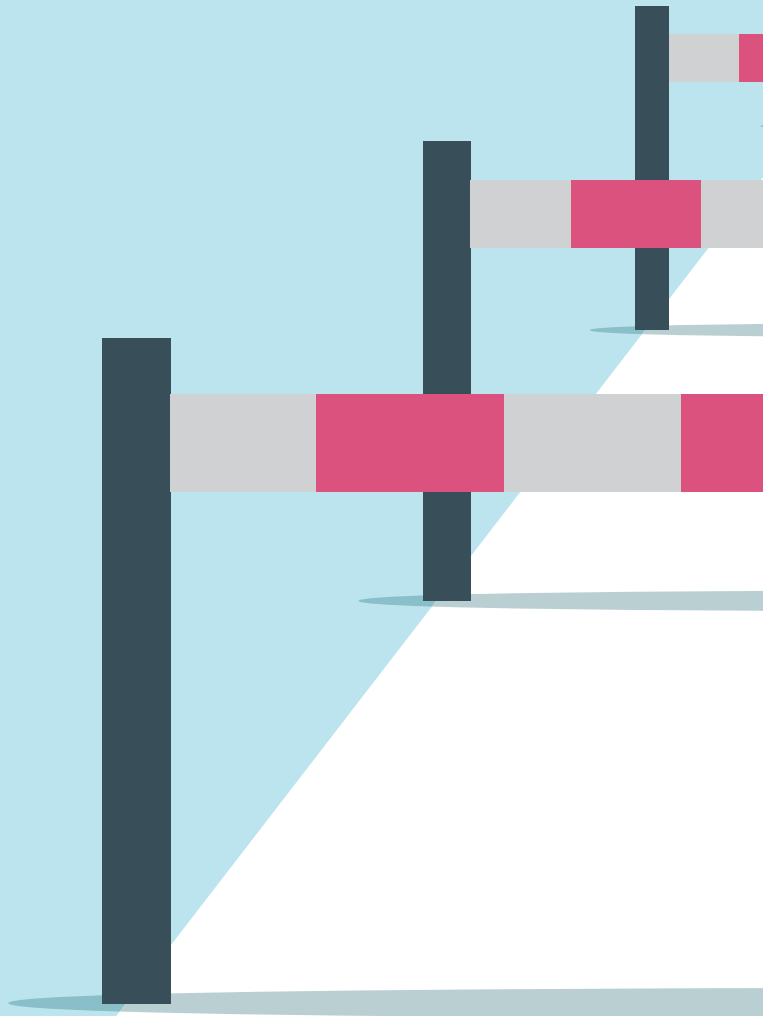
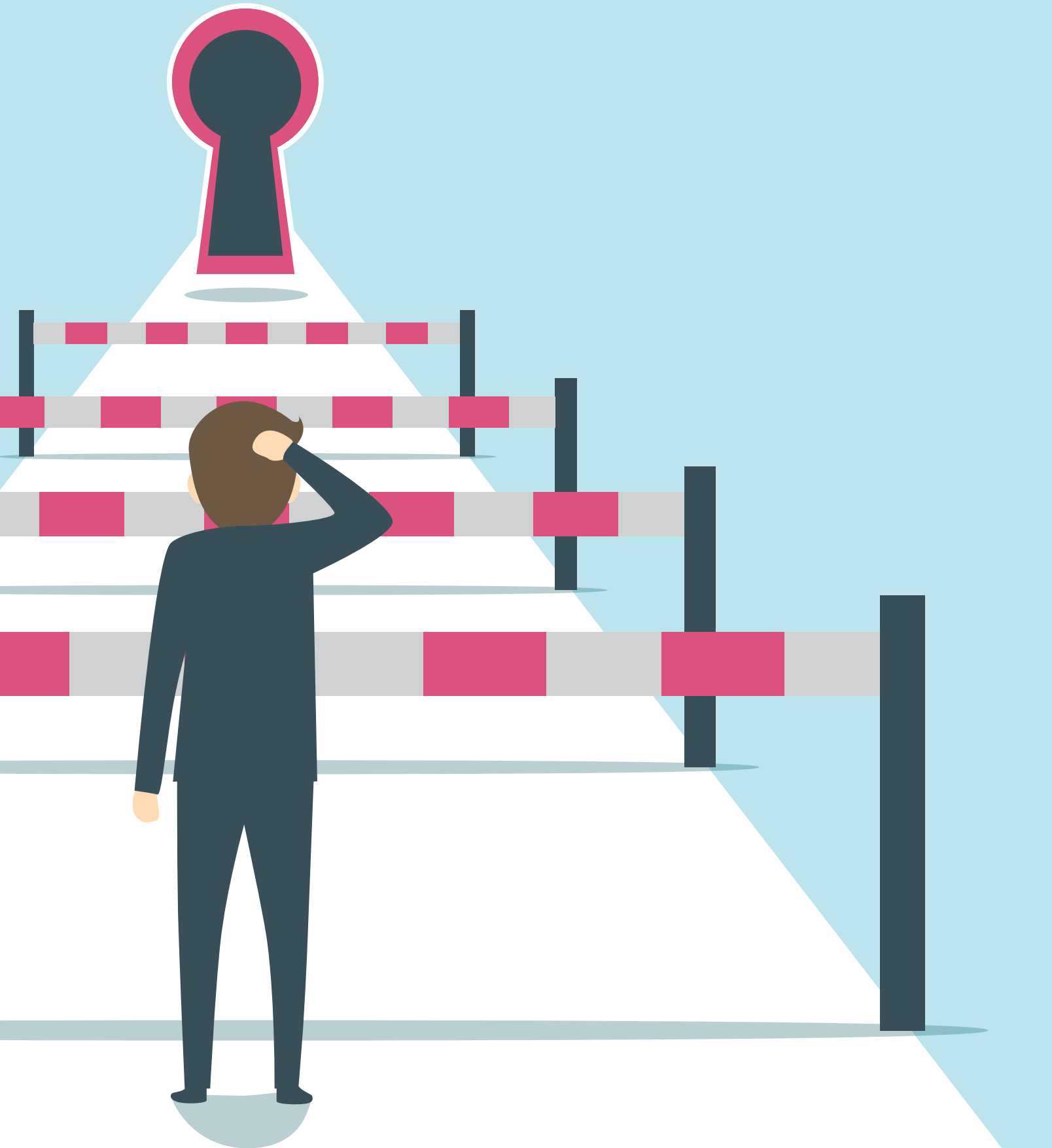
Mental Health Parity Compliance: *Hidden Hurdles*

