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# Mental Health Parity: Managing Compliance Across Commercial, Medicaid, and Duals Products

Health Care Compliance Association  
Compliance Institute  
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## Presented by

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2

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## Agenda

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1. History and overview of Parity requirements
2. Parity compliance vs. general program compliance
3. Application of Parity to Medicaid and Dual Eligibles
4. Trends in Parity compliance, enforcement, and litigation

## History and Overview of Parity Requirements

## Legislative and Regulatory History

- **1996: Mental Health Parity Act (MHPA)**
  - Prohibits large group health plans from imposing annual/ lifetime dollar limits on mental health benefits that are less favorable than such limits imposed on med/surg benefits.
- **2008: Mental Health Parity and Addiction Equity Act (MHPAEA)**
  - Applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements
- **2009: Children's Health Insurance Program Reauthorization Act (CHIPRA)**
  - Applies the parity requirements of MHPAEA to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans
- **2010: Affordable Care Act (ACA)**
  - Mandates that MHPAEA compliance Mental Health/Substance Use Disorder (MH/SUD) treatment services be provided as part of an "Essential Health Benefits" (EHB) package under individual, small group, and Medicaid non-managed care Alternative Benefit plans (ABPs)
- **2013 & 2016: MHPAEA Final Rules**
  - MHPAEA Commercial Market Final Rule issued on Friday, November 8, 2013; effective January 13, 2014, MHPAEA Medicaid final rule issued March 30<sup>th</sup> 2016, states required to have demonstrated compliance by October 2, 2017

## MHPAEA – Key Requirements

- **Financial requirements and quantitative treatment limitations (QTLs)** applied to MH/SUD benefits must be no more restrictive than the predominant (1/2) type of financial requirements applied to substantially all (2/3) medical/surgical benefits (med/surg)
- **Aggregate lifetime dollar limits and annual dollar limits (AL/ADLs)** may not be applied to MH/SUD benefits unless
  - They apply to at least one-third of M/S benefits, *AND*
  - The limits for MH/SUD benefits accumulate jointly with, or are no more restrictive than, the limits for M/S benefits.
- **Non-Quantitative Treatment Limits (NQTLs)** -- Processes, strategies, evidentiary standards or other factors used to apply MH/SUD and med/surg **NQTLs must be comparable and no more stringent**
- If **out-of-network coverage** is available for medical/surgical benefits, it must be made available for mental health or substance use disorder benefits

## Parity in Financial Requirements and QTLs

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- **Substantially All Test:** Entity must demonstrate that any financial requirement or QTL for MH/SUD benefits in a classification of benefits (or sub-classification) applies to at least 2/3 of med/surg benefits in the classification (or sub-classification)
- **Predominant Test:** Entity must demonstrate that any financial requirement or QTL that passes the substantially all test and is in place for MH/SUD benefits in a classification (or sub-classification) is no more restrictive than the predominant (more than ½) level of financial requirement or QTL used for med/surg benefits in the classification
  - Ex: In the inpatient, in-network classification, a copay is in place for 85% of med/surg benefits, therefore a copay may be used for inpatient, in-network MH/SUD benefits. A copay of \$100 is used for 60% of inpatient, in-network med/surg benefits to which a copay applies, therefore the copay for MH/SUD benefits in the inpatient, in-network classification must be \$100 or less

Note: For any financial requirement or QTL for which there is no predominant level, the entity must demonstrate that it combined levels until it exceeded the ½ threshold and selected the least restrictive level of the combination

## Parity Requirements for Disclosures

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- Plans and insurers must make MH/SUD **medical necessity criteria** available to any enrollee, potential enrollee or contracting provider upon request
- Plans and insurers must make available the **reason for any denial** of reimbursement or payment for services for MH/SUD benefits to the enrollee

## Parity Requirements for NQTLs

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- Plans may not impose a non-quantitative treatment limit (NQTL) on MH/SUD benefits unless
  - any **processes, strategies, evidentiary standards, or other factors** used in applying the NQTL are
  - **comparable to, and are applied no more stringently than,** the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits
  - in the same classification.

