GBS Health & Benefits Compliance

Mental Health Parity Requirements and Recent Changes in Final Rule

On September 9, 2024, the Departments of Labor, Health and Human Services, and the Treasury released a final rule to strengthen the Mental Health Parity and Addiction Equity Act (MHPAEA). The purpose of the rule is to ensure that individuals with private health insurance receive mental health and substance use disorder (MH/SUD) benefits on par with medical/surgical (M/S) benefits, without facing additional restrictions.

A key element of the final rule is the introduction of stronger protections against restrictive nonquantitative treatment limitations (NQTLs). Notably, it requires group health plans and insurance issuers to collect and analyze data on NQTLs imposed on MH/SUD services and make adjustments if the data indicates insufficient access.

The final rule applies to issuers and employer sponsors of group health plans for plan years starting on or after January 1, 2025, but certain requirements, such as the NQTL data evaluation, is effective for plan years beginning on or after January 1, 2026.

Overview of MHPAEA

MHPAEA requires parity between a group health plan's M/S and MH/SUD benefits, covering:

- Financial requirements, including deductibles, copayments, and coinsurance;
- Quantitative treatment limitations, like day or visit limits; and
- NQTLs, which affect the scope or duration of benefits, such as prior authorization, step therapy, and provider network standards.

The MHPAEA standards apply to group health plans sponsored by employers with more than 50 employees. Additionally, due to reforms from the Affordable Care Act, small group market insured health plans must also meet federal MH/SUD parity requirements.

The 2021 Consolidated Appropriations Act amended MHPAEA, requiring health plans and issuers to conduct comparative analyses of NQTLs applied to M/S versus MH/SUD benefits. These analyses must include a detailed explanation of plan terms, practices, and the basis for the plan's conclusion that it the NQTLs are in line with MHPAEA.

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Historically, compliance with MHPAEA has been dismal. The Departments continue to receive complaints and investigate cases where health plans and issuers are not compliant with MHPAEA, meaning plans often apply more restrictive conditions on MH/SUD benefits compared to M/S care. This noncompliance, particularly in the design and application of NQTLs, creates greater barriers for individuals seeking MH/SUD coverage. The final rule aims to address these issues, reinforcing MHPAEA requirements and guiding health plans and issuers towards compliance.

Key Overall Changes in the Final Rule

To align with the final rule, health plans and issuers must:

- Define MH conditions and SUDs according to the latest International Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders
- Provide meaningful benefits, including core treatment, for each covered MH condition or SUD in every classification where M/S benefits are offered
- Avoid designing NQTLs using discriminatory factors and evidentiary standards against MH conditions and SUDs
- Collect and evaluate relevant outcomes data, taking action to address significant disparities in access to MH/SUD benefits compared to M/S benefits
- Document comparative analyses with specific elements and make them available to the Departments, relevant state authorities, or individuals upon request

NQTL Data Requirements under Final Rule

NQTLs on MH/SUD benefits must not be more restrictive, in writing or operation, than those applied to M/S benefits within the same classification. Under the final rule, plans and issuers are required to collect and assess data to evaluate the impact of NQTLs on access to MH/SUD and M/S benefits. If data indicates significant material differences in access, this suggests a potential MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits. If material differences in access exist, the plan or issuer must take reasonable action, as necessary, to address them to ensure compliance with MHPAEA in operation.

Comparative Analysis Standards

The final rule establishes minimum standards for developing comparative analyses to assess whether an NQTL, as written and in operation, complies with MHPAEA's requirements. Plans and issuers that cover both M/S benefits and MH/SUD benefits and impose NQTLs on MH/SUD benefits must perform and document a comparative analysis of the design and application of each applicable NQTL. The final rule requires the comparative analysis to contain, at a minimum, six content elements:

1. A description of the NQTL, including identification of benefits subject to the NQTL
2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL

3. A description of how factors are used in the design or application of the NQTL
4. A demonstration of comparability and stringency, as written
5. A demonstration of comparability and stringency in operation, including the required data, evaluation of that data, explanation of any material differences in access and description of reasonable actions taken to address such differences
6. Findings and conclusions

In most cases, issuers and third-party administrators (TPAs) will prepare comparative analyses for employer-sponsored health plans. However, the final rule requires the comparative analyses for ERISA-covered plans to also include a plan fiduciary's (employer's) certification that they have engaged in a prudent process and monitored their service providers.

The final rule generally applies to plan years beginning on or after January 1, 2025. However, the provisions implementing the following requirements are effective for plan years beginning on or after January 1, 2026:

- The meaningful benefits standard
- The prohibition on discriminatory factors and evidentiary standards
- Required use of outcomes data
- Certain related comparative analysis requirements

Enforcement, Penalties and Financial Exposure

According to DOL Congressional reports, most plans are not in compliance with the MHPAEA. The Departments have specifically signaled intent to prioritize providing greater clarity of the rules as well as increasing enforcement measures. In addition, several states are focusing on mental health parity by amending state laws and increasing state enforcement efforts. In sum, employers and issuers of group health plans that fail to comply with MHPAEA face exposure from a variety of scenarios:

- Excise Taxes:
  - The Internal Revenue Service (IRS) can impose an excise tax of $100 per day per affected individual for non-compliance with MHPAEA. This penalty accrues daily until the violation is corrected.
- Civil Monetary Penalties:
  - The Department of Labor (DOL) has the authority to investigate and enforce MHPAEA violations. While the DOL itself does not have independent authority to assess civil penalties specific to parity violations, it can refer cases to the IRS for excise tax assessments. Additionally, the Centers for Medicare & Medicaid Services (CMS) can assess a civil monetary penalty of up to $100 per day per affected individual if a state fails to substantially enforce MHPAEA requirements.

- Private Right of Action:
  - Individuals covered under employer-sponsored group health plans have the right to file lawsuits to recover benefits due to them under the plan, enforce their rights, or clarify future benefits under the plan. This means that plan participants can take legal action against employers or plan issuers for MHPAEA violations.
- State Enforcement Actions:
  - State insurance agencies may also enforce MHPAEA compliance for fully insured plans. Penalties and enforcement mechanisms can vary by state but may include fines, corrective action plans, or other remedies.

October 2024

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