Recent Developments in Mental Health Parity

Although the Mental Health Parity and Addiction Equity Act (MHPAEA) and associated regulations have been around for a while, behavioral health advocacy groups have expressed significant concern about a lack of enforcement to ensure compliance among health plans and employers. Federal and state governments have stepped up efforts to encourage MHPAEA compliance. This article presents recent developments in mental health parity, including a summary of the parity law requirements, new warning signs for nonquantitative treatment limitations, a confusing answer to a frequently asked question from the U.S. Department of Labor, an update on enforcement developments and the results of recent Milliman research on cost patterns since MHPAEA went into effect.

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The Mental Health Parity and Addiction Equity Act (MHPAEA) and associated rules have been in place for most health plans and employers for seven years. Interim final rules were effective for health plan renewals on or after July 1, 2009, and the final rules became effective for renewals on or after July 1, 2014.

However, there are still many noncompliant plan designs on the market, including designs by state and federal governments. Enforcement activities appear to be picking up, and noncompliant plans could face a penalty of up to $100 per member per day. This article presents recent developments in mental health parity, including a summary of the parity law requirements, new warning signs for nonquantitative treatment limitations (NQTLs), a confusing answer to a frequently asked question from the U.S. Department of Labor (DOL), an update on enforcement developments and the results of recent Milliman research on cost patterns since MHPAEA went into effect.

A Summary of the Parity Requirements

MHPEA’s purpose is to ensure that health plans provide benefits for mental health and substance use disorders (MH/SUD) at levels that are comparable with those for medical/surgical benefits. The regulations require that MH/SUD benefits be compliant within each of these six benefit classifications: (1) in-network inpatient, (2) out-of-network inpatient, (3) in-network outpatient, (4) out-of-network outpatient, (5) emergency room and (6) prescription drugs.

The rules require plans to pass two detailed tests for quantitative financial requirements:
1. Member cost sharing can be applied to MH/SUD benefits only if a particular type of cost sharing (copay, coinsurance, deductible, etc.) applies to substantially all (at least two-thirds, based on allowed costs) of the medical/surgical benefits in the classification being tested.

2. If cost sharing is allowed in the classification, the predominant level of cost sharing (the level applying to greater than 50% of the allowed costs) must be determined.

These same two tests apply to quantitative treatment limits, as well (inpatient day limits, outpatient visit limits, etc.). For example, consider a plan in which 80% of in-network, inpatient medical/surgical benefits are subject to a $250 per day copay and that is the only quantitative financial requirement. In this case, the only financial requirement that could be applied to MH/SUD benefits would be a per day copay of up to $250 per day.

The rules also address NQTLs, such as utilization management, the use of medical necessity criteria, step therapies, network tier design, standards for provider admission to participate in a network (including reimbursement rates) and preauthorization criteria. The processes, strategies, evidentiary standard or other factors used to manage the MH/SUD benefits must be “comparable to, and applied no more stringently than” those used for managing medical/surgical benefits.

Quantitative financial requirements in the outpatient, in-network benefit class and problems with the use of NQTLs represent the most common areas of noncompliance. A safe harbor established as of July 1, 2009 allowed plans to separate the outpatient benefits into two subclasses—one for outpatient office visits and the other for other outpatient benefits. This helped plans considerably because of the common use of copays for office visits and coinsurance/deductible for many non-office-visit outpatient benefits.

**Warning Signs for NQTLs**

DOL and the Department of Health and Human Services (HHS) recently published *Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations that Require Additional Analysis to Determine Mental Health Parity Compliance*. The departments published the information to provide examples of MH/SUD benefit plan provisions that should trigger careful analysis of the corresponding medical/surgical benefits to ensure that NQTLs complied with MHPAEA.

Language contained in the following provisions (absent similar restrictions on the medical/surgical side) can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL. Further review of the processes, strategies, evidentiary standard or other factors used in applying the NQTL to both MH/SUD and medical/surgical benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance. The categories and examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance issued by the departments.

- Preauthorization and preservice notification requirements
- Blanket preauthorization requirements
- Treatment facility admission preauthorization
- Medical necessity review authority
- Prescription drug preauthorization
- Extensive prenotification requirements
- Fail first protocols
- Progress requirements
- Treatment attempt requirements
- Probability/likelihood of improvement
- Written treatment plan requirements
- Written treatment plan
- Treatment plan required within a certain time period
- Treatment plan submission on a regular basis
- Other
  - Patient noncompliance
  - Residential treatment limits
  - Geographical limitations
  - Licensure requirements
  - Network design

**April 2016 FAQ**

A published response to an April 2016 frequently asked question on compliance is surprising to most actuaries who perform MHPAEA compliance testing.

