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Mental Health Parity: Compliance Steps for Plan Sponsors

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Plan sponsors face a myriad of difficulties in ensuring their group health plans comply with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).[1] MHPAEA prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on MH/SUD benefits than medical or surgical benefits.[2] Generally all group health plans, whether self-funded or fully-insured, that provide MH/SUD benefits must comply with parity rules, with limited exceptions for small employers (less than 51 employees), retiree-only health plans, or plans that meet the increased cost exemption.

Compliance with MHPAEA has taken on a sharper focus under the 21st Century Cures Act, which was signed into law on December 18, 2016, and requires the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of Treasury (Treasury) to: (1) issue guidance to improve compliance of group health plans and health insurance coverage with parity between MH/SUD benefits and medical or surgical benefits; (2) publish public feedback on the disclosure request process for documents relating to parity requirements; and (3) audit plan documents for compliance with parity.[3] To this end, on June 16, 2017, the DOL, HHS, and Treasury released ACA implementation FAQs Part 38, a Paperwork Reduction Act Notice, and a Draft Model Form, and solicited comments.[4] On April 23, 2018, the agencies released Proposed FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX,[5] along with an updated Model Form to request documentation from an employer group health plan or insurers regarding treatment limitations (incorporating the public comments on the draft form),[6] and a Self-Compliance Tool For MHPAEA designed to assist plan sponsors.[7]

Along with increased disclosure requirements, plan sponsors will be under greater pressure to ensure compliance with MHPAEA. The President's Commis-

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[1] Pub. L. No. 110-343, Div. C, §511, §512.

[2] ERISA §712(e) defines medical or surgical benefits as benefits with respect to services for medical or surgical services as defined under the terms of the plan or health insurance coverage, but does not include mental health or substance use disorder services. Mental health benefits are with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable federal and state law. Substance use disorder benefits are benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable federal and state law.

[3] Pub. L. No. 114-255, Div. B, §13007.

[4] The model form could be used by participants, enrollees, or their authorized representatives to request relevant MHPAEA disclosures. Payers asked the agencies to cut down on the amount of information the MHPAEA regulations and disclosure require a plan sponsor to provide. The full list of commenters and comments is at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38.

[5] [Proposed] FAQS About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX (hereinafter the Proposed MHPAEA FAQs), https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-proposed.pdf.

[6] *See* https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf.

[7] 2018 MHPAEA Self-Compliance Tool, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf.

ISSN 0747-8607

sion on Combating Drug Addiction and the Opioid Crisis issued its final report November 1, 2017, which recommended, among other things, that the DOL be granted increased authority to oversee and investigate insurers for parity violations, as well as for federal and state regulators to use a standard data collection tool for documenting and disclosing compliance strategies for parity of non-quantitative treatment limitations for SUD benefits.

According to the report on the DOL Employee Benefit Security Administration's (EBSA's) enforcement activity from 2017, the DOL conducted 187 investigations of employer group health plans (out of 2.2 million plans) for MHPAEA compliance and cited 92 violations,[8] more than double the number of violations cited in 2016 (44). Furthermore, litigation by Employee Retirement Income Security Act beneficiaries involving claims based on MHPAEA have continued at a steady pace over the years. Many ERISA lawsuits have been brought by parents acting on behalf of dependent children with behavioral health conditions, especially with respect to autism-spectrum conditions and eating disorders. ERISA plaintiffs have pursued class actions over parity issues. Further, courts have allowed limited health care provider and provider association standing for assigned post-service claims, increasing the incentive for litigation by non-plan participants.

To address the increasing risks to plan sponsors of parity compliance, this article focuses on the legal requirements, enforcement, and litigation activity and provides a checklist for best practices in auditing plan compliance. This article is organized into four sections: (1) summary of the MHPAEA requirements; (2) outline of regulatory enforcement actions; (3) discussion of recent MHPAEA litigation; and (4) a step-by-step checklist for periodic plan review by plan sponsors to ensure MHPAEA compliance.

MHPAEA REQUIREMENTS

If an employer group health plan offers MH/SUD benefits, the plan should ensure that the benefits are provided in parity with medical or surgical benefits with regards to: (1) annual and lifetime limits; (2) financial requirements and quantitative treatment limitations; and (3) non-quantitative treatment limitations.