by | **Stephanie Patrick**

The road to compliance with mental health parity rules is filled with hidden hurdles. Being aware of these obstacles may help employers and health plan sponsors avoid violations.





It was just not my day.

I had an important 9:00 a.m. meeting. Very important. That is why I set two alarms—neither of which apparently worked. When I finally awoke at 8:42 a.m., I was immediately in panic mode. Into the shower for the world's fastest rinse. Thankfully, I had picked out my clothing the night before. Unfortunately, my cat found my neatly arranged attire the perfect spot to vomit during my shower. I quickly perused my closet, found nothing suitable, and settled on a wrinkled shirt and mismatched pants (which no one should see) for my virtual meeting. As I headed up the stairs to my home office, my sock-clad foot found a rogue Lego, precipitating a nasty tumble back down. I finally settled into my chair at 8:59. I congratulated myself on an impressive turnaround time, but my computer had other ideas. One infuriatingly complicated password reset and system update later, I logged on, only four minutes late. I had just opened my mouth to apologize for my tardiness when my smoke detector began to blare . . . Sigh.

We've all had days like this. We try to be proactive and make the right decisions, but things can still seem to turn out wrong. It's an important reminder for health plan sponsors in light of the emphasis that the Department of Labor (DOL) has placed on auditing plans for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

What Is MHPAEA?

The Department of Labor MHPAEA Self-Compliance Tool provides the following description of the Mental Health Parity and Addiction Equity Act (MHPAEA).

> *MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.*

Despite your best efforts, there may be hidden hurdles that trip up your plan.

Some are easy to clear; others are more difficult.

Hidden Hurdle 1: Equality Does Not Equal Parity

One primary part of mental health parity—one that on the surface seems easy to understand—is the concept that a plan cannot charge participants more for mental health services[1] than it does for medical services. The sidebar "What Is MHPAEA" provides additional background on the law. Most plans have addressed this requirement by setting mental health cost-share amounts equal to medical cost-share amounts. But this approach only works if the plan's benefit structure aligns with the structure required for compliance testing.

According to MHPAEA rules, a plan is allowed to apply a financial requirement (e.g., deductible, copayment or coinsurance) or quantitative treatment limit (QTL) (e.g., day or visit limits) to a mental health benefit if both of the following are true.

