Mental Health Parity for Plan Sponsors: Understanding Your Compliance Obligations

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Sarah Kanter

Clarissa Kang

PHONE: 415-788-3111 FAX: 415-421-2017 WEB: www.truckerhuss.com

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Agenda

- MHPAEA Basics – History and key requirements
- Regulatory Update -- Where do things stand now?
- NQTL Comparative Analysis
  - What is it, who does it, and what do you need to know about it?
  - What can we learn from the MHPAEA Reports to Congress?
- Litigation – Overview of recent litigation decisions
- Responding to MHPAEA Document Requests
- Government Investigations – What to expect in a MHPAEA focused investigation

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MHPAEA: The Basics

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MHPAEA Timeline

- 1996 – Mental Health Parity Act of 1996 ("MHPA 1996") is enacted. Requires parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits.
- 2008 – Congress expands MHPA 1996 when it enacts the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act ("MHPAEA"). Adds provisions related to financial requirement and treatment limitations. Now applies to substance use disorder benefits in addition to mental health benefits.
- 2010 – the Affordable Care Act makes "mental health substance use disorder services; including behavioral health treatment" one of ten Essential Health Benefits ("EHBs") that must be covered by non-grandfathered health plans in the individual and small group markets.
- 2013 – Final Regulations implementing MHPAEA are issued.

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MHPAEA Timeline Continued

- 2020 – The Consolidated Appropriations Act, 2021 ("CAA") is enacted. Expressly requires plans to perform and document a comparative analysis of nonquantitative treatment limitations ("NQTLs") that apply to mental health/substance use disorder benefits. Also requires the Departments to submit a report to Congress that summarizes the comparative analyses requested and reviewed by the Departments
- 2024 – Departments issue the 2024 Final Rule which amends part of the 2013 Final Rule and adds new regulations regarding the NQTL comparative analysis
- January 2025 – The ERISA Industry Committee ("ERIC") sues to invalidate the 2024 Final Rule
- May 2025 – Departments seek to stay the ERIC litigation, and announce an enforcement pause on the 2024 Final Rule and a "broader reexamination" of the Departments' enforcement approach under MHPAEA

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Useful Acronyms

- MHPAEA – The Mental Health Parity and Addiction Equity Act
- MH/SUD – Mental Health and Substance Use Disorder benefits
- QTLs – Quantitative Treatment Limitations
- NQTLs – Nonquantitative Treatment Limitations

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MHPAEA The Basics

- Prohibits a group health plan from applying **financial requirements** or **treatment limitations** to MH/SUD benefits **that are more restrictive** than the **financial requirements** or **treatment limitations** that apply to medical surgical benefits
- Treatment limitations include both QTLs and NQTLs
- Benefits offered under a plan are divided into **six classifications**:
    1. Inpatient, in-network
    2. Inpatient, out-of-network
    3. Outpatient, in-network
    4. Outpatient, out-of-network
    5. Emergency Care; and
    6. Prescription Drugs
- Certain subclassifications are permitted (e.g., office visits)

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Financial Requirements / Quantitative Treatment Limitations

- Financial Requirements: deductibles, copayments, coinsurance, out-of-pocket expenses
- Quantitative Treatment Limitations (QTLs) are limits which can be expressed with a number:
  - Frequency of treatment
  - Number of visits
  - Days of coverage
  - Days in a waiting period
  - Other similar limits on the scope or duration of treatment

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Parity in Financial Requirements/QTLs (The "Quantitative Parity Analysis")

- Within each benefit classification compare the financial requirements and treatment limitations that apply to MH/SUD benefits to the financial requirements and treatment limitations that apply to medical/surgical benefits
- For each "type" of financial requirement (e.g., copays) or treatment limitation (e.g., annual visit limits) ask: Does it apply to "substantially all" of the medical surgical benefits in the classification?
  - This is a mathematical test
  - "substantially all" means two-thirds of all medical/surgical benefits in the classification, based on the dollar amount of all plan payments for the classification that are expected to be paid for the plan year.

