EMPLOYERS RESPOND TO FINAL RULE ON MENTAL HEALTH PARITY

Written By Laura Carabello

Pushbacks and mixed responses from the self-insured community and other payers to the final rule of the Mental Health Parity and Addiction Equity Act (MHPAEA) are resonating throughout the industry. Conversely, praise from other healthcare stakeholders expresses that this regulation is long overdue.

Although federal law does not mandate insurers and employers to provide mental health coverage, under the new final rule, those that do will have to upgrade their benefits. The rule also requires non-federal governmental health plans to comply with mental health parity, which was not the case when the regulation was first enacted. Some aspects of the final rule will take effect in 2025, while others will be implemented in 2026.

Essentially, MHPAEA requires plans that cover mental health and substance use disorders (MH/SUD) to treat these benefits the same or better than medical/surgical benefits, specifically regarding:

- Quantitative Treatment Limitations (QTLs), such as plan copays, deductibles or visit limitations.

- Non-quantitative Treatment Limitations (NQTLs), such as prior authorization requirements, network adequacy, provider reimbursement rates or medical necessity determinations.

Health plans must assess their mental health networks, payment rates and prior authorization (PA) policies to ensure they are not more restrictive than for medical care. As health plans evaluate their provider networks, they must determine how much they pay out-of-network providers and how often they utilize PAs. Careful study of these issues will help health plans make changes to their mental health coverage when needed.

MENTAL HEALTH RELEVANT STATS

- The Integrated Benefits Institute analyzed data to identify the prevalence, lost productivity, and compounded effects of comorbidities in the US workforce. The average annual cost per employee due to mental health issues is about $1,488, including lost time ($445), job turnover ($533) and healthcare ($510).

- According to government reports, patients enrolled in private health plans paid an average of $1,500 per year in out-of-pocket costs for mental health care, largely because they seek coverage from out-of-network providers.

- Studies show that members with coverage are about four times as likely to go out-of-network for mental healthcare compared to physical healthcare. Analysts say this could create a spike in out-of-network balance billing and Independent Dispute Resolution (IDR), the process for determining the appropriate out-of-network (OON) payment rate for certain services and items.

Christine Cooper, CEO, aequum, explains, "For non-emergency mental health services, the likelihood of balance billing is significant and could only worsen the person's mental health," says Cooper. "Medical debt can be a major stressor in a patient's life. Compounding that with a mental health crisis, this fragile population needs an advocate to help reduce their medical bills while allowing them to continue with their care."

Christine Cooper, CEO

Cooper advises that if patients cannot find a mental health provider, "We may see an uptick in patients coming through the emergency room. This will lead to an increase in the usage of the Independent Dispute Resolution (IDR) process in mental health cases."

IDR is a way to resolve payment disputes between health plans or issuers and providers, facilities or air ambulance services. The process is established by the No Surprises Act (NSA) and is used when open negotiations are unsuccessful.

EXECUTIVE SUMMARY OF THE FINAL RULE

1. Formalizes, clarifies, and expands on requirements regarding a plan's Comparative Analysis

   of non-quantitative treatment limitations or requirements (NQTLs) applicable to mental health and/or substance use disorder benefits.

2. Requires group health plans and health insurance carriers (issuers) to conduct a two-part analysis to determine parity compliance with regard to NQTLs. This effectively raises the bar as to what employers must do to show that any NQTL meets parity requirements. Plans must proactively review relevant plan data to demonstrate operational compliance and ensure the design and application of any NQTL passes MHPAEA muster.

3. Plans and issuers to provide "meaningful benefits" to treat covered mental health and substance use disorders in each benefit classification in which medical/surgical benefits are provided. "Meaningful benefits" in this context means covering at least one "core treatment" (if one exists).

4. Directs plans to rely on independent medical standards in treatment decisions, which must be based on unbiased, current medical literature.

5. The final rule is generally effective for plan years beginning on or after January 1, 2025. However, and importantly, the final rule delays the effective date for some of the more complex changes, including the application of the design and application analysis and relevant data analysis, to plan years beginning on or after January 1, 2026.