A. The financial requirement or QTL applies to "substantially all," or two-thirds, of medical/surgical benefits in the classification.
B. If A is true, the level of financial requirement or QTL must be the "predominant" one—the one that applies to more than 50% of the medical/surgical benefits in that classification.

While this may seem obvious, the classification structure described by MHPAEA can sometimes lead to surprises. The allowed classifications are:

1. Inpatient, in network
2. Inpatient, out of network
3. Outpatient office visits, in network
4. All other outpatient services, in network
5. Outpatient office visits, out of network
6. All other outpatient services, out of network
7. Emergency care
8. Prescription drugs.

The "Peach Plan" sidebar provides a quick example of how a plan with equal benefits may trip up on this requirement.

Hidden Hurdle 2: When You Don't (and Can't) Know How Your Plan Is Run

The 2021 Consolidated Appropriations Act (CAA) added new documentation requirements for mental health parity

compliance. Effective February 10, 2021, health plans must have a comparative analysis of nonquantitative treatment limits (NQTLs) available upon request by DOL or the plan's participants.

NQTLs are any nonnumeric limits on the scope or duration of benefits or treatment. While DOL has not released a complete list of NQTLs, it has provided enough examples to indicate the thoroughness of its expectations. Any rule, process or procedure that may in any way reduce the benefits that a participant receives should be considered in the NQTL process. Many NQTLs are not described in plan documents and, if they are, the methods applied are not described in detail. Following are a few examples.

- Review of claims for medical necessity
- Exclusion of investigational or experimental drugs
- Formulary design for prescription drug programs
- Standards for provider admission into a network
- Reimbursement rates paid to providers

Most plans rely heavily on their vendor and professional partners in the administration of day-to-day operations. As a result, most of the information needed to review any individual NQTL will come from one or more sources outside of the plan itself. Herein lies the problem.

When working with large medical carriers or pharmacy benefit managers (PBMs)—whether in a self-funded or fully insured arrangement—plans that request NQTL information are often provided standard blanket statements that are not specific to each plan's setup or arrangement with the carrier. These generalized documents often lack the detailed information needed to complete the thorough review process required by DOL for an NQTL comparative analysis. In some cases, the standard documents may not be accurate for the plan at all. For example, a standard medical vendor document may describe the process consistent with a self-funded administrative services only (ASO) arrangement. For any jointly administered plan where either a third-party administrator (TPA) or the fund office pays the claims, this standard document will not reflect the actual process in place for the plan. For example, the standard medical necessity or utilization management review process that applies when the carrier pays the claims may be described in the standard documents. If the carrier is not the claims payer, however, these processes may not be applied the same way or at all. The TPA or fund office may

Peach Plan

The Peach Plan has always found it valuable for its participants to have strong relationships with their primary care providers (PCPs). As a result, its benefits cover in-network PCP office visits with a low copay requirement and without requiring the participant to meet the deductible. In-network specialist office visits are subject to the deductible and the plan's coinsurance. About 60% of the plan's office visit claims are for specialist visits; 40% are for PCP visits.

Because neither the PCP nor the specialist claims rise to the level of two-thirds of claims, there is not a financial requirement that meets the "substantially all" rule. In this case, the plan cannot apply deductible, coinsurance or copays to mental health office visits.

One way to avoid this hurdle is to apply the same type of financial requirements to all benefits within each of the eight classifications outlined above. If the Peach Plan transitioned all office visits to a copay type structure, it could maintain the primary care provider copay and set a higher specialist copay amount that would result in a similar financial result for the plan. Since all medical office visit claims would then be subject to copays, the plan would be allowed to apply a copay for mental health office visits. Further, since 60% of the claims (more than 50%) were for specialist visits, that higher copay would be considered the predominant one and the Peach Plan would be allowed to utilize the higher specialist copay for mental health visits.

takeaways

- The Mental Health Parity and Addiction Equity Act (MHPAEA) requires health plans that offer mental health benefits do so in a way that is no more restrictive than medical/surgical benefits.
- One of the compliance issues that plans may face is whether they can apply financial requirements or quantitative treatment limitations due to the structure of compliance testing.
- Plans are now required to conduct a comparative analysis of nonquantitative treatment limitations (NQTLs), but much of this data is supplied by outside parties that may provide standardized reports that are not specific to each plan's unique setup.
- Plans that exclude mental health benefits should carefully check their prescription drug coverage. Covering any prescription drug that is used to treat a mental health condition may require a plan to add management criteria, such as prior authorizations, or to cover mental health benefits in all classifications, including inpatient and outpatient care.

have different processes and standards in place for medical necessity or utilization management review.