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Parity in Financial Requirements / QTLs

- Does it apply to "substantially all" of the medical/surgical benefits in the classification?
  - No – Cannot apply the financial requirement or QTL to MH/SUD in the same classification
  - Yes – But the level of the financial requirement or QTL cannot be more restrictive than the "predominant" level that applies to the plan's medical surgical benefits. (Predominant = the level that applies to more than one-half of medical/surgical benefits in that classification subject to the financial requirement or QTL)
- A plan is **not** required to perform this test every year unless there is a change in plan design, cost-sharing structure or utilization that would affect a financial requirement or treatment limitation within a classification

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No Cumulative Limits

- A plan cannot apply separate cumulative financial requirements (e.g., deductible, out of pocket maximum) and QTLs (e.g., annual visit limits) to medical/surgical benefits and MH/SUD benefits in a classification.
- A tricky example:
  - A plan imposes an annual $250 deductible on all medical/surgical benefits and a separate annual $100 deductible on all MH/SUD benefits
    - This VIOLATES the no separate cumulative limits rule

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Nonquantitative Treatment Limitations (NQTLs)

- NQTL: a treatment limitation that is **not expressed numerically** which otherwise limits the scope or duration of benefits for treatment under a plan. Examples include:
  - Medical management standards that limit or exclude benefits (e.g., medical necessity, medical appropriateness, experimental or investigative)
  - Formulary design
  - Standards for provider admission to participate in the network
  - Plan methods for determining out of network payment level (e.g., Usual, Customary and Reasonable charges, allowed amounts, external benchmarks);
  - Step therapy / Fail First policies

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NQTL Parity General Rule (2013 Final Rule)

- A plan cannot impose NQTLs on MH/SUD benefits in a classification unless:
- Under the terms of the plan **as written and in operation**
- Any **processes, strategies, evidentiary standards or other factors** used in applying the NQTL:
  - Are (i) **comparable to,** and (ii) **applied no more stringently** than the processes, strategies, evidentiary standards and other factors used in applying the NQTL to medical/surgical benefits in the classification
  - The focus is not on results, but whether the underlying processes, strategies, evidentiary standards or other factors are in parity.
- NOT a mathematical test like financial requirements/QTLs
- We will discuss the NQTL comparative analysis requirement later in this presentation

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NQTL Parity General Rule - Example

- A plan requires prior authorization that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient MH/SUD benefits
- Inpatient benefits for medical/surgical conditions are routinely approved for seven days after which a treatment plan must be submitted by the patient's physician and approved by the plan
- For inpatient MH/SUD benefits, routine approval is given for one day, after which a treatment plan must be submitted by the patient's physician and approved by the plan
- In this example the plan violates MHPAEA because it is applying a stricter NQTL in practice to MH/SUD benefits than is applied to medical/surgical benefits

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NQTL Parity General Rule - Example

- A plan generally provides coverage for medically appropriate medical/surgical benefits and MH/SUD benefits
- The plan automatically excludes coverage for inpatient SUD treatment in any setting outside of a hospital
- For inpatient treatment for other conditions the plan will provide coverage if the prescribing physician obtains authorization from the plan that the inpatient treatment is medically appropriate for the individual based on clinically appropriate standards of care
- The plan violates MHPAEA. Although medical appropriateness is applied to both MH/SUD benefits and medical/surgical benefits, the absolute exclusion for SUD treatment is not comparable to the conditional exclusion for other conditions

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Regulatory Update

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2024 Final Rule – Key Provisions

- We will not spend too much time on the 2024 Final Rule
- Focus of the 2024 Final Rule is ensuring parity in ***access*** to MH/SUD benefits as compared to medical/surgical benefits
  - Preamble cites many independent studies showing there remain material differences in access to MH/SUD benefits. One big factor looked at is the higher use of out-of-network providers for MH/SUD benefits.
- Effective date of plan year staring on or after January 1, 2025, for some provisions, and January 1, 2026, for other provisions
- **New and revised definitions for key terms** – requiring plans to use objective, independent and current standards by referencing the ICD and DSM when defining "mental health benefits," "substance use disorder benefits," and "medical/surgical benefits" – Many plans already incorporate similar definitions