6. Employer plan sponsors must adhere to current MHPAEA rules, which are still in effect, and plans should already be taking steps to ensure compliance with those rules. Plans must have a current Comparative Analysis on hand and confirm that they have reviewed the conclusions reached on NQTL compliance therein. If a Comparative Analysis has not been conducted since the enactment of the Consolidated Appropriations Act of 2021 (CAA), it's well past time to take that action.

7. Requires an ERISA plan fiduciary to certify they have engaged in a prudent process to select at least one qualified service provider to complete the plan's Comparative Analysis.

Source: 2023 Lockton
https://global.lockton.com/us/en/news-insights/final-mental-health-parity-rules-signal-significant-changes-that-plan

EMPLOYERS RESPOND

Scott Haas, CLU, RHU, Partner, Senior Vice President, USI Insurance Services, attests to the prevailing lack of awareness among plan sponsors: "Most plan sponsors are not aware of the final regs because their advisors are not talking about it. Nor are the advisors talking about the Consolidated Appropriations Act (CAA) and the compliance risk to the plans. "

In his opinion, the agencies in which the advisors reside are waiting for the legal and regulatory process to dictate the minimum compliance requirements and at what point in time to be serious.

"Because these agencies are being paid overrides by the BUPAs and PBMs, they are trying to figure out a glide path to other fee-based strategies that will support the services they provide to their clients," continues Haas. "The overrides contribute greatly to any agency's overall ability to provide a broad-based scope of service. Furthermore, each agency's fiscal model is unique to them. This means inclusive and a la carte services within a fee basis are dependent upon the advisor/agency the plan sponsor retains and varies from A to Z."

Haas is advising its clients to wait and see what the appeals to the final rule produce in clarity and reduction in the complexity of compliance. Quantifiable compliance is one thing. Non-quantifiability is another issue that requires service providers to disclose policies, processes, methodologies, etc. Most are not forthcoming about their fully insured books of business let alone to the self-insured clients they serve. I believe the bigger threat to plan sponsors is from class action activity more than the DOL. There are not enough DOL agents in the world to police mental health parity, let alone the CAA. "

But Nick Soman, CEO, Decent is well aware of the final mental health parity rule and says

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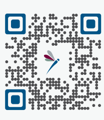
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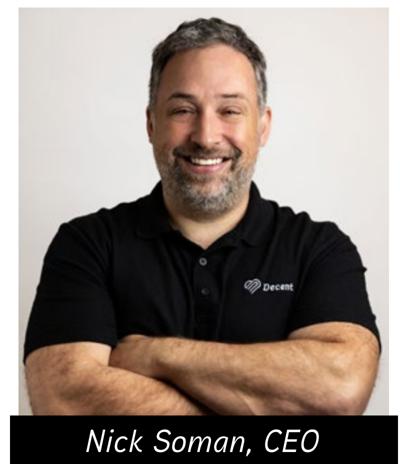


Nick Soman, CEO

his Company has proactively exceeded its requirements.

"We offer unlimited mental health care to all members, not due to regulations, but because we believe it's fundamental to comprehensive healthcare," offers Soman. "Our plans are built around a Direct Primary Care model to facilitate easy access to mental health services, with $0 expenses for in-network care."

He says that by eliminating barriers to treatment, they have seen a significant portion of our members accessing these vital services without financial strain.

"This approach ensures compliance with parity regulations while aligning with our mission to provide truly decent healthcare that prioritizes both physical and mental wellbeing," he says.

PROVIDER RESPONSE

The American Medical Association, an advocacy organization for physicians, came out in support of the final rule.

A statement from Bruce A. Scott, MD, president of the AMA, expressed support: "While the AMA continues to evaluate the final rule, the AMA strongly supports multiple provisions that will help increase transparency, oversight and enforcement of MHPAEA in areas such as prior authorization and network adequacy. Health plans have violated MHPAEA for more than 15 years, and this final rule is a step in the right direction to protect patients and hold health plans accountable for those failures."

The American Psychological Association (APA) believes the rule targets the issue of network adequacy and recognizes that low pay for mental health providers is a major cause of network inadequacy.

Dr. Jared Skillings, chief of professional practice at the APA, provides this perspective: "While some insurance companies may claim network inadequacy is primarily due to a workforce shortage. We disagree."

