MAKE MENTAL HEALTH PARITY A PRIORITY FOR YOUR PLAN

Written By Kaitlyn MacLeod, Esq.

In their recent 2022 Mental Health Parity and Addiction Equity Act ("MHPAEA") Report to Congress, the U.S. Department of Labor ("DOL") reiterated that mental health parity is a top enforcement priority for the current administration. In the DOL's eyes, plans are not fully complying with the MHPAEA Non-Quantitative Treatment Limitations (NQTL) Comparative Analysis requirement put in place last year, resulting in DOL audits and insufficiency findings.

WHAT IS THE MHPAEA AND DOES IT AFFECT YOUR PLAN?

The goal of the MHPAEA is to reduce stigma, discrimination and barriers inside and outside of the health care system for people with mental health or substance use disorder ("MH/SUD") conditions.

Treatment for MH/SUD conditions often operate in a disparate and separate system than treatment for medical and surgical ("M/S") care. The MHPAEA is intended to promote equal access to treatment for MH/SUDs by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than to M/S benefits.

The Consolidated Appropriates Act of 2021 amended the MHPAEA to require covered plans to produce a current NQTL Comparative Analysis that can be requested at any time by a plan participant or the DOL/CMS.

This required report must include an analysis of the plan's NQTLs in both writing and in practice, along with conclusions on parity and corrective action plans. Typical NQTLs include utilization reviews, prior authorization, provider credentialing standards, and plan provisions (like medical necessity or experimental/investigative determinations and exclusions).

MHPAEA applies to self-funded or fully-insured plans with over 50 employees, meaning that these plans also need to have a NQTL Comparative Analysis on file. While the MHPAEA does not apply directly to small group health plans, its requirements are applied indirectly through the ACA's essential health benefit requirements for mental health coverage.

Even if the MHPAEA does not apply, some states have implemented mental health parity requirements that are even stricter than federal requirements, so mental health parity is still a concern.

BARRIERS TO MENTAL HEALTH AND SUBSTANCE USE DISORDER ACCESS FOR PLAN PARTICIPANTS

Seeking treatment for MH/SUD conditions can often be a significant barrier to individuals who may need said treatment – there is a stigma attached to "needing help" to manage these issues.

Labor Secretary Marty Walsh expressed his own experience with the struggle to seek help with alcoholism by writing "I knew something was wrong, but it was so hard to take that first step. I'm so grateful that as a union member I had access to the care I needed, because once I did ask for help, my life started to change for the better."

Once an individual does decide to seek care, obtaining that care can often be an obstacle in its own right. Walsh described that "[f]rom identifying professionals who will take your insurance to figuring out what requirements you need to meet for treatment to be covered by your plan, the process can be incredibly difficult to navigate. Not only is this frustrating for those who need critical services – in many cases, it's illegal."

In 2019, nearly 52 million adults in the United States experienced some form of mental illness and in 2020, an estimated 40.3 million people had a substance use disorder. The COVID-19 pandemic has only exacerbated MH/SUD conditions in the US – between August 2020 and February 2021, the percentage of adults exhibiting symptoms of anxiety/depressive disorder has increased from 36.4% to 41.5%.

Further, deaths resulting from substance overdose rose by approximately 30,000 from when comparing 2019 numbers to 2022. U.S. Secretary of Health and Human Services Xavier Becerra noted that access to mental and behavioral health support is critical as the COVID-19 pandemic continues to impact so many lives across the country, but "health plans and insurance companies are falling short of providing access to the treatment many working families need."

JUMPSTART INTO COMPLIANCE

Now that NQTL Comparative Analyses are required for most plans, how do you complete one? It is a detailed process that takes vendor and plan administrator participation to obtain sufficient information to conduct an analysis of each individual NQTL to ensure that MH/SUD benefits do not have any limitations that are stricter than corresponding M/S benefits.

A common example is duration limitations – many plans impose visit limits for higher cost services, but plans must understand that those limits should not apply to MH/SUD benefits if there are not any limits for M/S benefits.

It is essential to have a plan's NQTL Comparative Analysis on hand before a DOL audit occurs. The DOL typically require plans to produce a detailed NQTL analysis within a very short timeframe (10-14 days). It is not practical to compile a detailed report with the level of information needed within that short timeframe.

The 2022 MHPAEA Report's main takeaway is that many plans and issuers were unprepared for a request of their analysis – and approximately 40% of plans responded to the DOL with a request for an extension to compile the required analysis.

EBSA found that plans stated they were unable to comply because they erroneously assumed that vendors would prepare a comparative analysis for the plan, or that those vendors would have prepared their own comparative analysis that the plan could rely on – in many cases, vendors had not. Compliance is ultimately the responsibility of the plans themselves.