Classification of Benefits

The first step in determining whether a benefit package is designed and delivered in compliance with MHPAEA is to identify and classify benefits as MH/SUD or medical or surgical benefits and then into one of six classifications of benefits (for a total of twelve categories). The six classifications are:[9]

- Inpatient in-network,
- Inpatient out-of-network,
- Outpatient in-network,
- Outpatient out-of-network,
- Emergency, and
- Prescription Drugs.

To ensure compliance with MHPAEA, plan sponsors should confirm that any condition or disorder defined in a plan as being (or not being) a mental health condition or substance use disorder is consistent with generally recognized independent standards of current medical practices. This ensures that benefits are not classified in order to avoid parity requirements.[10] The definitions must be consistent with generally recognized independent standards of current medical practice.[11] Three tools that plans may use to MH/SUD benefits are: (1) the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5); (2) the most current version of the International Classification of Diseases (ICD-10); or (3) state guidelines.

All services covered under the group health plan must be identified and classified. Services can be placed into multiple classifications but will be analyzed based on how they are developed and applied to enrollees with a primary MH/SUD diagnosis in comparison to how the limits on that benefit are developed and applied as to enrollees with a primary medical or surgical diagnosis. For part of the analysis, it may be necessary to distinguish the dollars expended for services based on the benefits classification.

Important Note: These classifications of benefits will serve as the basis for all the other steps in the MHPAEA analysis so it is very important that the plan consistently classify benefits, have a firm evidentiary basis for the classification decisions, and have access to data on all the benefits by classification. For many health plans, this initial step in the process takes as long as or longer than any other part of the MHPAEA process. Further, it will be impossible to prove to a regulator that a plan is operating in a compliant manner if plan sponsors only develop the classifications in response to a market conduct exam or other request. Regulators are likely to conclude that the plan sponsors have not been analyzing plan benefit and limit changes for MHPAEA compliance.

Annual and Lifetime Limits

The annual and lifetime dollar limits parity requirements only apply to the extent that the MH/SUD benefits are not essential health benefits.[12] The annual and lifetime dollar parity requirements include a one-

[8] EBSA, FY 2017 MHPAEA Enforcement, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2017.pdf.

[9] DOL Reg. §2590.712(c)(2)(ii)(A).

[10] Preamble to Final Regulations, 78 Fed. Reg. 68,239, 68,242 (Nov. 13, 2013).

[11] *See* DOL Reg. §2590.712(a).

[12] ERISA §715; I.R.C. §9815; PHSA §2711.

ISSN 0747-8607

third rule, two-third rule, and a rule for plans that do not fit either category.[13]

One-third rule. If a plan does not include an aggregate lifetime or annual limit on any medical or surgical benefits or includes a limit that applies to less than one-third of all medical or surgical benefits, then the plan may not impose an aggregate lifetime or annual dollar limit on any MH/SUD benefits.

Two-third rule. If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical or surgical benefits, then the plan must either: (1) apply the limits to the medical or surgical benefits as it would otherwise apply to the MH/SUD benefits in a manner that does not distinguish between the medical or surgical benefits and MH/SUD benefits; or (2) not include an aggregate lifetime or annual dollar limit on MH/SUD benefits that is less than the aggregate lifetime or annual dollar limit on medical or surgical benefits.

Doesn't Fit Into a Category. If a group health plan that provides medical or surgical benefits and MH/SUD benefits does not include an aggregate lifetime limit or annual limit on substantially all medical or surgical benefits, then it may not impose such limits on any MH/SUD benefits. Similarly, if the plan includes an aggregate lifetime or annual limit that applies to less than one-third of all medical or surgical benefits, then the plan may not impose any aggregate or annual limits on any MH/SUD benefits.

Financial Obligations and Treatment Limitations

MHPAEA also requires that the predominant level of financial obligations and quantitative treatment limitations that is applied to MH/SUD benefits within a classification offered under a group health plan must not be more restrictive than financial obligations and treatment limitations that apply to substantially all medical or surgical benefits within the corresponding classification.

Federal regulations break down treatment limitations into two categories: quantitative treatment limitations (QTLs), which are numerical in nature (e.g., the number of covered visits), and non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of treatment benefits (e.g., preauthorization requirements). NQTLs are not subject to the predominant and substantially all tests described in this section, but are instead subject to a different test for comparability and stringency as described below.

Financial requirements (e.g., copays, co-insurance, and deductibles) and QTLs for MH/SUD benefits must be no more restrictive than the predominant financial requirements and QTLs that apply to substantially all medical or surgical benefits in the same classification.

[13] DOL Reg. §2590.712(b); Treas. Reg. §54.9812-1(b).