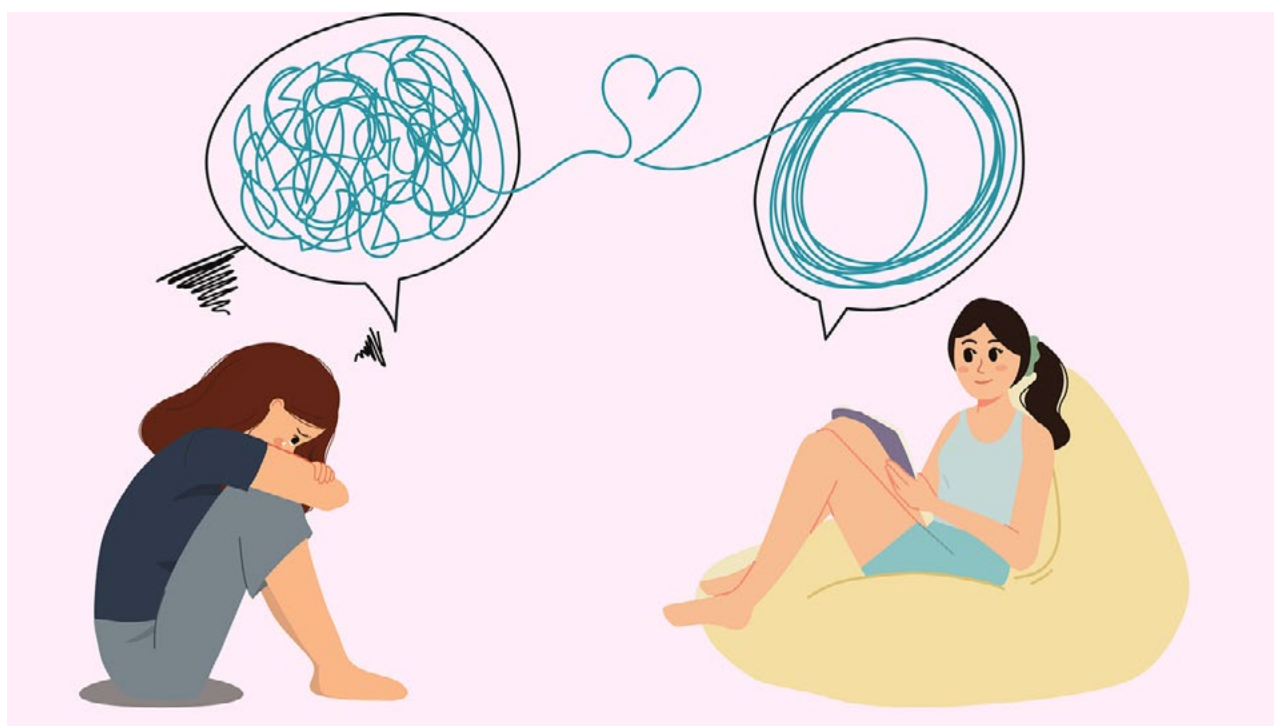
He says the final rule is aimed at closing the gaps by requiring health insurers to evaluate which mental health providers' services are covered by their plans, how much those providers are paid, and how often they require or deny prior authorizations for coverage. Such requirements may push health plans to add mental health providers to networks,

HEALTH INSURERS RESPOND

In a joint statement, America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association, the ERISA Industry Committee, representing large employers, and the Association of Behavioral Health and Wellness, including several insurers, said the rule will have "severe unintended consequences" -- increasing costs without improving access. They contend that with nearly 50 million Americans experiencing a mental illness, there's no question that addressing the shortage of mental health providers must be a top priority.

But they also argue that there are proven solutions to increase access to mental health and substance use disorder care, including more effectively connecting patients to available providers, expanding telehealth resources and improving a for primary care providers. They decry that the final rule falls short of promoting these solutions and, instead, complicates compliance to the extent that it will be virtually impossible to operationalize, resulting in worse patient outcomes. The ERISA Industry Committee is considering all possibilities, including litigation, to challenge the regulation.