## The NQTL Test

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For each NQTL, in each classification:

1. **Which benefits?** – Identify the benefits that are subject to the NQTL
2. **Why is it applied?** – Identify and define the factors relied upon to decide whether or not to apply an NQTL type to these benefits
  - ❖ Identify the sources or evidence base used for each factor
3. **How does it apply?** – Identify and define the factors relied upon to design how the NQTL type applies to benefits in a classification
  - ❖ Identify the sources or evidence base used for each factor
4. **What is the impact?** – Identify the operations measures that are being used to determine the impact of the NQTL
  - ❖ Identify the evidence that the impact is being tracked and any relevant data

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# Parity Compliance vs. Program Compliance

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## Parity Compliance vs. Program Compliance

### PROGRAM COMPLIANCE

- Ensure a compliance plan is in place that addresses key areas including:
  - health care fraud, waste and abuse;
  - financial record keeping and reporting;
  - outcome and process measure reporting;
  - compliance with employment, whistleblower;
  - utilization review and other insurance laws;
  - rules for appeals and grievances;
  - marketing and enrollment procedures
- Program compliance also requires procedural and staffing requirements including:
  - Compliance Officer, Compliance Committee and high-level oversight;
  - Training and education;
  - Lines of communication;
  - Disciplinary standards;
  - System for routine monitoring and identification of compliance risks.

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## Parity Compliance vs. Program Compliance

### MHPAEA COMPLIANCE

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- Comprehensive analysis of plan operations across an enormous range of benefit design and administration otherwise only subject to limited, if any, regulatory oversight
- Documentation of plan operations that is not generally produced in a manner conducive to performing the analytical steps of the MHPAEA process

**The MHPAEA analysis process itself is complex and must be updated when benefit design or administration policies are changed in a manner that may impact the MHPAEA analysis**

## Parity Compliance vs. Program Compliance

### MHPAEA COMPLIANCE, cont.

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- Requires unique data collection and analysis for each step and type of limit:
  - **Benefit Classification:** Identify which classification or sub-classification of benefits each service procedure or medication is assigned for both MH/SUD and med/surg benefits
  - **FRs and QTLs:** Demonstrate that all FRs and QTLs imposed on MH/SUD services satisfy the substantially all (2/3) and predominant (1/2) tests in each classification
  - **NQTLs:** Demonstrate that the processes, strategies, evidentiary standards, or other factors used in designing and operationalizing each NQTL for both MH/SUD and med/surg in each classification of benefits are comparable and no more stringently applied
  - **Disclosures:** Ensure that processes are in place to disclose medical necessity criteria and individual determinations as required

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## Application of Parity to Medicaid

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## Final Parity Rules for Medicaid and CHIP

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- States required to certify compliance and post documentation supporting such certification on their public website no later than October 2, 2017
- Parity applies to enrollees in:
  - Medicaid managed care organizations (“MCOs”)
  - Medicaid benchmark or benchmark-equivalent plans (“Alternative Benefit Plans” or “ABPs”) and
  - The Children’s Health Insurance Program (“CHIP”)
- DOES NOT apply to beneficiaries not enrolled in an MCO, ABP, or CHIP
- Largely the same approach as under commercial Parity rules regarding FRs, QTLs, and NQTLs, but CMS focus is on *State* compliance

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## Final Parity Rules for Medicaid and CHIP

### APPLICATION TO MEDICAID BENEFITS

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- Parity applies to all benefits delivered to MCO enrollees, including benefits delivered through a PIHP, or PAHP, or fee-for-service
- If MCO has responsibility for offering all medical/surgical and MH/SUD benefits, the MCO must conduct the parity analysis
  - Must also tell the state of changes required to bring the MCO contract into compliance with parity requirements
  - In these states, Medicaid programs do not submit parity documentation to CMS
- If MCO does not offer all benefits, the state must compile the parity analysis:
  - State may require managed care entities to collect relevant information and complete a preliminary analysis
  - State must provide completed documentation to CMS, and will be held accountable for the accuracy and completeness of the parity analysis

## Final Parity Rules for Medicaid and CHIP

### MH/SUD PARITY AND ABPs

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- ACA mandates that MH/SUD treatment services be provided as part of an “Essential Health Benefits” (EHB) package that individual, small group plans, and Medicaid non-managed care ABPs must provide
- All plans required to cover the EHB, including MH/SUD must do so in compliance with MHPAEA, effectively applying MHPAEA to the individual and small group market
- ABPs must meet the financial requirements and treatment limitations components of the mental health parity provisions
  - Regardless of whether services are delivered in managed care or non-managed care arrangements
  - ABPs were reviewed for FR and QTL compliance during the approval process