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2024 Final Rule – Key Provisions

- **Designing and applying NQTLs**
  - Keeps the same framework as the 2013 Regulations, but goes into much greater granularity and detail
  - Adds definitions for, “processes,” “strategies,” “evidentiary standards,” and “factors”
  - Prohibits use of “discriminatory” factors and evidentiary standards
  - Adds a requirement that plans must collect and evaluate relevant data on the impact of the NQTL on access to MH/SUD benefits – if data suggests NQTL leads to material differences in access then plan needs to address the material differences and document it
  - Special rule for evaluating NQTLs related to network adequacy, and suggested corrective actions plans can take

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2024 Final Rule – Key Provisions

- **Meaningful Benefits**
  - If a plan provides any benefits for a MH/SUD condition in any classification it must provide "meaningful" benefits for the condition in every classification in which medical/surgical benefits are provided.
  - "Meaningful" means providing a "core treatment" for the condition or disorder" in each classification in which the plan provides a benefit for a "core treatment" for one or more medical conditions or surgical procedures (e.g., ABA therapy for ASD or nutritional counseling for eating disorders)
  - This requirement effectively resulted in a benefits mandate, and was viewed in the benefits community as being particularly vulnerable to legal challenge

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2024 Final Rule – Key Provisions

- **Comparative analysis**
  - Includes content requirements for the comparative analysis requirement imposed by the CAA
  - Previously the Departments had released sub regulatory guidance and a MHPAEA self-compliance tool to assist with compliance
  - Most notable was fiduciary certification requirements for ERISA plans

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2024 Final Rule – Key Provisions

- **Comparative analysis – Fiduciary Certification (ERISA plans)**
  - As part of the comparative analysis one or more named fiduciary must certify:
    - They have engaged in a prudent process to select one or more qualified service providers to perform and document the comparative analysis;
    - Have satisfied their duty to monitor the service provider
  - DOL expects a prudent fiduciary will:
    - Review the comparative analysis
    - Ask questions as needed to understand it
    - Ensure that a services provider responsible for performing the comparative analysis provides assurance that the NQTL and associated comparative analysis complies with MHPAEA

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2024 Final Rule – Key Provisions

- **Comparative analysis – Fiduciary Certification**
  - Incorporates general ERISA fiduciary standards regarding the selection and monitoring of service providers which includes:
    - Objective selection process (no conflicts of interest or self-dealing),
    - Obtaining information necessary to assess qualification of the vendor, quality of the work product, reasonableness of the fees (not required to select the lowest bidder as long as the fees are “reasonable”)
    - Not considering one factor (e.g., cost) to the exclusion of another factor (e.g., quality of the work)
    - Documenting the selection process
    - Continuing to monitor the performance of the vendor, and document the monitoring performed

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2024 Final Rule – ERIC Lawsuit (January 2025)

- ERISA Industry Committee brings lawsuit challenging the 2024 Final Rule.
  - Hired Eugene Scalia (former Secretary of Labor) to bring the lawsuit
- Alleges the 2024 Final Rule:
  - Exceeds the Departments authority under MHPAEA
  - Violates the due process clause of the 5th Amendment
  - Is arbitrary and capricious and otherwise violates the Administrative Procedures Act
- Also alleges, the January 1, 2025, effective date for some provisions is arbitrary and capricious because it did not leave enough time for plans to come into compliance

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2024 Final Rule – Enforcement Pause

- **May 2025 - Government's Court Filing in ERIC litigation**
  - Federal government files motion asking the court to hold the case in abeyance pending the Department's reconsideration of the Final Rule.
  - Departments will issue a non-enforcement policy with respect to the provisions of the 2024 Final Rule that are effective in 2025 and 2026
  - Departments will reexamine their current MHPAEA enforcement program more broadly