In “FAQs about Affordable Care Act Implementation (Part 31),” released on April 20, 2016, Question 8 stated: “When performing ‘substantially all’ and ‘predominant’ tests for financial requirements and quantitative treatment limitations under MHPAEA, may a plan or issuer base the analysis on an issuer’s entire overall book of business for the year?”
The answer was:

No. Basing the analysis on an issuer’s entire overall book of business expected to be paid for the year or book of business in a specific region or State is not a reasonable method to determine the dollar amount of all plan payments under MHPAEA. To the extent group health plan-specific data is available, each self-insured group health plan must use such data in making their projections. For large fully-insured group health plans, for which the premiums are determined on an experience-rated basis, the issuer should generally have group health plan-specific data to make projections. If a large, fully-insured plan does not have sufficient group health plan-specific data to make projections, data from other similarly-structured group health plans with similar demographics can be utilized for the analysis.

For insured small group and individual market plans, the health insurance issuer should use data at the “plan” level (as opposed to the “product” level) to perform the substantially all and predominant analyses, as such terms are defined in 45 CFR 144.103.32. If an issuer does not have sufficient data to calculate the substantially all and predominant tests at the plan level, it can use data at the product level to inform its projections of expected spending in the benefit classification at issue (provided that the issuer can demonstrate the validity of the projection method based on the best available data).

The response seems to be inconsistent with language in the final rules: “Any reasonable method may be used to determine the dollar amount expected to be paid under a plan for medical/surgical benefits subject to a financial requirement or quantitative treatment limitation.” Taken at face value, the FAQ would likely result in increased cost and complexity of performing the parity compliance testing because of the requirement for plan-specific data. In addition, it could result in plan designs being found to be compliant for some large or self-insured groups but not for others (based on the cost data alone). An individual or small group plan design may be found compliant for some network configurations or areas but not for others.

In October 2016, the following additional guidance was provided: If an actuary who is subject to and meets the qualification standards for the issuance of a statement of actuarial opinion in regard to health plans in the United States, including having the necessary education and experience to provide the actuarial opinion, determines that a group health plan or issuer does not have sufficient data at the plan or product level for a reasonable projection of future claims costs for the substantially all or predominant analyses, the group health plan or issuer should use other reasonable claims data to make a reasonable projection to conduct actuarially appropriate analyses. Data from other similarly structured products or plans with similar demographics may be used for the analyses if actuarially appropriate.

**Enforcement of MHPAEA Compliance**

There have been new efforts to step up enforcement of the parity law and rules at both the state and federal levels. On March 29, 2016, a presidential memorandum was released establishing an interagency Mental Health and Substance Use Disorder Parity Task Force.

The task force has been directed to coordinate across agencies to (a) identify and promote best practices for compliance and implementation, (b) identify and address gaps in guidance, particularly with regard to substance use disorder parity and (c) implement actions during its tenure and at its conclusion to advance parity in mental health and substance use disorder treatment.

The director of the Domestic Policy Council will serve as chair of the task force. Other departments involved are the Departments of Treasury, Defense, Justice, HHS and Veterans Affairs, the Offices of Personnel Management, National Drug Control Policy and other agencies.

The task force will conduct outreach to patients, consumer advocates, health care providers, mental health and substance abuse disorder treatment specialists, employers, insurers and state regulators. A report on the task force’s findings and recommendations was to be presented to President Obama before October 31, 2016.

The establishment of the federal task force and the increased visibility that will result regarding proper implementation of MHPAEA by health plans and employers are significant steps in the direction of greater enforcement of the parity law and rules.

Some states also are working to boost MHPAEA compliance. In New York, for example, the New York State
Psychiatric Association (NYSPA) has launched its Parity Enforcement Project, a joint initiative of NYSPA and the American Psychiatric Association (APA). The project is intended to provide psychiatrists and their patients with a new approach and new tools to fight back against discriminatory practices by health plans. The central goal is to identify and challenge existing parity violations, particularly in the context of disparate medical necessity reviews for behavioral health benefits, including:

- Reductions in the frequency of covered or reimbursed visits
- Prepayment medical record reviews
- Requests for peer interviews
- Requirements for outpatient treatment reports
- Imposition of prior authorization requirements on behavioral health treatment
- Imposition of numerical visit limits
- Notification that behavioral health treatment will no longer be covered by the health plan.

Under the Employee Retirement Income Security Act (ERISA) and MHPAEA, plan participants and providers are entitled to receive access to certain plan information, reasons for denial of coverage or benefits, and copies of the medical necessity criteria used to make benefit determinations. In order to facilitate these document requests, NYSPA prepared form letters that psychiatrists and patients can use. Through document requests and sharing of materials, they hope to identify ongoing patterns and practices of discrimination—the next step in ensuring full enforcement of the parity laws.