Non-Quantitative Treatment Limitations

Group health plans are also prevented from applying NQTLs to MH/SUD benefits in any classification unless under the terms of the plan, the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitations to MH/SUD benefits in the classification are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in applying limitations to medical or surgical benefits in the same classification.[14] This requirement is extremely sweeping and requires an analysis of how *any* QTL is developed *and* applied including a detailed analysis of the processes, strategies, and evidentiary standards used in the development and application. Some NQTLs that the DOL said presumptively require additional analysis to determine compliance with mental health parity includes blanket preauthorization requirements for all MH/SUD benefits, preauthorization for treatment facility admission, and extensive pre-notification requirements for MH/SUD benefits. The recently released proposed DOL FAQs include detailed guidance on NQTLs that further emphasizes the sweeping scope of the MHPAEA requirement in this area.[15] Specific examples includes standards for exclusions of experimental or investigative treatment, applying as an example controlled randomized trials for ABA Therapy for autism spectrum disorder, application of dosage limits for prescription medications, and differences in step therapy protocols applied to MH/SUD benefits.

Opioid Use and Medication Assisted Treatment

A timely example of an NQTL that presents a challenge for MHPAEA compliance relates to medical management techniques intending to ensure the effective delivery of Medication Assisted Treatment (MAT) for opioid use disorder. MAT is any treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment, in combination with behavioral health services. Federal agencies and consensus panels have recommended that the pharmacologic intervention of

[14] DOL Reg. §2590.712(c)(4)(i). Non-quantitative treatment limitations include: (1) medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether treatment is experimental or investigative; (2) formulary design for prescription drugs; (3) network tier design for plans with multiple network tiers; (4) standards for provider admission to participate in a network, including reimbursement rates; (5) plan methods for determining usual, customary and reasonable charges; (6) refusal to pay for higher cost therapies until it can be show that lower-cost therapy is not effective; (7) exclusions based on failure to complete a course of treatment; and (8) restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of the benefits for services provided under the plan.

[15] Proposed MHPAEA FAQs.

ISSN 0747-8607

MAT be delivered in conjunction with a number of other services, including a comprehensive psychosocial assessment, initial and yearly medical assessment, medication dispensing, drug tests, identification of co-occurring disorders and neuropsychological problems, counseling to stop substance abuse and manage drug craving and urges, evaluation of and interventions to address family problems, HIV and hepatitis C virus (HCV) testing, education, counseling, and referral for care, and referral for additional services as needed.

As a result of recommendations like these and understandable concerns relating to diversion, many health plans have developed prior or continuing authorization requirements for the prescription drug service element of MAT that require the documentation of engagement in some or all of the recommended support services as a condition of continued access to the prescription. Unfortunately, this type of NQTL is rarely, if ever, applied to medical or surgical prescription drugs and if it is not, it is a per se MHPAEA violation because the NQTL comparability and stringency test cannot be applied to nothing.

Possible Solution: As such, plans should explore alternative mechanisms for medical management system design to ensure utilization of evidence-based comprehensive treatment for MAT. The most straightforward approach would be to apply more frequent authorization procedures for MAT when the patient is not utilizing the other ancillary support services, provided that this NQTL is supported by a properly staffed diagnostic and treatment committee.

Eating Disorders

With respect to eating disorders, the DOL released a FAQ on June 16, 2017, about MHPAEA implementation and the 21st Century Cures Act, Part 38. In the FAQ, the DOL confirmed that eating disorders are mental health conditions and thus treatment of the disorder is covered under MHPAEA. Thus, group health plans should be designed in a manner to ensure eating disorder benefits comply with QTLs and NQTLs. In the Proposed MHPAEA FAQs released on April 23, 2018, under Question 9 a plan that excludes inpatient, out-of-network treatment for eating disorders but provides inpatient, out-of-network care for medical or surgical benefits violates MHPAEA by imposing a setting-specific exclusion for MH/SUD benefits that is not comparably imposed on medical and surgical benefits.[16]

Plan Sponsor Disclosure Obligations

MHPAEA places disclosure obligations on plan sponsors. Group health plans and health insurance issuers must disclose QTLs and NQTLs to plan beneficiaries and authorized representatives upon request. On June 16, 2017, the DOL and HHS created a draft model form, which was updated and released on April 23, 2018, that plan beneficiaries and their authorized representatives may use to request information on MH/SUD benefits and treatment limitations from group health plans.[17] The form is presented as a tool to assist beneficiaries in requesting information related to denial or possible denial of MH/SUD benefits. Users may request detailed explanations regarding denial or restrictions of MH/SUD benefits. The form provides notices to group health plans regarding the different types of information that it must be ready to provide in the event of an MH/SUD coverage denial or even a government audit. Plan sponsors should be prepared for increased obligations created by the form. Employers should be aware that providers may use the form to obtain information regarding claim denials or reimbursement rates related to MH/SUD benefits.