## Final Parity Rules for Medicaid and CHIP

### MH/SUD PARITY AND CHIP

- CHIP state plans are deemed to satisfy parity requirements related to financial requirements and treatment limitations if:
  - The plan elects to cover all required Early and Periodic Screening, Diagnostic and Treatment (“EPSDT”) services (§1905(r) of SSA), and
  - The state informs individuals under 21 about the availability of the full range of EPSDT services available to them and provides/arranges for medically necessary screenings, diagnostic services, and treatments (§1902(a)(43) of SSA)
- States that apply NQTLs to EPSDT services must ensure that the application of these limits is consistent with the parity provisions
- CHIP programs that do not provide full EPSDT benefits and therefore do not meet the deeming requirements must:
  - Conduct a full analysis of the CHIP state plan and delivery system (including MCOs/PIHPs/PAHPs) to determine compliance with the parity standards

## Final Parity Rules for Medicaid and CHIP

### MEDICAID SERVICE CLASSIFICATIONS

- CMS finalized the use of **four classifications** of benefits in assessing parity under the Final Rule: inpatient, outpatient, emergency care, and prescription drugs
  - Does not distinguish between in-network and out-of-network classifications, but policies that limit access to out-of-network providers are analyzed as NQTLs
- Final Rule does not define which services are in which classification
  - States required to compile the analysis may provide the benefit classifications to the managed care entities
  - These terms are subject to the design of a state’s managed care program and their meanings may differ depending on the benefit packages
  - May require guidance from State to perform classification
- CMS declined to create a new intermediate level services classification but allows for MCO/PIHP/PAHP/state to assign intermediate level services to any of the four benefit classifications
  - Must be reasonable and done using the same standards for both medical/surgical services and MH/SUD services

## Final Parity Rules for Medicaid and CHIP

### OVERSIGHT OF MH/SUD PARITY

- States must conduct oversight to ensure that enrollees in MCOs receive services in compliance with parity requirements
  - CMS reviews Medicaid parity documentation as part of the MCO contract review process, and CHIP documentation through a dedicated SPA
  - States have discretion as to how they perform oversight of MCOs
  - CMS encourages states to include parity oversight and implementation terms in their MCO contracts
  - CMS has provided technical assistance and tools to clarify the types of documentation it seeks to show compliance with parity requirements
- The parity analysis must be updated when there is a change in delivery system, benefits, or limits that would impact parity compliance
  - State documentation demonstrating compliance must be made available to the general public through the state's web site by October 2, 2017

## Parity and Medicare-Medicaid Dual Eligibles

### PARITY APPLIES ONLY TO DUALS' MEDICAID BENEFITS

- MHPAEA does *not* apply to Medicare, but does apply to Medicaid benefits for Medicare-Medicaid dual eligible beneficiaries, including demonstration plans.
- The MHPAEA analysis should look to the full set of covered Medicaid benefits, even if Medicare is the primary payer.
- For any QTLs, the expenditure data will be unusual and may invalidate some QTLs that would pass muster in a Medicaid-only MCO.
- For NQTLs, it may be difficult to identify any "as applied" processes or data for benefit classifications where Medicare is the primary payer.
- CMS does not consider Medicaid's coverage of Medicare premiums and cost sharing as a benefit for purposes of MHPAEA.

## Parity and Medicare-Medicaid Dual Eligibles

### PRESCRIPTION DRUG BENEFITS

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- Full-dual eligible beneficiaries are *not entitled* to Medicaid coverage for drugs that are *coverable* under Medicare Part D (without regard to whether any particular drug is actually covered under a Part D formulary).
- The only Medicaid prescription drug coverage for MMP enrollees is for drugs covered by the state's Medicaid program that are not coverable under Medicare Part D (e.g. OTC medications and dietary supplements).
- If the MMP includes no Medicaid coverage for MH/SUD drugs, this may seem to violate the requirement to provide MH/SUD coverage in every classification for which M/S coverage is provided.
- CMS has not provided guidance or pursued enforcement on this issue.

