitations, pre-authorization requirements); and (3) prohibited lifetime limits (among other changes). Final regulations implementing MHPAEA were issued in 2010 [75 Fed. Reg. 5452 (February 2, 2010)] and updated in 2013 [78 Fed. Reg. 68239 (November 13, 2013)]. The Affordable Care Act extended MHPAEA's protections to small and individual plans by treating these benefits as "essential health benefits" for purposes of determining compliance with the ACA. As discussed below, beginning in 2021, the CAA mandates enforcement of these provisions and gives the DOL new authority to do so. Guidance implementing the CAA was issued on April 2, 2021 [FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 PART 45].

What Is "Parity?"

Parity is required both as to "quantitative limits" and "non-quantitative" limits. No particular benefit is mandated, the only restriction is that mental health benefits must not be subject to greater limits than other medical benefits—this necessarily involves comparisons between the two to apply the statute.

Parity is based on six different classifications for which "parity" (*i.e.*, comparability between mental health benefits and medical/surgical benefits) is required. Plans are required to classify each benefit provided under the plan into one of the following, then determine/compare the type and "predominant level" of each limitation (the "predominant level" is used to determine what restrictions may be placed on mental health benefits):

1. inpatient, in-network benefits;
2. inpatient, out-of-network benefits;
3. outpatient, in-network benefits;
4. outpatient, out-of-network benefits;
5. emergency care; and
6. prescription drug benefits (special rules apply to these).

[26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii)]

The "predominant level" is the level that applies to more than half of the comparable medical benefit and is the most restrictive quantitative limit that can be applied to a comparable mental health benefit.

Nonquantitative limitations include a limitation on the scope or duration of benefits that cannot be quantitatively evaluated (*i.e.*, reduced to numbers) and thus can apply in a wide variety of circumstances. The MHPAEA regulations prohibit a plan or an issuer from imposing non-quantitative limitations, either in writing *or in operation*, more stringently to mental health benefits than they do to other medical benefits. Because of this operational compliance requirement, plans are required to obtain (or perform) a comparison based on actual claims data, which only the carrier (or third-party administrator for a self-funded plan) will have.

To assist plans with compliance, the DOL has issued (and regularly updates) a self-compliance tool that that includes definitions and compliance tips, as well as general information and illustrations. [*https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf*] For example, if a plan provides both medical benefits as well as mental health benefits and covers medical benefits in all benefit classifications, but does not cover outpatient services for mental health benefits for either in-network or out-of-network providers, the Plan fails to meet MHPAEA's parity requirements.

What Changed in 2021?

The CAA created a new requirement for non-quantitative limitations which took effect on February 10, 2021. Under the new law, each plan must create a written "comparative analysis" of each non-quantitative limit on mental health benefits and must provide that analysis to the DOL (or other agency with authority or a participant or beneficiary) upon request. [P.L. 116-260, § 203] The DOL and other federal agencies with jurisdiction to enforce this issued a joint FAQ on April 2, 2021, providing initial guidance on the new

requirement. These comparative analyses are required to be sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying a non-quantitative limitation is comparable and applied no more stringently to mental health benefits than to medical benefits.

For the short term, the DOL has announced that it is rolling out enforcement through existing investigations and intends to focus on any complaints received as well as the following:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

[*See https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf, Q&A 9*]

If the DOL determines that the plan is not in compliance with MHPAEA, the plan must demonstrate compliance no later than 45 days after the DOL's initial determination of noncompliance. If the plan fails to do so, the DOL can make a final determination of compliance in which case, within 7 days after that, the plan must notify all individuals enrolled in the plan that the coverage is noncompliant with MHPAEA. This could trigger private litigation (and the DOL and other agencies, such as state insurance boards, retain their authority to take additional enforcement actions).

What's Next?

The DOL has already started enforcement of the new CAA requirements. Plan sponsors will want to work with their brokers and other advisors to bring health plans into compliance. Plans should check with their insurers or, for self-funded plans, their third-party administrators promptly to confirm that the new comparative analysis that is required is available and obtain a copy (or at the very least, confirmation of the date it will be available and calendar a follow up). ■