COMMON COMPLIANCE CHALLENGES IN CURRENT PLAN LANGUAGE

When drafting NQTL Comparative Analyses, we have come across plan language and operational data that is consistently problematic. In the past year, EBSA has requested a NQTL analysis on the following common NQTL violations:

- Pre-certification/concurrent care requirements;
- Limitations on applied behavior analysis or treatment for autism spectrum disorder;
- Network provider admission standards;
- Out-of-network reimbursement rates; and
- Treatment plan requirements.

The following is an overview of common compliance issues that often trip up plans.

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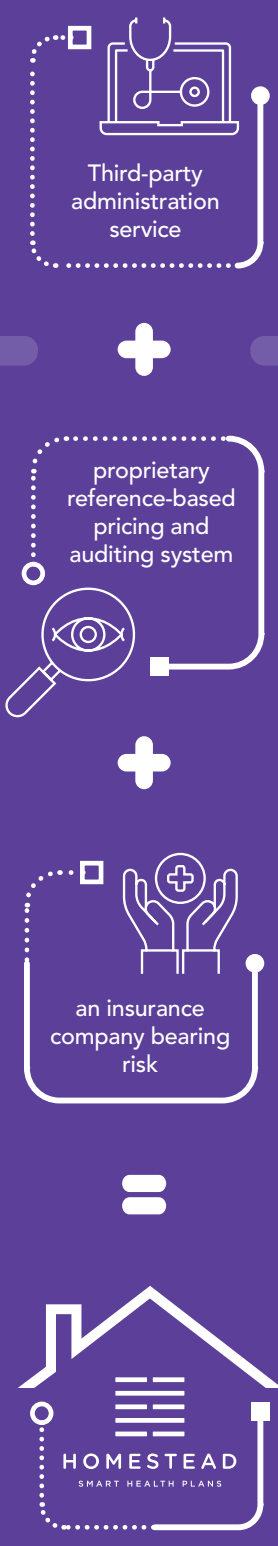

Don't settle for a traditional health benefits plan

What are you waiting for?

ABA Therapy

Many plans exclude ABA Therapy, one of the key treatments used for Autism Spectrum Disorder, due to the high cost of the treatment. Research has shown that early intervention and access to ABA therapy can improve the trajectory of a child's development.

The DOL has indicated that ABA Therapy in particular is a MHPAEA compliance concern – and that plans need to have evidence that an ABA Therapy exclusion is no more stringent than any comparable M/S benefit.

Pre-Certification Requirements for MH/SUD Benefits

It is not uncommon to come across pre-certification requirements for all (or the vast majority of) MH/SUD benefits, while not requiring pre-certification for the same scope of M/S benefits.

This is a classic example of a parity issue. Plans cannot have an overly strict list of MH/SUD benefits subject to pre-certification, without also having an equally strict list of M/S benefits subject to those requirements.

EBSA has identified pre-certification as a common issue and has had plans alter pre-certification requirements and even provide an opportunity for participants to submit claims through retroactive changes in plan terms.

Autism Spectrum Disorder

Autism Spectrum Disorder coverage and associated limitations can often crop up based on state-level requirements for coverage. For instance, some plans follow Wisconsin state law's requirement to cover Autism treatment for ages two to nine, for a cumulative total of four years, and for intensive-level treatment of less than 20 hours per week.

While providing coverage in line with state law will meet compliance on a state-level, it does not guarantee compliance with any federal laws. In particular, the MHPAEA requires that any of these limitations on autism spectrum disorder be no stricter than similar M/S conditions – this means that age limitations, duration of coverage, and weekly hour limitations cannot be stricter than any limitations that are in place for M/S conditions.

In many cases, M/S conditions do not have age, duration, or weekly hour limitations, so these restrictions may create compliance issues with the MHPAEA.

NEXT STEPS FOR THE DOL AND COMPLIANCE

The DOL is seeking action from Congress to amend ERISA to expressly provide the DOL with the authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans, as well as assess civil monetary penalties for parity violations.

The DOL and EBSA have made their stance clear – mental health is their priority and it should be a plan's priority to comply with the MHPAEA as well. Now more than ever, it is imperative to ensure that plans are complying with the MHPAEA and its NQTL Comparative Analysis requirement.

This is important not only to avoid the consequences of a DOL audit, but also to ensure that access to mental health treatment is available to plan participants in a meaningful way. ■

Kaitlyn MacLeod, Esq. joined the Phia Group, LLC as an attorney in the summer of 2021. As a member of the consulting team, Kaitlyn works on general consulting, plan document compliance, mental health parity analyses, and general compliance issues.

Kaitlyn attended University of Massachusetts Amherst, graduating cum laude with her B.A. in Political Science and Legal Studies. She earned her Juris Doctor at Northeastern University School of Law where she participated in the Amicus Curiae project and graduated with a concentration in Labor, Work & Income. After law school, Kaitlyn worked as an attorney representing and advising employers on employment law compliance. She is licensed to practice law in the Commonwealth of Massachusetts.