## Parity Enforcement and Oversight

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<div style="border: 1px solid black; padding: 5px; text-align: center; width: 100px; margin: 0 auto;"><b>ERISA PLANS</b></div>	<ul style="list-style-type: none"> <li><b>DOL</b> generally has primary enforcement authority over private sector employment-based plans that are subject to ERISA but not over insurers and has only a limited CMP authority</li> <li><b>IRS</b> enforces against ERISA plans and their sponsors, and Church Plans through excise taxes of \$100/day/individual</li> <li><b>ERISA plan participants and beneficiaries</b> may bring suit under ERISA § 502(a)(1) and/or (a)(3)</li> </ul>
<div style="border: 1px solid black; padding: 5px; text-align: center; width: 100px; margin: 0 auto;"><b>FULLY INSURED</b></div>	<ul style="list-style-type: none"> <li><b>State insurance commissioners</b> have primary authority over insurance issuers' compliance with federal parity rules, <b>HHS</b> has secondary enforcement authority to impose CMP \$100/day/individual (HHS has no authority over ERISA plans)</li> <li><b>HHS</b> has CMP authority over QHPs in the marketplace for MHPAEA, and exercises direct or collaborative enforcement in states that lack authority</li> <li>MHPAEA does not preempt State laws and all 50 states, DC, Puerto Rico, and Guam have some sort of MH/SUD parity-type provisions</li> </ul>
<div style="border: 1px solid black; padding: 5px; text-align: center; width: 100px; margin: 0 auto;"><b>MEDICAID</b></div>	<ul style="list-style-type: none"> <li><b>State Medicaid agencies</b> have enforcement authority over MCOs, PIHPs and PAHPs</li> <li><b>CMS</b> has enforcement authority over states in the delivery of Medicaid benchmark or benchmark-equivalent plans (ABPs), CHIP, and a state's performance of its obligations to oversee MCOs, PIHPs, and PAHPs</li> </ul>

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## Parity Enforcement and Oversight

### SELECT STATE PRACTICES IN COMMERCIAL MARKET REGULATION AND ENFORCEMENT

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- Oregon – Issued regulations with small but meaningful differences from MHPAEA final rules, e.g., plans must use a “single definition of medical necessity” for MH/SUD and medical surgical benefits
- California – The Department of Managed Health Care (DMHC) requires plans to submit detailed NQTL information about MHPAEA compliance
- Massachusetts – The Division of Insurance requires plans to submit information about compliance with MHPAEA and state parity statutes, including denial rates, authorization rates, appeal overturn rates.
- Illinois – IL statutes 215 ILCS 5/370c and 5/370c.1 require plans to use ASAM criteria and no other criteria when making SUD medical necessity determinations
- DC – 2019 legislation requires market conduct exams, detailed parity compliance documentation, and Medicaid coverage for MAT without limits

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## Parity Enforcement and Oversight

### DOL ENFORCEMENT AGAINST GROUP HEALTH PLANS

- Employee Benefits Security Administration (EBSA) enforces MHPAEA for 2.2 million private employment-based group health plans covering 130.8 million participants
- In FY 2016 and 2017, EBSA closed 378 parity cases (~ ½ of all plan investigations), resulting in 136 citations for MHPAEA violations.
  - 49% NQTLs
  - 28% QTLs
  - 9% cumulative FRs
  - 9% annual dollar limits
  - 5% coverage in all classifications
- Recently established regional interagency task forces to target parity issues affecting access to treatment for opioid addiction
- Creating MHPAEA specialty teams that will target and evaluate NQTLs imposed by large behavioral health providers and issuers

*SOURCE: EBSA enforcement fact sheet, available at <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-2018-pathway-to-full-parity.pdf>*

## Parity Enforcement and Oversight

### MEDICAID PARITY RULE ENFORCEMENT

- Most state Medicaid agencies were required to comply with the Medicaid Parity Final Rule by October 2, 2017
  - Variety of states were granted extensions for demonstrating compliance, and few states have completed the documentation process
- States with carve-outs required to document parity compliance across entire delivery system for covered beneficiaries
  - Each entity involved in the delivery system is required to cooperate in providing information to the state for provision to CMS
- All states with managed care must post public documentation of parity compliance, but no clear requirements for format or content
- States must update documentation when making relevant changes to benefits, benefit limits, or delivery system structure

## State Enforcement and Oversight

### MISSOURI

- *Processes: When an individual presents for services and is determined eligible, the provider must complete the DLA-20© and enter the assessments results/scores in to CIMOR in order to bill.*
- *Strategy: The assessment helps to guide treatment, know where and what the individual needs assistance with. It is also to collect data for individuals served in the program as a measure of progress in treatment and CSTAR service efficacy. Tying the billing to the assessment helps ensure quality and needed services are being delivered to the individual. Outcomes measurement and monitoring helps individuals with substance use disorder manage their treatment which can reduce the need for specialized, high cost services.*
- *State analysis determined that this requirement is an NQTL that violates MHPAEA and they are amending regulations to change the requirement.*
- <https://dss.mo.gov/mhd/mc/pdf/mental-health-parity-compliance.pdf>