Currently, many providers obtain authorizations from patients to pursue claims and appeals on their behalf. Providers may take advantage of this form by requiring patient authorizations for all MH/SUD claims and submitting the form in order to negotiate claim denials or reimbursement rates.[18] Because the burden is on the plan sponsor and issuer to provide the requested information, plan sponsors will need to ensure compliance with the request.

Under the most recent DOL FAQs, the DOL specifically addressed employer obligations to disclose information regarding in-network and out-of-network MH/SUD providers.[19] The DOL points out that such information should be included in the SPD and the employer will not be deemed to have satisfied its disclosure obligations if it provides an outdated provider directory, However, plan sponsors would be permitted to provide a hyperlink or URL with the plan's enrollment materials to find current MH/SUD providers.[20]

MULTI-AGENCY ENFORCEMENT REGIME

MHPAEA's application to particular types of insurance or health plan markets varies and has evolved since its original passage. This history, in addition to the general complexity in the multi-agency, federal/state regulation of insurance and health plans has resulted in a convoluted MHPAEA enforcement regime. Further, insurance and group health plan members and their treating providers have standing under certain circumstances to sue employers, issuers, and third-party administrators directly, adding additional layers to consider.

The original MHPAEA statute only applied to group health plans and group health insurance cover-

[16] Coverage restrictions based on facility type are NQTLs under MHPAEA.

[17] The Draft Model Form was published by the agencies under the ACA implementation FAQs Part 38, a Paperwork Reduction Act Notice.

[18] One strategy to limit assignments of claims by plan participants to providers is to include plan language rendering assignments between plan participants and providers as unenforceable against the plan.

[19] Proposed MHPAEA FAQs, Q/A 11.

[20] Proposed MHPAEA FAQs, Q/A 12.

ISSN 0747-8607

age for groups with more than 50 employees and to certain Medicaid coverage plans offered through managed care delivery systems. It was subsequently amended by the Patient Protection and Affordable Care Act (ACA)[21] to also apply to individual health insurance coverage and then by HHS[22] through the definition of the essential health benefits to both the individual and small-group insurance markets, including those on the Marketplace insurance exchanges. The three agencies responsible for implementing MHPAEA (DOL, HHS, and Treasury) issued joint final regulations in November 2013.[23] Finally, the Centers for Medicare and Medicaid Services (CMS) within HHS issued regulations applying MHPAEA to other aspects of the Medicaid program in 2016.[24]

The DOL and the Treasury have jurisdiction over ERISA group health plans and the DOL enforces MHPAEA for 2.2 million private employment-based group health plans covering 130.8 million participants and beneficiaries. The DOL has authority to require the plan to make changes to address any plan provisions that violate MHPAEA and pay any improperly denied benefits. Although DOL investigations are generally triggered by plan participant complaints and focus on the particulars of a specific plan participant or beneficiary, the DOL will also generally seek a global correction, working with the plans' service providers to find improperly denied claims and correct the problem for other plans administered by the same employer, issuer, or third-party administrator. On April 23, 2018, the DOL released a Report to Congress summarizing the DOL's efforts to implement MHPAEA since the 2016 Report to Congress, including a detailed discussion of the EBSA investigation process and a roadmap for the DOL's activities in the future. These global corrections represent a significant financial risk to plans, employers, and administrators likely to be greater than any penalties that could be imposed.[25]

For health insurance issuers, states have primary enforcement authority. HHS also has secondary enforcement authority to impose civil penalties on insurance issuers when the state elects not to enforce MHPAEA or CMS determines that the state has failed to substantially enforce MHPAEA. As of December 2017, CMS is enforcing MHPAEA with respect to insurance issuers in four states: Missouri, Oklahoma, Texas, and Wyoming. In these states, CMS reviews policy forms of issuers in the individual and group markets for compliance with MHPAEA prior to the products being offered for sale in the states.

In addition, with regards to the application of MHPAEA to Medicaid programs, CMS has enforcement authority over state Medicaid agencies. Further, state Medicaid agencies have the primary enforcement authority over Medicaid managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans.