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2024 Final Rule – Enforcement Pause

- **May 15, 2025 Notice of Non-Enforcement**
  - Cites ERIC lawsuit, and the President's Executive Order "Ensuring Lawful Governance and Implementing the President's Department of Government Efficiency' Deregulatory Initiative") as the impetus for the pause in enforcement
  - Departments reconsidering the 2024 Final Rule including whether to modify or rescind it
  - Key points include:
    - 2024 Final Rule will not be enforced, and Departments will not pursue enforcement actions based on a failure to comply **until a final decision in the ERIC litigation PLUS 18 months;**
    - Applies to portions of 2024 Final Rule that are new in relation to the 2013 Final Rule
    - Departments will take a broader reexamination of their respective enforcement under MHPAEA

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2024 Final Rule – Enforcement Pause

- **May 15, 2025 Notice of Non-Enforcement**
  - Plans may continue to rely on:
    - 2013 Final Rule
    - FAQ Part 45
    - Other sub regulatory guidance
  - "MHPAEA provides critical protections for workers, individuals, and their families who need treatment for mental health conditions and substance use disorders. During this period of nonenforcement as the Departments revisit the 2024 Final Rule, the Departments remain committed to ensuring that individuals receive protections under the law in a way that is not unduly burdensome for plans and issuers."

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NQTL Comparative Analysis

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NQTL Comparative Analysis – What is it?

- The CAA added a requirement that plans **perform and document** a comparative analysis of the design and application of any NQTLs that are imposed on MH/SUD benefits (effective on February 10, 2021)
- The comparative analysis must be made available to the Departments (DOL, IRS or HHS) or applicable State authorities upon request
- Prior to the CAA, this was considered a "best practice"
- Department of Labor's MHPAEA Self-Compliance Tool includes a section on NQTLs that outlines a process for conducting a comparative analysis of NQTLs
  - Examples and compliance tips
  - Potential warning signs that could indicate noncompliance

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NQTL Comparative Analysis – What is it?

- The 2024 Final Rule contained detailed requirements regarding the comparative analysis. Because the 2024 Final Rule is not being enforced (and may be changed or rescinded) we will focus on prior guidance.
- FAQ Part 45 (issued in April 2021) provides details regarding what should be in a comparative analysis:
  - Must be **sufficiently specific, detailed, and reasoned** to demonstrate the processes, strategies, evidentiary standards or other factors used in developing and applying a NQTL are comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits
  - A **general statement of compliance** and conclusory references to broadly stated strategies, evidentiary standards or other factors is **insufficient**
  - Must include a **detailed, written, and reasoned explanation of the specific plan terms and practices at issue**, and include the basis for the plan's conclusion that the NQTL complies with MHPAEA

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NQTL Comparative Analysis – Who Does It?

- For fully-insured plans, the insurer is responsible for performing the comparative analysis
- For self-funded plans, the medical TPA (e.g., Cigna, Blue Shield) will perform a comparative analysis, but this is not usually specific to the plan
- Plans hire a third party vendor to perform the plan's own comparative analysis. There are a handful of companies that perform this service
  - The vendors will review the analyses prepared by the TPA and will also do their own analyses based on data specific to the plan (e.g., comparing approval rate for prior authorization services between MH/SUD and medical/surgical)
- The 2024 Final Rule contained a fiduciary certification requirement regarding the comparative analysis, but this requirement is not being enforced

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NQTL Comparative Analysis – Contents (FAQ Part 45)

1. Identify the NQTL
   - Example: Prior authorization review is a prior assessment that services are medically necessary, within the standards of care, and are covered by the plan
2. Identify all the services within each classification to which the NQTL applies, identify which are MH/SUD versus medical/surgical
   - Example: Prior authorization applies to the following inpatient, in-network benefits:
     - MH/SUD
       - Residential treatment
       - SUD detoxification
     - Medical/surgical
       - Inpatient rehabilitation
       - Skilled nursing facilities

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NQTL Comparative Analysis – Contents (FAQ Part 45)