## State Enforcement and Oversight

### WASHINGTON STATE

- *The one area of concern raised by this analysis is the outpatient BH benefit managed by the BHO system. BHOs require all outpatient services to be prior authorized, while very few outpatient services in the M/S benefit require prior authorization.*
- *While the administrators accepted the need to remove prior authorization for most outpatient services, there were concerns about the effect this would have on other aspects of their system. For example, data from the current outpatient authorization process is used by the state for various quality and performance measurement activities.*
- *In order to rectify the discrepancy between the outpatient BH and M/S benefits, the state will remove the language in BHO contracts that requires initial authorization for all outpatient services. The contract language will allow authorization of some of the highest intensity services, such as the Program for Assertive Community Treatment (PACT). Allowing the BHOs to require prior authorization for some, but not all, of their outpatient benefit brings that system in alignment with the outpatient M/S benefit.*
- <https://www.hca.wa.gov/assets/program/washington-state-parity-analysis.pdf>

## State Enforcement and Oversight

### ARIZONA

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- *Actions taken by the State to resolve identified Parity compliance issues*
  - *For comparison purposes against the extent of documentation required for MH/SUD residential and HCTC services, the State completed research and provided information to Mercer on documentation needed to place a member in a SNF, ALF or a LTC hospital. The review confirmed that there are more extensive documentation requirements for these services, such as current chest x-ray, H&P physician's orders for SNFs and a preadmission screening and resident review, which was deemed appropriate based on the complexity of the member's needs and the intensity of treatment in these levels of care. As such, the required documentation associated with the UM NQTL for MH/SUD benefits appears to be comparable to the documentation requirements for M/S benefits.*
- <https://www.azahcccs.gov/Resources/Downloads/GovernmentalOversight/ArizonaMHPAEAReport.pdf>

## Parity Enforcement and Oversight

### LITIGATION – SUMMARY OF TRENDS

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- Plaintiffs have mostly been beneficiaries bringing claims under ERISA/MHPAEA or state parity statutes
- Relatively limited state AG litigation to date in most states
- Class action attempts are common
- Courts have allowed limited provider and provider association standing for assigned post-service claims
- Highest number of claims involve pediatric patients
- Settlements common following preliminary motions practice
- Third-party administrators frequently made party to suits



## Parity Enforcement and Oversight

### LITIGATION – COMMON CLAIMS

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- Common subjects of claims:
  - Experimental/investigational exclusion policies, especially for ABA services
  - Age restrictions for medical necessity
  - Categorical exclusions for residential MH/SUD treatment, especially for eating disorders (as either QTL or NQTL)
  - Quantitative visit limits
  - Disparate medical management in practice (more stringent review of MH/SUD prior authorization requests, etc.)

## Parity Enforcement and Oversight

### LITIGATION – KEY CASES

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- *Rea v. Blue Shield of California*, 226 Cal. App. 4th 1209, 172 Cal. Rptr. 3d 823 (2014), as modified on denial of reh'g (July 9, 2014)
  - Extends *Harlick v. Blue Shield of California*, 686 F.3d 699, 713 (9th Cir. 2012) which came to similar ruling for ERISA plan
  - Court held that the CA Parity Act requires Knox-Keene Act health care service plans to provide residential treatment for eating disorders where medically necessary, even when not set forth in the plan
  - Knox-Keene applies coverage mandates for enumerated services while Parity Act requires coverage for enumerated severe conditions
  - Court found that the Parity Act expanded scope of coverage mandate to mental health benefits

## Parity Enforcement and Oversight

### LITIGATION – KEY CASES, cont.

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- R.H. v. Premera Blue Cross, No. C13-97RAJ, 2014 WL 3867617 (W.D. Wash. Aug. 6, 2014).
  - ERISA class action suit alleging that defendant plan violated MHPAEA and WA state parity law in applying age and visit limits on neurodevelopmental therapy (NDT) and applied behavior analysis (ABA) services
  - Settlement resulted in an unprecedented expansion of coverage for NDT and ABA services for class members prospectively and allows all class members to seek damages for past claims denials on an individual basis