Finally, participants and beneficiaries in ERISA group health plans may bring suit under ERISA §502(a)(1) and/or §502(a)(3). As discussed below, these participant or provider-led suits, including class actions, have been a major focus of MHPAEA enforcement activity.

MHPAEA LITIGATION

As discussed above, according to the 2016 report on EBSA's enforcement activity, EBSA reviewed 187 plans (out of 2.2 million plans) for MHPAEA compliance and cited 92 violations.[26] The violations break down as follows:

- 48.91% NQTLs,
- 28.26% financial limitations or QTLs,
- 8.7% cumulative financial requirements or treatment limitations,
- 5.43% coverage in all classifications,
- 8.7% annual dollar limits.

These findings reflect the fact that the DOL has significantly increased the rigor in which it cites violations as the number of citations (92 through 187 investigations) is more than double those found in 2016 from a similar number of investigations (44 through 191 investigations). In addition, NQTLs continue to be the most complex area of MHPAEA compliance. As discussed above, NQTLs require data collection and analysis of compliance across an enormous range of operational activity, in many cases covering areas previously subject to limited, if any, regulation.

Although EBSA enforces MHPAEA with respect to private employment-based group health plans (which can be self-insured, fully-insured, or a combination of both), EBSA is statutorily precluded from directly enforcing MHPAEA against insurance companies. This includes when EBSA determines that the insurance company is the party responsible for the parity violation. In the 2018 Report to Congress, the DOL highlighted that both the Mental Health Parity and Substance Use Disorder Parity Task Force and the President's Commission on Combating Drug Addiction and the Opioid Crisis have recommended that Congress enact legislation to allow direct enforcement against health insurance issuers to ensure compliance with the law.[27] On April 24, 2018, as a part of the consideration of the Opioid Crisis Response Act of 2018 by the Senate Health, Education, Labor and Pensions (HELP) Committee, Sen. Chris Murphy (D-

[21] Pub. L. No. 111-148.

[22] 45 C.F.R. §156.115(a)(3).

[23] 78 Fed. Reg. 68,240 (Nov. 13, 2013).

[24] 81 Fed. Reg. 18,389 (Mar. 30, 2016).

[25] DOL 2018 Report to Congress, Pathway to Full Parity, 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.

[26] FY 2017 MHPAEA Enforcement, *see* n.8, above.

[27] DOL 2018 Report to Congress, Pathway to Full Parity at 7.

ISSN 0747-8607

Conn.) introduced an amendment that would have implemented this recommendation.[28] The amendment failed on a party-line vote of 11–12. Murphy will probably propose the amendment again during the Senate floor debate or as a part of future legislation. Such an expansion in the DOL's enforcement authority would fundamentally alter the dynamic of MHPAEA enforcement by empowering them to take action against insurers directly.

Litigation by ERISA participants and beneficiaries involving claims based in MHPAEA have continued at a steady pace over the years since the release of the final rule. Conversely, there has been relatively limited litigation or enforcement activity initiated by state insurance commissioners or attorneys general, although additional funding appropriated in 2016 for the Health Insurance Enforcement and Consumer Protections Grant Program for MHPAEA enforcement may lead to greater activity in the coming year as activity ramps up.

Most ERISA plan participants suing under ERISA §502(a)(1) and/or §502(a)(3) have been parents acting on behalf of dependent children with behavioral health conditions, especially autism-spectrum conditions and eating disorders. Class action attempts have been a common characteristic of these cases. Further, courts have allowed limited provider and provider association standing for assigned post-service claims. Third-party administrators have frequently been made party to suits, especially when they are substantially in control of plan design and operations.

The most common subjects of these ERISA plan participant claims under MHPAEA include (1) plan policies for excluding coverage of a service as being experimental or investigational (especially applied behavior analysis (ABA), a treatment for autism spectrum disorder); (2) age restrictions in medical necessity criteria for certain behavioral health services; (3) categorical exclusions for residential behavioral health treatment, especially for eating disorders (as either QTL or NQTL); (4) disparate quantitative visit limits; and (5) disparate medical management in practice (more stringent review of behavioral health prior authorization requests, etc.).

Select MHPAEA Cases Against Group Health Plans

Rea v. Blue Shield of California.[29] The Court of Appeal of California held that the California 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. The court said the California Parity Act expanded the scope of the coverage mandate to mental health benefits.

