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Compliance Today - August 2021
Best practices for mental health parity: Considerations for implementation

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On December 27, 2020, deep within the lengthy Consolidated Appropriations Act (CAA), Congress enacted additional compliance and oversight requirements for group health plans and health insurers (plans and insurers) (referred to as the Strengthening Parity in Mental Health and Substance Use Disorder Benefits Act).[1] The purpose of these new requirements is to codify existing subregulatory guidance regarding certain requirements for compliance programs under the Mental Health Parity and Addiction Equity Act (MHPAEA).[2] Since its passage in 2008, MHPAEA has required health plans and insurers to ensure that beneficiaries have access to benefits that are designed and delivered in a manner that does not discriminate against individuals with mental health conditions or substance use disorders. The new requirements in the CAA provide further specificity as to the types of documentation and comparative analysis that are required for plans and insurers to demonstrate that their nonquantitative treatment limitations (NQTLs) are nondiscriminatory. NQTLs include a very broad range of managed care practices, including medical necessity criteria and clinical coverage guideline development, utilization management, provider network recruitment and reimbursement rate methodologies, and other practices that constitute a limit on the scope or duration of services.[3] The CAA mandates a step-wise NQTL compliance approach that essentially mirrors and codifies the guidance in the U.S. Department of Labor (DOL) Self-Compliance Tool.[4] To comply with these step-wise NQTL compliance requirements, plans and insurers need to develop and maintain detailed documentation about the processes, strategies, and evidentiary standards they rely upon in the implementation of these NQTLs.

While these requirements specific to NQTLs are unique to MHPAEA, the associated documentation and comparative analyses activities should feel familiar because they mirror some of the traditional documentation and auditing and monitoring functions of a corporate compliance program. Ultimately, plans and insurers need to demonstrate, upon request, that they are continually maintaining compliance with regard to parity—in effect maintaining the capacity to rebut a presumption of noncompliance at any time. This includes auditing and monitoring factors used to determine and apply the NQTLs for mental health/substance use disorder services to demonstrate that they are comparable and no more stringent than those for medical/surgical services in the same classification. Moreover, when noncompliance is identified, the plan or insurer has a system to proactively implement corrective action.

Section 203 of the CAA provides five specific factual and data analytical information steps for each NQTL that

plans and insurers must make available upon request:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all of the benefits (mental health/substance use disorder and medical/surgical) to which each term applies in each benefit classification, i.e., inpatient (in/out of network), outpatient office-based (in/out of network), outpatient other (in/out of network), emergency, and prescription drugs;
2. The factors used to determine that the NQTLs will apply to mental health/substance use disorder benefits and medical/surgical benefits;
3. The evidentiary standards used for the factors (every factor shall be defined, with any other source or evidence relied upon identified);
4. The comparative analysis demonstrating that the process, strategies, evidentiary standards, and other factors used to apply the NQTLs are designed and applied comparably and no more stringently than other NQTLs for traditional medical/surgical coverage; and
5. The specific findings and conclusions reached by the plans and insurers with respect to the health insurance coverage, including analysis related to compliance.