Is Your Mental Health Parity Compliance Up To Par?

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Compliance with the requirements of the Mental Health Parity and Addiction Equity Act of 2008, or MHPAEA, is an enforcement priority for the U.S. Department of Labor in 2018 and should be on the radar of group health plan sponsors. With certain exceptions, the MHPAEA requires that "large employer" group health plans (and health insurance issuers) that provide mental health or substance use disorder (MH/SUD) benefits do not impose less favorable conditions or more stringent limits on those benefits than they do on the same classification of medical and surgical benefits. The MHPAEA does not require a plan to cover any specific MH/SUD, but if it does cover such a condition, then it must be covered in parity with the medical and surgical benefits. Thus, there must be parity in financial requirements, quantitative treatment limitations, or QTLs, and nonquantitative treatment limitations, or NQTLs. Further, while the MHPAEA allows aggregate lifetime and annual dollar limits on MH/SUD benefits that meet the parity requirements, such dollar limits for MH/SUD benefits that are covered as essential health benefits are prohibited. Assessment of parity factors is complex, and the guidance regarding these issues is piecemeal.

In addition to the MHPAEA and regulations that have been issued by the DOL, U.S. Department of Health and Human Services, and U.S. Department of the Treasury over time, evolving MHPAEA guidance which has been issued to date includes:

- DOL, Treasury and HHS FAQs issued:
    - April 20, 2016 (Part 31).
    - Oct. 27, 2016 (Part 34).
- DOL, Treasury and HHS guidance issued June 16, 2017:
    - FAQs Part 38.
    - Draft MHPAEA Disclosure Template.
- DOL, Treasury and HHS guidance issued April 23, 2018:
    - Proposed FAQs Part 39.
    - Pathway to Full Parity-DOL 2018 Report to Congress.
    - Fiscal Year 2017 MHPAEA Enforcement Fact Sheet.
    - 2018 Self-Compliance Tool for the MHPAEA.
    - Revised Draft MHPAEA Disclosure Template.
    - HHS Action Plan.

As a preliminary matter, plan sponsors must be able to identify and distinguish between the medical/surgical benefits and the MH/SUD benefits provided among the following

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categories: (1) Inpatient in-network; (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) emergency, and (6) prescription drugs. Then, using the array of available and applicable guidance, they must be able to determine that there is parity among all applicable financial requirements (e.g., co-pays, deductibles), QTLs (e.g., covered office visits), NQTLs (e.g., scope or duration of treatments such as preauthorization requirements, fail-first or medical management techniques), and lifetime or annual dollar limitations (as applicable) for the medical/surgical benefits and the MH/SUD benefits. This task is not straightforward because each element of the analysis is replete with nuances, formulas and tests, which are beyond the scope of this overview.

In addition to compliant plan design, plan sponsors must also be able to meet disclosure obligations to plan beneficiaries and authorized representatives upon request regarding the treatment limitations and medical necessity determinations, which will become critical in the event of a claim denial. It is important to ensure that there is a process in place to respond to requests for information regarding compliance with the parity requirements for the covered benefits. A response to this type of disclosure request must be provided within 30 days. The recent guidance included a draft model disclosure template that a plan participant could use for this type of request.

Interestingly in the recently proposed FAQs, bipolar disorder was specifically named as an example of a condition that does not require coverage. While plans are not required to cover specific conditions under the MHPAEA, bipolar disorder is an increasingly common diagnosis in society that employees often believe is covered under their plans. It is curious why an employer would offer any MH/SUD benefits in their plan and not cover this condition, or other conditions which are most prevalent in the population. A plan that may have otherwise been designed to cover this type of condition would be afforded more support not to cover it if this example is finalized in the FAQs following the close of the comment period (which ends June 22, 2018). Further, it is difficult to administer specific exclusions when the same pharmaceuticals may be used for different conditions. Plan sponsors that offer MH/SUD benefits should be wary of excluding prevalent societal conditions, as this will undoubtedly lead to claim denials and ensuing appeals, as well as potential litigation. Even if they would not pass muster as claims, they would be a drain on an employer’s resources responding to such actions, and would not further the purpose of providing health benefits to ensure the well-being and productivity of employees.

Given the current landscape, sponsors of group health plans should review and utilize the self-compliance tool issued on April 23 to undertake an analysis of their programs with appropriate parties such as insurers, claims administrators and pharmacy benefit managers to ascertain the level of compliance with parity requirements. Employers may be able to identify the benefits and service classifications, financial requirements, QTLs and NQTLs in their program on their own, but not necessarily the application of them to the benefits to determine parity levels. It is important to ensure that the parity rules are being met and to be prepared in the event a claim denial is appealed, a lawsuit is commenced under the Employee Retirement Income Security Act, or the DOL commences an audit or investigation, especially if they require a correction of parity violations.

At this time, plan sponsors should also:

- Ensure plan documents and summary plan descriptions clearly define medical/surgical- and MH/SUD-covered benefits and limitations and evaluate consistent operation of plan terms;
- Confirm that conditions are properly classified (e.g., that benefits for eating disorder treatment are classified as mental health benefits);
- Update summary plan descriptions for disclosure of provider networks;
- Be able to identify the factors used to develop limitations and standards used to evaluate them;
- Review consistency in utilization reviews among service providers;
- Ensure necessary information is provided in claims and appeals procedures and that information is organized and available to be provided in the event of a request for same; and
- Revisit parity compliance issues whenever plan design changes are made.

As the DOL concludes in its "Pathway to Full Parity" report, it is hopeful that as a result of its efforts individuals will continue to receive the benefits of parity protections under the law, and receive the oftentimes life-saving treatment they need. Plan sponsors should do their part to seriously evaluate their plan designs and ensure compliance with these critical measures.

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