COMPLIANCE BULLETIN

HIGHLIGHTS

- The DOL is actively enforcing compliance with MHPAEA.
- Federal agencies have finalized resources to help group health plan sponsors comply with MHPAEA.
- Employers should consider using available resources to review their group health plan's compliance with MHPAEA.

IMPORTANT DATES

30 Calendar Days
To avoid possible penalties under ERISA, health plan sponsors should respond to participants' requests for information about MH/SUD benefits within 30 calendar days.

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FEDERAL AGENCIES FINALIZE RESOURCES FOR MENTAL HEALTH PARITY COMPLIANCE

OVERVIEW

The Departments of Labor, Health and Human Services and the Treasury (Departments) have finalized resources to promote compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA requires parity between mental health and substance use disorder (MH/SUD) benefits and medical and surgical benefits. These resources include:

- *Final FAQs* on mental health parity;
- A *final model form* that plan participants may use to request information about their MH/SUD benefits.

The Departments also maintain a *self-compliance tool* and have identified *warning signs* of potential MHPAEA violations.

ACTION STEPS

Employers should work with their issuers and benefit administrators to confirm that their health plan's coverage of MH/SUD benefits complies with MHPAEA, including any non-quantitative treatment limitations (NQTLs). Employers should consider using the Departments' resources to understand MHPAEA's requirements and review their plan designs.

COMPLIANCE BULLETIN

MENTAL HEALTH PARITY

MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable limitations on those benefits than on medical and surgical coverage. MHPAEA's parity requirements generally apply to group health plans and health insurance issuers that provide coverage for MH/SUD benefits in addition to medical and surgical benefits.

According to the DOL, it is actively enforcing MHPAEA's requirements. Because many MHPAEA violations involve NQTLs, employers should carefully review their coverage of MH/SUD benefits to confirm that any NQTLs satisfy the parity requirements.

PARITY REQUIREMENTS

Under MHPAEA, the **financial requirements** (such as coinsurance and copays) and **treatment limitations** (such as visit limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits in a benefit classification.

In addition, MHPAEA imposes parity requirements on the **non-quantitative treatment limitations (NQTLs)** that plans may place on MH/SUD benefits. An NQTL is generally a limitation on the scope or duration of benefits for treatment. NQTLs include medical management standards, formulary designs for prescription drugs, plan methods for determining usual, customary and reasonable charges, exclusions based on a failure to complete a course of treatment and restrictions based on facility type or provider specialty.

AVAILABLE RESOURCES

The Departments' *final FAQs* and *warning signs* of problematic NQTLs highlight aspects of plan design that should be carefully reviewed for MHPAEA compliance. The *self-compliance tool* includes a questionnaire that employers can complete to help determine whether their group health plan complies with MHPAEA.

PARTICIPANT DISCLOSURES

MHPAEA requires group health plans and issuers to disclose certain information to plan participants about the plan's coverage of MH/SUD benefits, including the following:

+ Upon request, health plan sponsors and issuers must disclose information on medical necessity criteria for both medical and surgical and MH/SUD benefits, as well as the processes, strategies, evidentiary standards and other factors used to apply an NQTL with respect to medical and surgical and MH/SUD benefits. To avoid possible penalties under ERISA, plan sponsors should respond to these requests within 30 calendar days. If a plan sponsor does not respond within 30 calendar days, penalties of up to $110 per day may apply.

+ Group health plans that are subject to ERISA must provide the reasons for a denial of MH/SUD benefits in the plan's claim denial notice in accordance with the Department of Labor's (DOL) claims procedure regulations. Participants in plans that are not subject to ERISA may request this information, and the plan sponsor must respond within a reasonable time and in a reasonable manner.

FINAL MODEL FORM FOR PARTICIPANT REQUESTS

To help improve MHPAEA disclosures, the Departments released a *final model disclosure request form* that participants, enrollees or their authorized representatives may use to obtain information on their plan's coverage of MH/SUD benefits. The form may be used to request general information about the plan's coverage of MH/SUD benefits or specific information in response to a claim for MH/SUD benefits that was (or may be) denied or restricted by the plan. Plan participants are not required to use the model form to request information about their MH/SUD benefits—health plan sponsors and issuers must respond to participant requests for this information even if the model form is not used.

MHPAEA ENFORCEMENT

The DOL, through its Employee Benefits Security Administration (EBSA), enforces MHPAEA's requirements for private-sector employment-based health plans. EBSA conducts MHPAEA compliance reviews, including for compliance with NQTL requirements, in all its investigations where MHPAEA applies. When EBSA identifies MHPAEA violations in a specific group health plan, it asks the plan to make necessary changes to any noncompliant plan provision and to pay any improperly denied benefit claims.

In fiscal year 2018, EBSA closed 285 health plan investigations, 115 of which included reviews of MHPAEA compliance. These investigations resulted in 21 citations for MHPAEA violations. During the 2018 fiscal year, 55 percent of MHPAEA violations involved NQTLs.

Enforcement Example: A self-funded plan imposed a preauthorization requirement for all outpatient MU/SUD benefits after 24 visits. This requirement did not apply to outpatient medical/surgical benefits. As a result of EBSA's investigation, the plan completely removed preauthorization requirements (including the visit limit threshold) for MH/SUD benefits from its plan documents, and notified participants that the plan's requirement to provide documentation for medical necessity to continue treatment after 24 mental health or substance use disorder visits was eliminated. The plan re-adjudicated 174 impacted claims for 47 participants, and paid $20,075 in claims to the affected participants and their providers.

MORE INFORMATION

More information regarding MHPAEA compliance is available on the DOL's *website* for MH/SUD parity.