MENTAL HEALTH PARITY COMPLIANCE IN THE ERA OF COVID-19

Written By Corrie Cripps

The COVID-19 pandemic has led to a spike in mental health and substance use disorder ("MH/SUD") challenges, especially in the employer/employee realm, which highlights the importance of MH/SUD benefits in health plans.

Even before the coronavirus pandemic, many health plans struggled in the area of Mental Health Parity and Addiction Equity Act (MHPAEA) compliance, especially since case law is being developed in this area on a regular basis across the country.

BACKGROUND

The MHPAEA, as amended by the Affordable Care Act (ACA), generally requires that group health plans ensure that the financial requirements and treatment limitations on MH/SUD benefits they provide are no more restrictive than those on medical or surgical benefits. These are also referred to as quantitative and non-quantitative treatment limitations ("QTL" and "NQTL" respectively).

MHPAEA generally applies to group health plans that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. Some self-insured plans are exempt from MHPAEA, such as those with 50 or fewer employees.[1] MHPAEA does not require that self-insured group health plans cover MH/SUD benefits; it only requires that if a plan does cover MH/SUD benefits that the benefits are in parity with the medical/surgical benefits.

The U.S. Department of Labor (DOL), specifically the Employee Benefits Security Administration (EBSA), has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans.

EXPANSION OF THE REGULATIONS

The Consolidated Appropriations Act, 2021, ("the Act") further enhances federal mental health parity protections, with an emphasis on compliance regarding NQTLs on MH/SUD benefits.[2]

On and after February 10, 2021, health plans that impose an NQTL on MH/SUD benefits must perform and document a comparative analysis of the NQTL's design and application. The comparative analysis and other plan information (such as applicable plan provisions and evidentiary standards relied upon to design and apply the NQTL) must be made available to the applicable state or federal agency upon request.

At the time of this publication, we are currently waiting for additional guidance from the federal agencies on this comparative analysis documentation requirement. In the meantime, plan sponsors should continue their MHPAEA compliance efforts.

NQTLS

NQTLs are generally limits on the scope or duration of benefits for treatment that are not expressed numerically, such as medical management techniques, provider network admission criteria, or fail-first policies. In terms of MHPAEA compliance, plans should ensure that any NQTLs applicable to MH/SUD benefits are comparable to the limitations that apply to the medical/surgical benefits in the same classification.

NQTLs are commonly the area where health plans fall short of MHPAEA compliance. In its "Warning Signs" document, the DOL provides examples that serve as a "red flag" that a plan may be imposing an impermissible NQTL.[3]

The examples include preauthorization and pre-service notification requirements; fail-first protocols; probability of improvement; written treatment plan required; patient non-compliance; residential treatment limits; geographical limitations; and licensure requirements. This is a good resource for plans to use when reviewing their plan documents for MHPAEA compliance.

Another helpful DOL resource is its self-compliance tool for evaluating compliance with the MHPAEA, which was just updated in October 2020.[4]

The tool includes best practices, warning signs/red flags, guidance for developing internal plan compliance procedures, and a table for evaluating provider reimbursement rates in the MHPAEA context. However, plans should note that the self-compliance tool is not intended to be a substitute for full MHPAEA compliance testing.

In terms of a Plan's Plan Document/Summary Plan Description, you will often find NQTL language in the utilization management/pre-certification/preauthorization section as well as in the sections that describe the medical benefits and medical exclusions.

Some plans make the mistake, when reviewing their documents for MHPAEA compliance, to only update the medical benefit grids, unaware that other sections of the document have an impermissible NQTL on a MH/SUD benefit.

MH/SUD AND THE CORONAVIRUS PANDEMIC

There have been several recent studies on the MH/SUD crisis that is linked to the coronavirus pandemic. A U.S. Centers for Disease Control and Prevention study, published in August 2020, found that almost 41% of respondents are struggling with mental health issues stemming from the pandemic.[5]

Similarly, the Kaiser Family Foundation (KFF) published its findings from its July 2020 poll, which concluded that "[t]he pandemic is likely to have both long- and short-term implications for mental health and substance use, particularly for groups likely at risk of new or exacerbated mental health struggles."[6]

A recent article on CNN highlights that many people who had MH/SUD issues before the pandemic are experiencing their levels of uncertainty and fear double.[7]

The challenges that stem from the pandemic affect eating disorders, can cause drug relapses, as well as lead to increased levels of depression. And those who may not have experienced MH/SUD issues before the pandemic may now have issues with their stress levels, depression, and sleep disturbances.


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As noted above, the MHPAEA does not require that self-insured group health plans cover MH/SUD benefits. Some self-insured group health plans choose not to cover any MH/SUD benefits; however, this is not a common plan design.

What these recent studies and polls indicate is that now, more than ever, health plans should consider not only the physical aspects of the pandemic but also the mental health and substance abuse struggles many plan participants are facing. If your current plan design excludes all MH/SUD benefits, maybe now is the time to reevaluate this decision.

Alternatively, if your current plan design does cover MH/SUD benefits, it is recommended that you perform of audit of the plan to ensure parity between the medical/surgical and MH/SUD benefits, which also includes any medical necessity standards.

COMPLIANCE ACTIONS

The DOL and the Centers for Medicare & Medicaid Services (CMS) issues an annual "MHPAEA Enforcement Fact Sheet". The fiscal year 2019 Fact Sheet was issued on March 16, 2020.[8] In fiscal year 2019, the EBSA conducted 183 MHPAEA-related investigations.

Of these, 68 investigations involved fully-insured plans, 91 investigations involved self-insured plans, and 24 investigations involved plans of both types (the plan or service provider offered both fully-insured and self-insured options). EBSA cited 12 MHPAEA violations in 9 of these investigations.

This Fact Sheet gives a glimpse into the kinds of compliance issues that the DOL is seeing in health plans. The main issues for MHPAEA compliance still appear to be dollar limitations/visit limits and NQTLs on MH/SUD benefits that are not similarly applied to the medical/surgical benefits. Employers can use this information to ensure they do not have these same issues in their plans.

CONCLUSION

The DOL's published enforcement reports suggest that the DOL is continuing to investigate compliance with MHPAEA. To ensure compliance, self-insured health plans should consider conducting periodic claims audits and reviews, and can use the DOL's self-compliance tools to assist with this.

This is especially important since the Consolidated Appropriations Act, 2021, added a new requirement for comparative analysis of the NQTL's design and application (if the health plan has an NQTL on MH/SUD benefits). Due to the coronavirus pandemic, MH/SUD issues will be in the limelight in 2021, which may mean even more health plan investigations by EBSA. Plan sponsors should review cost-containment techniques with counsel to ensure they are designed to mitigate risk in this area while ensuring compliance. ■

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