Litigation may likely ensue in light of the recent Supreme Court decision to overturn Chevron deference, which required federal courts to defer to agencies' interpretations of ambiguous federal laws. The mental health parity rule could be more vulnerable to a legal challenge.



PRIMARY CARE INTERVENTION MIGHT REDUCE SUICIDE ATTEMPTS

When employers weigh the value of mental health vs. physical health benefits, the issue of suicide prevention becomes critically important. Industry observers recommend the presence of integrated mental health specialists on primary care teams.

Some health systems already screen for depression in primary care, but the findings of a study -- originally funded to examine the integration of alcohol-related care in primary care -- suggest that going a step further to address suicidality in clinical practice could be potentially life-saving. Following the launch of an integrated suicide prevention program across Washington state, researchers observed a 25% drop in the rate of attempted suicides once a suicide screening and safety planning program was introduced to 19 primary care practices in the state.

A spokesperson for the study reported that some primary care teams expressed concerns about having the time and resources to address suicide during routine visits, but the team-based element of the program kicked in with having integrated mental health specialists available. A patient may have visited the doctor for a non-mental health-related issue, but thoughts of suicide in the last month could be noted during screening. Suicide then becomes the primary issue, one for which patients are ideally connected to mental health specialists the same day,

Source: Annals of Internal Medicine
https://www.acpjournals.org/doi/10.7326/M24-0024

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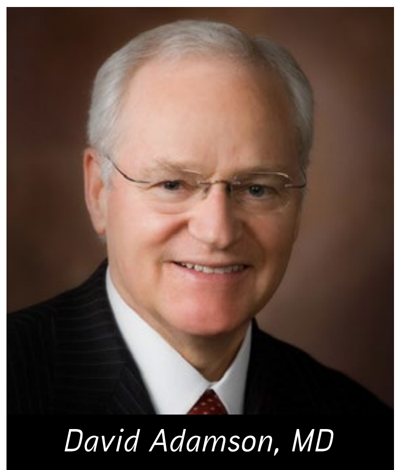
CONSIDER FERTILITY AND MENTAL HEALTH

As today's employers recognize the importance of offering fertility benefits, they are taking a vital step toward creating a healthier, happier and more productive workforce. Think of all the medical/surgical services such as in vitro fertilization (IVF), intrauterine insemination (IUI), egg freezing, and reproductive surgery (to name a few), along with one area that often goes overlooked: the emotional toll of infertility.

"Infertility is not just a physical health issue; it has profound emotional and psychological effects," says David Adamson, MD, Founder and CEO, ARC Fertility. "The process of trying to conceive, often without success, can lead to feelings of grief, loss, frustration and depression. The emotional strain of infertility is often compounded by financial stress, particularly when employees have to bear the high costs of fertility treatments like IVF out-of-pocket expenses.


David Adamson, MD

Dr. Adamson points to one national study of employer-provided healthcare plans, where nearly half of the respondents reported employees missing additional work time (beyond time missed for treatment or diagnosis) because of psychological stress, depression, or other conditions associated with their infertility. Respondents without coverage for infertility treatment were 2.354 times more likely than those with insurance to report missing time from work due to psychological stress, depression, or other conditions related to their infertility.

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"For many individuals and couples, the journey to parenthood can be fraught with emotional distress, financial strain and feelings of isolation," he continues. "To help ease the mental anguish of infertility, it is important to also provide a high-touch experience throughout the fertility journey, beginning with easy access to personalized 'human' care as well as digital resources. Emotional support, guidance and counseling to address mental health hurdles go hand-in-hand with the medical-surgical fertility services. The final rule indicates that these must be provided ."

SIIA ADVOCACY IN ACTION

SIIA has been actively monitoring the implications of this regulatory change on behalf of the self-insured community to gauge the impact of changes to increase access to mental health and substance use disorder (MH/SUD) benefits through increased compliance with the Mental Health Parity requirements.

The proposed regulations had focused exclusively on Non-Quantitative Treatment Limitations (NQTLs), such as prior authorization, concurrent review, and other utilization management tools that self-insured plans impose on MH/SUD benefits, requiring plans to ensure that the NQTLs imposed on MH/SUD benefits are comparable to the NQTLs imposed on medical and surgical (M/S) benefits.