3. Identify the factors, evidentiary standard or sources, or strategies considered in the design of application of the NQTL. Explain if any factors were given more weight than others and why
   - Example: The following factors are considered when determining whether prior authorization will apply: excessive or inappropriate utilization, clinical efficacy, high variability in length of stay. TPA identifies covered treatments and services that are subject to prior authorization in accordance with the XXX policies and with input from the internal XXX committee.
4. Definitions and sources used for the factors, evidentiary standards , strategies or processes
   - Example: in determining whether to implement prior authorization, TPA monitors utilization trends, and conducts trend analysis to identify treatments and services with potential for abuse/inappropriate use. TPA compares utilization data against prior history of use and against established benchmarks.

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NQTL Comparative Analysis – Contents (FAQ Part 45)

5. Is there a variation in the application of a guideline or standard used by the plan between MH/SUD and medical/surgical benefits. If so, explain process and factors for the variation
   - Example: Prior authorization for out-of-network hospitalization is generally not required for medical/surgical, but is required for MH/SUD. The variation is due to difference in the standards of care, quality and costs of out-of-network MH/SUD providers.
6. Does the application of the NQTL rely on specific decisions in the administration of benefits. If so, identify the decision maker, timing of decisions, and qualification of decision makers
   - Example: prior authorization is conducted by clinical reviewers who possess an active license relevant to their review functions. All reviews are conducted within 12 days for nonurgent care, and within 48 hours for urgent care.

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NQTL Comparative Analysis – Contents (FAQ Part 45)

7. Does the comparative analysis rely on experts? If so, include an assessment of each expert's qualification and the extent to which the plan relied on each expert's evaluations in setting recommendations
8. The findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified in the analysis within each classification, and their relative stringency
9. The date of the analyses, name and title of the person who performed the analyses

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NQTL Comparative Analysis – Other Documents

- A plan should have the following types of documents available to support its NQTL comparative analyses:
  - Records documenting the NQTL processes and how they are applied to both MH/SUD benefits and medical/surgical benefits;
  - Any documentation (e.g., guidelines, claims processing policies) that the plan has relied on to determine NQTL applied no more stringently to MH/SUD benefits;
  - Samples of covered and denied MH/SUD and medical/surgical claims
  - Documents related to MHPAEA compliance of service providers (if management of some or all MH/SUD benefits is delegated to a service provider)

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NQTL Comparative Analysis – Contracting Tips

- In the plan's administrative services agreement with its TPA, include language requiring the TPA to provide information necessary for the plan to perform the comparative analysis and a timeframe for providing the documentation
- In the plan's agreement with the vendor performing the comparative analyses require that the vendor must try multiple times to obtain needed information from the TPA, and document all attempts, and TPA's failure to provide requested information

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MHPAEA Report to Congress

- CAA requires:
  - Secretaries of DOL, HHS and Treasury to annually report to Congress on the result of the NQTL comparative analyses reviews
  - Secretary of Labor to submit a report to certain appropriate committees of Congress on MHPAEA compliance by group health plans every two years
- 2022 and 2023 MHPAEA Reports:
  - **Every** NQTL comparative analysis reviewed was insufficient in some way
  - Identified names of plans and issuers that received a final determination of noncompliance

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2024 MHPAEA Report to Congress (Released Jan 2025)

- During EBSA Reporting Period (August 1, 2022 – July 31, 2023) EBSA issued:
  - 17 initial letters requesting comparative analyses for 22 NQTLs
  - 45 insufficiency letters
  - 13 initial determination letters finding that plans and issuers had violated MHPAEA for 21 NQTLs
- Report states that non-compliance with the comparative analysis requirements remain “widespread,”
- However more comparative analyses are being deemed sufficient.
- Departments intend to make available a sample comparative analysis that uses written explanation with supporting documents

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2024 MHPAEA Report to Congress (Released Jan 2025)