In some cases, even when everyone involved is trying to provide the appropriate NQTL information, it may be difficult to obtain. Many claims payment systems incorporate numerous controls to help avoid fraud, waste and abuse. These controls are executed through review of large amounts of data by the claims system. The system can cross-reference many variables simultaneously that may indicate fraud, waste or abuse, including the provider's prior history, the participant's claim history and the diagnosis/procedure combinations. The claims system may automatically deny claims outside of certain thresholds and flag others for medical necessity review or additional detail. These systems are complex, and the coding developed to review the claims is often multilayered. This makes it difficult to directly map all the NQTLs embedded within the claims system.

The NQTL comparative analysis requirement has been challenging for health plans. In the *2022 MHPAEA Report to Congress*,[2] DOL, the Department of Health and Human Services (HHS), and the Department of the Treasury reported that none of the NQTL comparative analyses reviewed by either the Employee Benefits Security Administration (EBSA) or the Center for Medicare & Medicaid Services (CMS) contained sufficient information. The report called out a number of key issues that plans should consider in their NQTL comparative analyses but, so far, neither an acceptable example nor a full list of NQTLs has been provided to assist plans in compliance. The sidebar "MHPAEA Auditing Efforts" provides additional background on federal enforcement efforts.

Plans should be sure that their NQTL analysis addresses all of the violations or areas of concern stated within the 2022 report as well as those highlighted in the FY *2021 MHPAEA Enforcement Fact Sheet*[3] and the Self-Compliance Tool.[4] EBSA, CMS and the other departments mentioned also have resources that plans can utilize. Plans should do their best to build a specific, detailed and well-reasoned written comparative analysis but keep in mind that changes to the document or the plan may still be required after a departmental review.

Hidden Hurdle 3: Didn't We Exclude That?

Some plans exclude mental health benefits altogether. In those cases, plans should check the prescription drug coverage carefully. Covering any prescription drug that is used to treat a mental health condition or disorder may require a plan to cover mental health benefits in all classifications, including inpatient and outpatient care.

If a prescription drug can be used for a particular mental health condition and for other unrelated medical conditions, covering the drug would not necessarily override the plan's general mental health exclusion unless the plan covers the prescription drug specifically to treat that mental health condition. This means that any prior authorization, step therapy or exclusion override criteria must be reviewed to ensure that it is only for medical conditions and does not specifically permit use under a mental health diagnosis. An example would be a plan that excludes mental health and substance abuse treatment but covers certain drugs like fluoxetine (brand name: Prozac®) for uses outside of mental health disorders, including weight loss and headaches. That plan should have management criteria such as prior authorization requirements in place for those medications

MHPAEA Auditing Efforts

Both the Department of Labor (DOL) and the Centers for Medicare and Medicaid Services (CMS) have requirements related to auditing plans for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), but it is likely that federal departments intend to go above and beyond the minimum standards. The *2022 MHPAEA Report to Congress* states that DOL, the Department of Human Services and the Treasury will make enforcing the law a "top priority."

For health plans, this prioritization could mean increased risk of a mental health audit, a nonquantitative treatment limitation (NQTL) comparative analysis audit, or both, as well as increased scrutiny during these audits.

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to ensure that they are being used for conditions other than mental health conditions.

Best Efforts

In the ever-evolving world of mental health parity, even with the DOL Self-Compliance Tool, there is no clear road map to help ensure compliance for each component. Awareness of the expectations is one big step but, even after you know what you need to provide, the road to providing it may be complicated. Hang in there.

Endnotes

1. Any rules referenced for "mental health services" in this article also apply to substance use disorder services.
2. www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.
3. www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2021.pdf.
4. www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

bio

Stephanie Patrick, FSA, MAAA, is a senior consulting actuary for Horizon Actuarial Services, LLC, based in the Atlanta, Georgia office. She consults primarily on the design, financing and administration concerns for multiemployer health and welfare programs. In addition to performing actuarial projections for a wide variety of health and welfare plans, Patrick consults on plan design and eligibility strategy, vendor management, compliance with respect to benefit legislation and employee communications. She is a past Chair of the International Foundation of Employee Benefit Plans Professionals Committee, a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Patrick holds a B.S. degree in mathematics and philosophy from Vanderbilt University.

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