## Parity Enforcement and Oversight

### LITIGATION – KEY CASES, cont.

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- New York State Psychiatric Association, Inc. v. UnitedHealth Group, 798 F.3d 125 (2d Cir.2015)
  - Provider association found to have standing to bring suit on behalf of patients for MHPAEA violations under ERISA (ERISA § 502(a)(1) and (a)(3); 29 U.S.C.A. § 1132(a)(1) and (a)(3))
  - Providers had accepted assignment and therefore had standing
  - TPA was appropriate defendant because it “exercised total control over the plan’s claims process.”
  - Court ruling aligns with TPA liability under ERISA § 502(a)(1) in six other circuits (5th, 6th, 7th, 8th, 9th and 11th)

## Parity Enforcement and Oversight

### LITIGATION – KEY CASES, cont.

- Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., 821 F.3d 352, 357 (2d Cir. 2016)
  - Individual providers and provider associations allege MHPAEA violations in reimbursement practices (alleging lower rates)
  - Providers and provider associations do not have third-party standing to bring suit on behalf of patients for MHPAEA violations under ERISA (ERISA § 502(a)(1), 29 U.S.C.A. § 1132(a)(1))
  - Cites *Griswold v. Connecticut*, 381 U.S. 479 (1965) holding that providers have standing to raise constitutional, but not statutory claims on behalf of patients
  - Provider claims were not on their own behalf pursuant to assignment
  - Distinguishes *AMA v. Anthem* by stating that the providers here alleged third-party standing, not standing based on assigned claims
  - Also held that plan-wide reimbursement rate policies do not constitute fiduciary acts under ERISA

## 21st Century Cures Act (P.L. 114-255)

- Enacted and signed into law On December 13, 2016
- Requires the tri-departments (HHS, Labor, and Treasury) to:
  1. Issue guidance to improve the compliance of group health plans and health insurance coverage with requirements for parity between mental health and substance use disorder benefits and medical and surgical benefits,
  2. Publish feedback from the public on the disclosure request process for documents regarding parity requirements, and
  3. Audit the plan documents of group health plans and health insurers that repeatedly violate parity requirements. Title XIII, Sections 13001-130.

## Model parity disclosure form

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- On June 16, 2017, the federal regulators released ACA FAQs Part 38, a Paperwork Reduction Act Notice, and a Draft Model Form, and solicited comments.
- Payors had asked the regulators to cut down on the amount of information the MHPAEA regulations and disclosure form require a plan to provide.
- The model form can be used by participants, enrollees, or their authorized representatives, to request relevant MHPAEA disclosures.
- The full list of commenters and comments can be downloaded at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38>

## President's Commission on Combating Drug Addiction and the Opioid Crisis

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- Final report issued November 1, 2017
- Includes 56 recommendations that detail how the federal government can address the nation's ongoing opioid epidemic
- Relevant recommendations include:
  - Increased authority for the Department of Labor (DOL) to oversee insurers, levy monetary penalties and permit the DOL to launch investigations of health insurers independently for parity violations.
  - Federal and state regulators should use a standardized data collection tool for documenting and disclosing compliance strategies for non-quantitative treatment limitations (NQTL) parity.

## CHQI Parity Accreditation

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- ClearHealth Quality Institute (CHQI) has established the nation's first parity accreditation standards, outlining a logical sequence of steps for health insurers and health benefits administrators to assess MHPAEA compliance processes
- Offers three unique resources to support health plans
  - Parity Accreditation Standards
  - Online Parity Tool
  - Parity Regulatory Compliance Guide
- Provides a third party assessment to help determine whether a plan is meeting federal parity requirements

## CHQI Parity Standards Development Process

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- Regulators encouraged development of accreditation program
- 23 diverse stakeholders serve on the Standards Committee
- Committee met over 25 times during the past 18 months
- Comprehensive standards fill in regulatory gaps (e.g., elements of the NQTL comparative analysis)
- 60-day public comment period during the summer

## Parity Advocacy

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- ParityTrack, a collaboration of the Kennedy Forum and the Scattergood Foundation, has led the development of a variety of resources:
  - “Six-Step Parity Compliance Guide” for NQTLs
  - Litigation tracking with summaries of relevant caselaw
  - Model parity legislation for states, primarily focused on increased insurer transparency and enhanced regulatory agency enforcement
  - Variety of consumer resources and advocacy materials
- Parity@10 is a three year effort to pursue full enforcement
  - Launched in 2017 in five states – IL, MD, NJ, NY, and OH
  - An additional five states expected to be added.

## Questions?

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