- Comparative Analysis Deficiencies and Trends
  - Failure to document a comparative analysis before designing and applying the NQTL;
  - Conclusory assertions lacking specific supporting evidence or detailed explanation
  - Lack of meaningful comparison or analysis
  - Nonresponsive comparative analysis
  - Documents provided without adequate explanation
  - Failure to identify the specific MH/SUD and medical/surgical benefits or the MHPAEA classification affected by the NQTL
  - Focusing only on similarities – rather than differences to show parity
- Deficiencies attributed to:
  - Inadequate preparation by plans
  - Attempting to justify practices that were adopted without MHPAEA compliance in mind

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2024 MHPAEA Report to Congress – EBSA NQTL Enforcement Priorities

- **NQTLs relating to network adequacy and network composition**
  - How do plans create and monitor their networks?
  - How do they measure those processes' impact on access to MH/SUD benefits compared to medical/surgical benefits
  - Comparing out-of-network utilization and other outcomes
  - Methodologies resulting in disparate network provider rates
  - How are plans addressing the MH/SUD provider shortage?
- **Impermissible exclusions of key treatments for mental health conditions and substance use disorders**
  - Focusing on exclusions related to ABA therapy, medication for opioid used disorder, nutritional counseling for eating disorders, residential treatment MH/SUD, partial hospitalization for MH/SUD, speech therapy for mental health conditions, ASD treatment based on age

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Types of cases involving violations of MHPAEA

- Facial exclusion cases – Plan language excludes types of treatment for MH/SUD that are offered for med/surg issues – discriminatory on its face
- As-applied cases – Plan applies facially neutral plan term unequally between MH/SUD and med/surg benefits
- Internal process cases – Plan applies a more stringent internal process to MH/SUD claims than to med/surg claims

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MHPAEA Violations Alleged in Context of Benefits Litigation

- Claim for equitable relief under ERISA section 502(a)(3), 29 U.S.C. section 1132(a)(3) for violation of MHPAEA
- MH/SUD coverage alleged to lack parity with med/surg coverage – "as applied"
- Common factual background – residential treatment wilderness therapy of a minor dependent
- Challenges to pre-authorization requirements, categorical exclusion, level of care limitations
- Commonly asserted alongside benefits denial under ERISA section 502(a)(1)(B), 29 U.S.C. section 1132(a)(1)(B)
- Ancillary – possible claim for document penalties under ERISA section 502(c) for failure to provide ERISA section 104(b)(4) required documents – NTQL comparative analysis, for example
- May include allegations regarding inadequacy of MH/SUD network

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Challenges to MHPAEA Violation at Pleading Stage

- *Ryan S. v. UnitedHealth Group, Inc.*, 98 F.4th 965 (9th Cir. 2024) and *E.W. v. Health Net Life Ins. Co.*, 86 F.4th 1265 (10th Cir. 2023) overturned district court dismissals of MHPAEA claims
- Four part test from E.W. – (1) plausibly allege that the plan is subject to MHPAEA; (2) identify specific treatment limitation for MH/SUD benefits covered; (3) identify analogous med/surg care covered; (4) plausibly allege disparity between limitations on MH/SUD vs med/surg
- *Ryan S.* – For internal process cases, plaintiff does not need to allege categorical practice or the uniform denial of benefits to state a claim under MHPAEA. Plaintiff does not have to specify the different process that applies to the analogous med/surg benefits.
    - Must plausibly allege the existence of a procedure used in assessing MH/SUD benefits that is more restrictive than those used in assessing some other claims under the same classification
    - Inclusion of concurrent state agency report that UHC used an algorithm to trigger additional levels of review of MH/SUD as compared with other claims
- *N.R. v. Raytheon Company, et al.* (1st Cir. 2022) – Sufficient to allege that "the Plan defines habilitative services as mental health services and accordingly only applies the habilitative services exclusion to the treatment of mental health ailments." Determined to be a plausible reading of the plan and potentially successful MHPAEA claim. Plaintiff alleged that Defendants denied his coverage based solely on his ASD diagnosis, which would have been covered if based on physical illness

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Recent Summary Judgment Decisions on MHPAEA Violation Claims