Some members of Congress also have been working to increase enforcement of the rules. On October 15, 2015, U.S. Senator Rob Portman (R-Ohio) joined U.S. Senator Chris Murphy (D-Conn.) and U.S. Senator Kelly Ayotte (R-N.H.) in calling on HHS and DOL to take immediate, overdue action to fully implement and enforce MHPAEA.

In a letter addressed to HHS Secretary Sylvia Mathews Burwell and DOL Secretary Thomas E. Perez, the senators emphasized that implementation of MHPAEA has been incomplete and inconsistent. The senators warned that parity still is not a reality for individuals living with mental illness and addiction and that health plans routinely refuse to disclose medical management information, making it impossible for consumers and providers to determine if the plans are treating behavioral and physical health equally.

Noting that HHS and DOL are chiefly responsible for implementation and enforcement of the law, the senators requested that the agencies conduct thorough audits and issue additional parity guidance so that individuals seeking recovery and treatment for mental health disorders and substance abuse can access the benefits promised to them under MHPAEA.

**Postparity Utilization and Costs**

An important policy goal of MHPAEA was to eliminate disparities in financial requirements between behavioral and medical/surgical care. It would, therefore, be reasonable to expect that the implementation of MHPAEA would result in higher utilization of MH/SUD benefits and higher cost and utilization trends for behavioral health services as compared with nonbehavioral health services. The authors’ analysis of a large, nationwide, commercially insured claims database provides some evidence that this indeed has been happening.

With fewer restrictions in place to limit access to behavioral health care, increases in costs for these services are expected. Milliman examined allowed costs per member per month by major service category and in total for behavioral health.

### TABLE I

**Average Annual Cost Trends (2008-2013) for HMO Plans**

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<thead>
<tr>
<th></th>
<th>Behavioral</th>
<th>Nonbehavioral</th>
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</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>10.4%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Outpatient (including ER)</td>
<td>20.2%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Professional</td>
<td>10.8%</td>
<td>5.2%</td>
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</tbody>
</table>

### TABLE II

**Average Annual Cost Trends (2008-2013) for PPO Plans**

<table>
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<th></th>
<th>Behavioral</th>
<th>Nonbehavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>10.6%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Outpatient (including ER)</td>
<td>20.6%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Professional</td>
<td>6.4%</td>
<td>4.1%</td>
</tr>
</tbody>
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and nonbehavioral health care services. Milliman then calculated year-over-year cost trends, as well as average annualized allowed cost trends, to measure changes over time separately for health maintenance organization (HMO) plans and preferred provider organization (PPO) plans. This is to show patterns with in-network benefits only and those also providing out-of-network benefits. The cost trends observed for both HMO and PPO plans for nonbehavioral health care services are in line with typical medical cost trends for commercially insured business. The cost trends for behavioral health care services were significantly higher, up to two or three times that of nonbehavioral services. The trends for both HMO and PPO plans for behavioral and nonbehavioral services are shown in Tables I and II.

While the observed changes in benefit richness and cost trends could indicate the impact MHPAEA has had on behavioral health care services, it’s also possible these patterns were driven by other factors.

There is strong evidence, however, that many of the changes observed between 2008 and 2013 are related to parity regulations. Treatment limitations, step therapies and preauthorization requirements may have been reduced or eliminated entirely for certain plans under the law’s new requirements. The higher allowed cost trend rates may indicate a higher degree of benefit richness for members, resulting from increased coverage for behavioral health care services under the “cover one cover all” requirement.

Additional research is needed to determine if the increased use of MH/SUD benefits and reduced consumer out-of-pocket costs may result in healthier consumers, accompanied by improved patient experiences and reduced total health care costs.

In summary, MHPAEA compliance can be quite detailed and confusing. Behavioral health advocacy groups have expressed significant concern that MHPAEA and its associated rules have not been properly enforced to ensure compliance among health plans and employers. State and federal governments and agencies have taken action to increase focus on MHPAEA compliance. The law has improved access to MH/SUD benefits for people covered by commercial health plans and employers. The authors will continue to monitor such activity as well as emerging behavioral health care utilization and cost levels.

Endnotes
1. According to the Centers for Medicare and Medicaid Services, non-quantitative treatment limitations (NQTLs) are nonnumerical treatment limitations, including items such as medical management, step therapy and preauthorization. Quantitative treatment limitations are numerical, such as visit limits and day limits.
2. The “cover one cover all” requirement refers to the provision under MHPAEA that requires insurers that choose to cover a behavioral condition to cover it in all treatment classifications where medical/surgical benefits are provided.

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