

AGENCIES ISSUE GUIDANCE ON MENTAL HEALTH PARITY ISSUES, SIGNAL ENHANCED ENFORCEMENT

On April 23, 2018, the Departments of Labor, Treasury, and Health and Human Services released several pieces of guidance on issues arising under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including 2017 enforcement actions, guidance on mental health parity implementation, and an [action plan](#) for enhanced enforcement in 2018.

The guidance includes:

- [Proposed FAQs \(Part 39\)](#) regarding non-quantitative treatment limitations (e.g., non-numerical limits on benefits, such as preauthorization requirements) and plan disclosure issues;
- An [updated draft model disclosure form](#) participants may use to request information from employer-sponsored health plans;
- A [self-compliance tool](#) for group health plans, plan sponsors, insurance carriers, State regulators and other parties to evaluate MHPAEA compliance by a group health plan or insurance carrier; and
- A 2018 DOL report to Congress titled [Pathway to Full Parity](#).

Highlights of the April 2018 Guidance

2017 MHPAEA ENFORCEMENT ACTIONS

The DOL actively enforces MHPAEA during audits of employer-sponsored group health plans. These cases may stem from participant complaints where the facts suggest the problems are systemic and adversely impact other participants. Penalties for parity violations are limited to equitable relief; if violations are found by a DOL investigator, the investigator requires the plan to remove any offending plan provisions and pay any improperly denied benefits.

Each year the DOL publishes a fact sheet summarizing its enforcement activity during the prior year. Out of the 187 applicable investigations where MHPAEA applied, the DOL cited 92 violations for noncompliance with parity rules in 2017. The fact sheet provides 6 examples of MHPAEA enforcement actions and several are noteworthy because of their required corrections:

- **Restrictions on Residential Treatment Removed.** Removal of impermissible annual day limit on residential treatment for substance use disorder benefits along with payment of previously denied claims. The plan was required to issue a special notice to all participants alerting them of a 30-day window for submission of claims affected by the limitation. Four claims totaling \$74,165 were submitted, reprocessed and paid by the plan. The plan also revised its documents to remove the impermissible limitation for future plan years.
- **Participants reimbursed for excessive copayments.** The plan was required to reimburse over 200 participants a total of \$11,340 for excessive copayments. The plan had charged a higher specialist copayment of \$25 for in-network mental health/substance use disorder (MH/SUD) outpatient visits compared to \$20 for primary care in-network medical and surgical outpatient visits. The plan was revised to remove the impermissible financial requirement for future years.
- **Additional Coverage for Mental Health and Substance Use Disorder Treatment.** The plan failed to provide out-of-network coverage for inpatient and outpatient MH/SUD benefits (where it presumably provided for out-of-network coverage for medical and surgical benefits). As a result of the investigation, 52 MH/SUD claims were reprocessed and the plan paid \$24,152 in previously denied benefits. The plan also revised its documents to comply with parity requirements.

- **Denied Claims Repaid.** The plan paid approximately \$1,700 in claims after discovering errors made in claim administration and processing of counseling visits for a minor and outpatient hospital claims that the plan had pre-certified but later denied. The plan also failed to timely respond to an appeal.
- **Overly Stringent Precertification Requirements Eliminated.** A self-funded plan was required to remove an impermissible precertification requirement. The plan required precertification for some outpatient medical/surgical services but required precertification for all outpatient psychiatric chemical dependency and substance use disorder therapies.
- **Overly Stringent Benefit Requirements Eliminated.** As a result of the DOL's enforcement efforts a plan removed onerous requirements for mental health treatment where participants had to demonstrate that his or her mental illness affected more than one area of daily living to such extent that he or she was dysfunctional and that his or her condition would deteriorate without in-patient treatment.

PROPOSED FAQs (PART 39)

The April 2018 proposed FAQs provide additional guidance regarding non-quantitative treatment limitations (NQTs) and disclosure requirements under the MHPAEA. The proposed FAQs address whether specified plan designs are NQTs and, if so, whether the plan designs comply with the MHPAEA. Among other things, the FAQs clarify that health plans cannot:

- Deny claims for Applied Behavior Analysis therapy (which the plan classified as a mental health condition) as “experimental or investigative” when the NQTL standard, in practice, was applied more stringently to MH/SUD benefits than medical/surgical benefits;
- Reduce reimbursement rates for non-physician practitioners providing MH/SUD services without using a comparable process with respect to reimbursement of non-physician providers of medical/surgical services;
- Exclude coverage for inpatient, out-of-network treatment outside of a hospital for eating disorders such as a residential treatment center where it covers such treatments for medical/surgical conditions following physician authorization and a determination that the treatment is medically appropriate based on clinical standards of care; or
- Apply more stringent guidelines when setting dosage limits for prescription drugs to treat MH/SUD (e.g., buprenorphine to treat opioid use disorder).

Another proposed FAQ provides that the complete exclusion of coverage, including prescription drugs, for a particular condition (e.g., bipolar disorder) does not violate the MHPAEA, although it could raise issues under other laws, especially if the program is insured and subject to state mandate requirements.

The proposed FAQs also address ERISA disclosure requirements for MH/SUD benefits.

- If a plan uses a provider network and furnishes a provider directory with the plan's summary plan description, it must make reasonable efforts to ensure the directory's list of providers is accurate, current, and complete.
 - * The provider list may be furnished in a separate document that is accompanied by the plan's SPD if it is furnished automatically and without charge and the SPD contains a statement to that effect.
- If a plan uses a provider network, a hyperlink or URL for the provider directory may be used in enrollment and plan summary materials, subject to the DOL's electronic disclosure safe harbor requirements.

Additional proposed FAQs address mental health treatment limitations involving provider licensure, network adequacy standards, emergency room care, and use of step therapy “fail first” protocols.

For more examples of plan provisions that could be red flags that a plan might be imposing an impermissible NQTL, see [Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations \(NQTs\) that Require Additional Analysis to Determine Mental Health Parity Compliance](#).

UPDATED DRAFT MODEL DISCLOSURE FORM

The Departments have also issued an updated draft model disclosure form (initially released in June 2017) that plan participants can use to request MH/SUD-related information from their plan or insurer. Plan participants are not required to use the draft model form to request information about their MH/SUD benefits; plan sponsors and issuers must respond to participant requests for this information even if the model form is not used.

The updated form includes expanded background language and additional examples. For instance, the form now includes several examples of factors used in the development of a NQTL (e.g., excessive utilization and recent medical cost escalation) and evidentiary standards used to evaluate those factors.

SELF-COMPLIANCE TOOL

The guidance also includes an updated MHPAEA self-compliance tool that group health plans can use to determine whether they are compliant with the MHPAEA. The tool is the same audit checklist used by DOL investigators for enforcement purposes.

The updated self-compliance tool has significantly more comprehensive guidance regarding NQTLs and disclosure, along with additional examples of what parity is and what it is not.

The DOL has stated it will update the self-compliance tool every two years with additional guidance on MHPAEA's requirements, as appropriate.

NEXT STEPS FOR EMPLOYERS

It is clear from the release of this guidance that mental health parity enforcement remains a high priority for the U.S. Department of Labor. In light of the new guidance and enhanced enforcement, sponsors of health plans and plan administrators should review with their benefit consultants, legal advisors, and third-party administrators or insurance carriers their practices and plan provisions to ensure their compliance with the MHPAEA and take any corrective action. The new proposed FAQs, if finalized, should serve as a guide for future enforcement actions. Employers may also use the updated self-compliance tool to assist with assessing their health plans' compliance.

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