- Parity of treatment limitations are measured against "substantially all" (i.e. more than one) med/surg benefits. Ps need to focus on treatments as a whole and not just one. *See Midthun-Hensen on behalf of K.H. v. Grp. Health Coop. of S. Cent. Wisconsin, Inc.* (7th Cir. 2024)
- Lack of standing for MHPAEA claim because denial of benefits was not traceable to the alleged violation because court held that the benefits were not covered under the plan terms. *M. S. v. Premera Blue Cross*, (10th Cir. 2024)
  - Document penalties for failure to produce the administrative services agreement as a document required by ERISA section 104(b)(4). Note: Skilled Nursing InterQual Criteria were not deemed to be a document required to be disclosed because it did not establish legal rights or duties

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Document Requests

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Document Requests and Document Penalties

- ERISA section 104(b)(4) requires provision of certain governing documents upon written request to the plan administrator
- Final Rule released in September 2024 required provision of the NQTL Comparative Analysis upon request by a participant (within 30 days) and in relation to a document request related to an adverse benefit determination
  - Government agencies are rethinking the Final Rule; enforcement pause
  - NQTL Comparative Analysis is deemed an "instrument" under which a plan is established or operated within the meaning of section 104(b)(4)
  - Comparative Analysis is also considered "relevant" document under the DOL claims procedures and subject to disclosure
- Gray area now that the Final Rule is being reconsidered
- Participants in litigation may make the case for a court to deem an NQTL Comparative Analysis an instrument under which a plan is established or operated. Enforcement pause is only applicable to agency action

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DOL Investigation

- Investigations of Claims Fiduciaries and their books of business may lead to questions to the plans themselves
  - MHPAEA Comparative Analysis Report to Congress July 2023 by DOL, HHS, and Treasury
  - Part of DOL EBSA's strategic approach to NQTLs is to identify and focus on service providers that are in a position to enact widespread change
  - But EBSA does not limit itself to large service provider investigations and continues to enforce against plans where a request for comparative analysis is warranted
  - MHPAEA Enforcement and Implementation Report to Congress January 2025 by DOL, HHS, and Treasury
- Request for claims data – Scrutiny for exclusions for treatment of autism spectrum disorder, applied behavioral analysis (ABA) therapy for ASD, MAT (Medication Assisted Treatment) for SUDs, nutritional/dietary counseling for MH, residential treatment for MH/SUD, partial hospitalization for MH/SUD, speech therapy for MH, ASD treatment based on age
- Request for Comparative Analysis re limitations or exclusions or explanation as to why the exclusion is in parity, or demand that they stop engaging prohibited practices
- Denied claims suggest possible MHPAEA violation unless plan can explain coverage of MH/SUD on par with M/S
- NQTL Comparative Analysis can demonstrate compliance with MHPAEA
- Removal of exclusion or limitation and reversal of denied claims can potentially lead to resolution with DOL

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DOL Investigation – Letter to Plan Sponsor/Plan Fiduciary

Section 712(a)(8) of the Employee Retirement Income Security Act of 1974 (ERISA) requires group health plans and health insurance issuers that impose non-quantitative treatment limitations (NQTLs) on mental health or substance use disorder (MH/SUD) benefits to perform and document comparative analyses of the design and application of the NQTLs that demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). It also requires plans and issuers to make available to the Secretary of Labor (Secretary), upon request, the comparative analyses and supporting information demonstrating compliance with MHPAEA's requirements.

PHONE: 415-788-3111 FAX: 415-421-2017 WEB: www.truckerhuss.com

This letter concerns any exclusion in the [redacted] (Plan) of coverage, payment, or benefits for speech therapy services for the treatment of developmental delay in the in-network outpatient and out-of-network outpatient classifications and applied behavioral analysis therapy in the in-network outpatient and out-of-network outpatient classifications. Such an exclusion is (or may be) an impermissible separate treatment limitation or other violation of MHPAEA irrespective of any comparative analysis purporting to demonstrate compliance with MHPAEA. This letter, however, serves as a request by the Secretary under ERISA Section 712(a)(8) and Section 504 for the Plan to produce any comparative analyses and supporting information concerning the exclusion, as described in Attachments A and B.

