MHPAEA COMPLIANCE: RED FLAG NQTLs

The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to plans and carriers offering health insurance that covers both medical/surgical (MED/SURG) and mental health/substance use disorder (MH/SUD) benefits. Self-insured plans sponsored by small employers (50 or fewer employees) and stand-alone retiree-only medical plans that do not cover current employees are exempted.

Broadly, MHPAEA requires plans that cover MH/SUD benefits to provide such coverage on par with the plan's MED/SURG benefits. This means plans and insurers cannot impose financial requirements (e.g., deductibles, copays, coinsurance, or out-of-pocket maximums), quantitative treatment limitations ("QTLs," e.g., number of covered days, visits, or treatments), or nonquantitative treatment limitations ("NQTLs," e.g., coverage exclusions, prior authorization requirements, medical necessity guidelines, or network restrictions) on MH/SUD benefits that are more restrictive than those applied to MED/SURG benefits. Parity does not mean plans need to cover all mental health treatment, only that coverage guidelines, exclusions, provider networks, and claims practices must not be applied more stringently to MH/SUD benefits than to MED/SURG benefits.

The DOL has identified common "red flag" plan terms that signal possible MHPAEA noncompliance. While these terms do not automatically violate MHPAEA, they call for scrutiny. Plan sponsors should review their plan documents for the following red flags. These terms are typically found in the summary plan description's sections labeled "Covered Services," "Eligible Services," "Exclusions," "Definitions," or wherever prior authorization requirements are discussed.

Red flag plan terms that may be problematic if they are applied more restrictively to MH/SUD benefits than to MED/SURG benefits include NQTLs such as those bulleted below. Note that this NQTL list is not exhaustive.

- Additional or stricter prior authorization/precertification requirements particular to MH/SUD treatment, including prescription drugs.
- Additional or stricter review standards for continuing MH/SUD treatment (e.g., requiring peer-to-peer review of continuing care every X number of days).
- Requiring a case manager (also known as "care manager") only for MH/SUD benefits.
- Exclusions or restrictions on out-of-network MH/SUD benefits.
- Applying experimental/investigational exclusions only to MH/SUD treatment.
- Denial of higher-cost MH/SUD therapies (including prescription drugs) until a lower-cost therapy has been tried and failed (known as "fail first policies" or "step therapy protocols"), or stricter application of fail first policies on MH/SUD benefits.
- Exclusions for MH/SUD treatment where plan beneficiary fails to comply with treatment plan, such as leaving treatment early against a provider's medical advice.
- Exclusions for MH/SUD treatment based on chronicity or lack of treatability, likelihood of improvement, or functional progress.
- Exclusions, limitations, or additional requirements for treatment related to Autism Spectrum Disorder (e.g., applied behavioral analysis (ABA), intensive behavioral treatment (IBT) therapies, or speech therapy). These may include limitations on Autism Spectrum Disorder treatment based on age.
- Exclusions for speech therapy or cognitive therapy to treat MH/SUD conditions.
- Required treatment plan or physician supervision for MH/SUD services.
- Exclusions or limitations specific to eating disorders (e.g., nutritional counseling limitations).
- Exclusions, limitations, or additional requirements for MH/SUD residential treatment or partial hospitalization programs.
- Exclusions for MH/SUD treatment if provided in certain settings (e.g., wilderness, ranch, vocational, recreational, or educational settings).

- Exclusions for MH/SUD treatment programs or facilities based on licensing or accreditation.
- Geographical limitation related only to MH/SUD treatment.
- Virtual or telephonic visit restrictions on MH/SUD treatment.
- Exclusions for certain providers based on licensing (any additional training requirement must be applied to all providers and must not have a disparate impact on MH/SUD providers whose state licensing may not require the additional training).
- Exclusions based on MH/SUD diagnosis (e.g., excluding neuropsychological testing if ordered for depression but not if ordered for traumatic brain injury).
- Exclusions for medication-assisted treatment (MAT) for substance use disorders (e.g., excluding methadone for opioid addiction but not for pain management).
- Telehealth benefits for MED/SURG conditions only (or MH/SUD covered on more restrictive terms or higher cost-share).
- EAP exhaustion requirement applicable only to MH/SUD benefits.

If plan sponsors identify any of these bulleted terms in their plans, the first step is to look for a comparable exclusion or limitation applied to MED/SURG treatment in the same benefit classification (i.e., in-network inpatient; out-of-network inpatient; in-network outpatient; out-of-network outpatient; emergency care; and prescription drugs). Any term that appears to cover MH/SUD benefits less favorably than MED/SURG benefits should be further scrutinized to determine whether the plan design disparity is supported by independent professional medical and clinical standards.

In addition to red flag NQTLs, the plan's financial requirements and QTLs should be reviewed for parity. In particular, the DOL has targeted numerical limits on drug testing for MH/SUD disorders, visit limits on Autism Spectrum Disorder-related therapy, and higher cost-sharing for MH/SUD benefits, including imposing higher specialist copays on all MH/SUD outpatient services.

Since employers have ready access to plan documents, the plan terms are a good place to start the MHPAEA compliance assessment. However, NQTLs are often concealed from the plan documents (i.e., "as written"), only surfacing in how claims are reviewed, denied, or reimbursed (i.e., "in operation"). The DOL has also targeted practices related to disparate provider network adequacy or admission standards and reimbursement rates. These practices include arbitrarily applying a special reduction to all MH/SUD reimbursement rates, with no comparable reduction on MED/SURG reimbursement rates; creating vague or unexplainable disparities in reimbursement rates (e.g., lower rates for MH/SUD providers based on asserted "market characteristics," "leverage," or "negotiations"); or maintaining network adequacy or admission measurements that disfavor MH/SUD providers (e.g., a network composition target of 95% of members living within 10 miles of MED/SURG provider compared to 95% of members living within 30 miles of a MH/SUD provider). These practices are typically controlled by third-party administrators.

Because plan sponsors typically lack ready access to the design factors and application processes behind claims administration guidelines or network composition, they should treat employee complaints as red flags for potential areas of noncompliance. The challenged plan terms or practices (e.g., exclusion, limitation, coverage guideline, or reimbursement rate) should be closely examined with the carrier or third-party administrator handling claims. A plan sponsor's close attention to employee plan grievances may prevent a lawsuit or DOL investigation of a complaint.

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