The proposed regulations required plans to remain compliant with the Mental Health Parity law and comply with a number of mathematical tests – and satisfy various definitions – to determine whether an appropriate level of comparability was present.

Chris Condeluci

Chris Condeluci, Washington General Counsel, SIIA, affirms, "When the final regulations were released in September 2024, SIIA was pleased that its voice was heard: the Biden Administration opted against finalizing one of the mathematical tests called the "substantially all" test. SIIA, along with employer and labor groups, explained to the Administration how burdensome and unworkable this requirement was in its proposed form.

"However, there are other tests and definitions that the

Administration ultimately finalized that SIIA, along with its employer and labor friends, believe are near impossible to operationalize," says Condeluci. "There are questions that the Federal Departments exceeded their statutory authority with many of the finalized requirements, which could invite a lawsuit, especially now that courts cannot defer to the Federal Departments' interpretation of the law when developing regulations."

For access to the final regulations and a fact sheet of the regs, visit: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea.

THE PATH FORWARD

The time is now for plan sponsors to seek help from legal counsel, advisors, carriers and/or third-party administrator (TPA) partners to identify and address any problematic challenges to compliance with MHPAEA. The goal is to help employees get the mental help they need since many polls and surveys indicate that this is simply not the case.

The recent KFF Survey of Consumer Experiences with Health Insurance found that 17% of insured adults indicated that even with health coverage, they did not get the mental health care that they thought they needed in the past year. Of these individuals, more than 4 in 10 (44%) indicated that one of the reasons they did not get needed mental health care was that they could not afford the cost. Additionally, about a third of insured adults who did not get needed mental health services in the past year say their insurance not covering the services was a reason they did not get the care.

Despite these reports, many stakeholders in the self-insured community are still not certain that the new regulations are a solution.

Jeff Walter, CSFS®, President, Professional Benefit Administrators,

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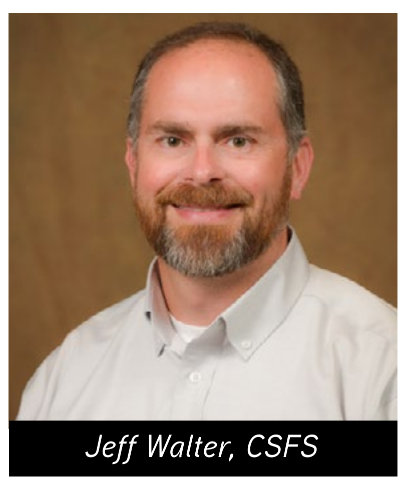
Jeff Walter, CSFS

Inc., says, "We appreciate the intentions of the MHPAEA as it helps break down significant barriers for people desperately in need of mental health services. Unfortunately, the final rule burdens our self-funded health plans with another layer of bureaucracy that continues to drive up the already excessive cost of sponsoring a health plan."

Walter believes there are more effective ways to prove compliance when an audit is required, adding,

"As our industry becomes more complex, agencies should focus on how to simplify regulations to make care available. It is apparent that these rules no longer create parity with other covered illnesses, conditions or services. Mental health is now elevated above all other covered services."

While the MHPAEA Final Rule provides more detail related to the NQTL requirements, there are still many unanswered questions. Lisa Campbell, Principal, Groom Law Group, Chartered, says it provides a delayed effective date for some of the more onerous requirements to plan years beginning on or after January 1, 2026, but still leaves many new provisions effective for plan years beginning on or after January 1, 2025.

Lisa Campbell, Principal

"This puts plans in a real bind, given that January 2025 is only a few short months away," she explains. "Many self-insured plans are working to get as much of what they need in place for the 2025 effective date, but there will most definitely be a lag in compliance given everything that needs to be completed."

Campbell's advice is that self-insured plans should not wait to develop an NQTL comparative analysis but instead do the best they can to develop and maintain an analysis for 2025, which includes the new fiduciary certification.

"This new requirement, effective in 2025, requires the named fiduciary of the plan to engage in a prudent process to hire a qualified expert to perform and document the NQTL comparative analyses and provide oversight of the expert by reviewing the NQTL comparative analysis and asking questions."■

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