PHONE: 415-788-3111 FAX: 415-421-2017 WEB: www.truckerhuss.com

Contact

Sarah Kanter
Clarissa Kang

Trucker Huss, APC

135 Main Street, 9th Floor
San Francisco, CA 94105
(415) 788-3111
skanter@truckerhuss.com
ckang@truckerhuss.com

www.truckerhuss.com

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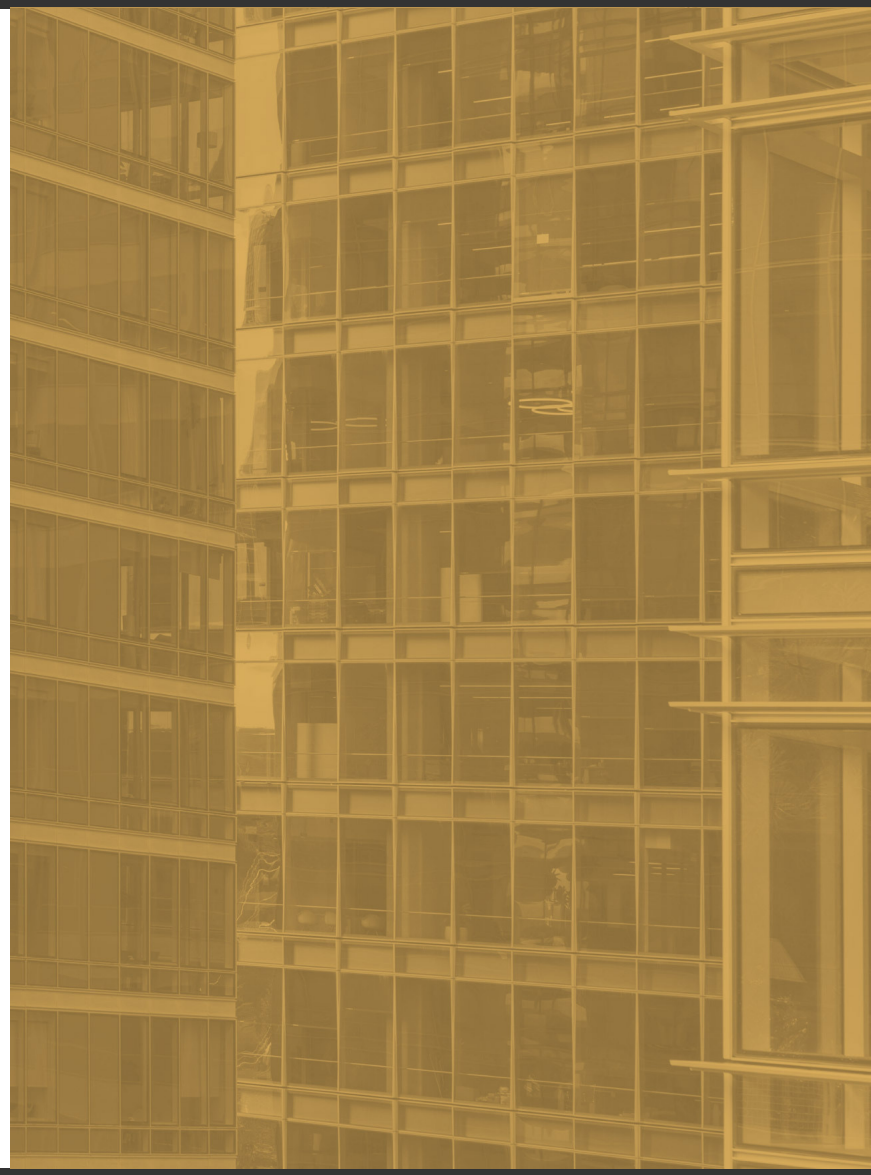

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