R.H. v. Premera Blue Cross.[30] An ERISA class action suit in the U.S. District Court of the Western District of Washington alleging that the defendant group health plan violated MHPAEA and Washington state parity law in applying age and visit limits on neurodevelopmental therapy (NDT) and applied behavior analysis (ABA) services. A 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.

New York State Psychiatric Association, Inc. v. UnitedHealth Group.[31] The Court of Appeals for the Second Circuit found that a provider association had standing to bring suit on behalf of plan participants for MHPAEA violations under ERISA §502(a)(1) and §502(a)(3). The providers had accepted assignment and therefore had standing. The third-party administrator was the appropriate defendant because it ''exercised total control over the plan's claims process.''

Am. Psychiatric Ass'n v. Anthem Health Plans, Inc.[32] Individual providers and provider associations alleged MHPAEA violations in reimbursement practices (alleging lower rates). The Second Circuit found that providers and provider associations do not have third-party standing to bring suit on behalf of plan participants for MHPAEA violations under ERISA §502(a)(1). The court cited *Griswold v. Connecticut*,[33] holding that providers have standing to raise constitutional, but not statutory claims on behalf of patients, and said that the provider claims were not on their own behalf pursuant to assignment. The Second Circuit distinguished *AMA v. Anthem* by stating that the providers here alleged third-party standing, not standing based on assigned claims. The court held that plan-wide reimbursement rate policies do not constitute fiduciary acts under ERISA.

Although litigation to date has been focused on third-party providers and provider associations, as compared to single-employer group health plans, the enforcement activity report from EBSA indicates that many group health plans, insurers, and administrators have potential liability related to MHPAEA, especially with regards to the application of NQTLs. Recent decisions certifying class actions and recognizing provider standing further increases the risk of litigation. Finally, the increased demand for addiction treatment arising from the ongoing opioid epidemic, especially costly services like residential, partial hospitalization, and intensive outpatient therapy, and associated pressure from political leaders, is likely to result in increased activity in the coming year.

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[28] Press Release, Sen. Chris Murphy, Republicans Reject Murphy's Amendment to Enact Trump Opioid Commission Recommendations to Hold Insurance Companies Accountable (Apr. 24, 2018).

[29] 226 Cal. App.4th 1209, 172 Cal. Rptr.3d 823 (2014), as *modified on denial of reh'g* (July 9, 2014). Extends the decision *Harlick v. Blue Shield of California*, 686 F.3d 699, 713 (9th Cir. 2012), which came to a similar ruling for an ERISA plan.

[30] No. 2:13-cv-00097-RAJ, 2014 BL 222434 (W.D. Wash. Aug. 6, 2014).

[31] 798 F.3d 125 (2d Cir. 2015).

[32] 821 F.3d 352 (2d Cir. 2016).

[33] 381 U.S. 479 (1965).

ISSN 0747-8607

STEP-BY-STEP COMPLIANCE PROCESS

Set forth below is a checklist of the step-by-step process for plan sponsors to use in determining compliance under their group health plans with MHPAEA. The MHPAEA analysis process is itself complex and must be performed regularly if benefit design or administration policies are changed in a manner that may affect the MHPAEA analysis. In fact, the plan should have policies and procedures in place prior to making any benefit design or administration policy changes to ensure that the changes are made in compliance with MHPAEA, especially the NQTL requirements. In addition, on April 23, 2018, DOL, HHS, and Treasury jointly released a much more detailed self-compliance tool for group health plans, plan sponsors, plan administrators, issuers, regulators, and other parties.

ISSN 0747-8607

MHPAEA CHECKLIST

Preparation

1. Identify benefit packages
2. Identify and classify services

Data Collection

1. Financial Requirements
   - Identify financial requirements that apply and organize by type of financial requirement
   - Identify amount of M/S spending subject to financial requirement in classification
   - Identify predominant financial requirement level
2. Quantitative Treatment Limitation (QTL)
   - Identify QTLs that apply
   - Identify amount of M/S spending subject to QTL in classification
   - Identify predominant QTL level
3. Non-Quantitative Treatment Limitation (NQTL)
   - Provide plan language describing NQTL and identify applicable services
   - Identify the factors (and source) used to determine that it is appropriate to apply the NQTL
   - Identify the source for the evidentiary standard for each of the factors
   - Identify the processes and strategies used to design the NQTL as written in the plan language
   - Describe the operation of the NQTL process in practice

Analysis

1. Financial Requirements and QTLs
   - Substantially all test
   - Predominant test
2. NQTLs
   - Comparability and stringency under the plan document terms
   - Comparability and stringency in operation

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