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Building a sustainable mental health parity compliance program

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Mental health parity has been a top regulatory issue for years, and enforcement activity is revving up in 2021. Developing a sustainable, year-round mental health parity compliance program is critical.

Background and context

Mental health parity laws protect members by requiring health plans to provide full and fair coverage of mental health and substance use disorder treatments. A health plan (whether fully or self-insured) is not required to offer mental health or substance use disorder benefits, but if it does, it may not impose higher cost share or more stringent limitations on those benefits than it imposes on comparable medical/surgical benefits. Similarly, a health plan must be able to demonstrate that it follows a comparable process in determining reimbursement rates for both providers of mental health and substance use disorder services and providers of medical/surgical services.

Regulators are actively auditing and enforcing federal and state mental health parity laws. States have increased enforcement efforts in recent years and have engaged in resource-intensive audits and examinations leading to large civil penalties. For example, the Pennsylvania Insurance Department issued a $1,000,000 penalty after a market conduct examination of a health plan found several mental health parity violations,[1] a Rhode Island Office of the Health Insurance Commissioner audit resulted in an insurer agreeing to make a $5 million contribution to mental health services after being found in violation of mental health parity,[2] and recent Delaware Department of Insurance mental health parity investigations have led to nearly $600,000 in fines.[3]

At the federal level, the U.S. Department of Labor (DOL) began auditing employer-sponsored health plans in April 2021 for compliance with a new requirement that plans analyze and document whether and why they provide mental health benefits that differ from comparable medical benefits.[4] In May, DOL doubled down on this effort and touted mental health parity compliance as its "highest enforcement priority" in healthcare. The time to build or strengthen your mental health parity compliance program is now.

Mental health parity regulations: A brief recap

From 1996 to the present, legislators and regulators have worked to ensure full and fair insurance coverage of mental health and substance use disorder treatments. Below is a brief recap of the federal laws and regulations that have created the parity requirements we see today.

Mental Health Parity Act (MHPA)

Before the Mental Health Parity Act of 1996,[5] health insurers and group plans could limit or restrict access to mental health and substance use disorder care without regard to medical/surgical services. With the passing of the act, health insurers were required to provide some equality in coverage, but it was limited in scope. The act only applied to large employer group health plans that had 50 or more employees and was limited to mental health parity for lifetime and annual dollar limit coverage. Plans were still able to offer restricted mental health annual visit limitations and were not required to cover substance use disorder treatment. Because of the limited scope of the 1996 MHPA, states attempted to supplement the requirements of the MHPA with their own parity laws. The Employee Retirement Income Security Act, however, limited the effect of state parity laws as self-insured group health plans are exempt from state mandates.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was passed by Congress in 2008.[6] Under the act, if a health plan provides mental health and substance use disorder benefits, any limitations or requirements for coverage must be equal to any limitations imposed on other medical/surgical benefits offered by the plan. For a health plan to comply with the MHPAEA, coverage must be comparable in financial requirements (e.g., deductibles, copayments, out-of-pocket limits); quantitative treatment limitations (e.g., annual and daily visit limitations); and nonquantitative treatment limitations (e.g., preauthorization requirements, medical necessity review, evidentiary standards).

In addition to having comparable financial requirements and limitations, a health plan must offer coverage for mental health/substance use disorder benefits in a comparable number of categories as medical/surgical benefits. Benefit classifications fall into six categories:[7]

1. Inpatient, in network;
2. Inpatient, out of network;
3. Outpatient, in network;
4. Outpatient, out of network;
5. Emergency care; and
6. Prescription drugs.

A health plan can impose a limitation on a mental health/substance use disorder benefit classification, but it must be equal to limitations and requirements of a comparable medical/surgical benefit classification.

The Affordable Care Act

In 2010, the Patient Protection and Affordable Care Act (ACA)[8] amended the MHPAEA by extending parity to non-grandfathered small-group and individual health plans. The ACA requires a plan or health insurer offering coverage in the individual and small-group markets to cover mental health and substance use disorder benefits as essential health benefits. To meet this requirement, plans must offer those benefits consistent with MHPAEA regulations.[9]

21st Century Cures Act

Enacted on December 13, 2016, the 21st Century Cures Act amended the MHPAEA by requiring the U.S. Departments of Labor, Health & Human Services, and the Treasury to issue clarifying information and illustrative examples that would aid health plans in meeting parity requirements.[10] As directed by section 13001(a) of the 21st Century Cures Act, these federal agencies created publicly available guidance documents and a self-compliance tool to help health plan sponsors and group plans improve compliance with the MHPAEA.

Consolidated Appropriations Act, 2021

The most recent amendment to the MHPAEA was the Consolidated Appropriations Act that was enacted December 27, 2020, and became effective February 10, 2021.[11] Affecting both fully insured and self-insured health plans, the act requires that if a plan imposes nonquantitative treatment limitations (NQTLs) on available medical and surgical benefits, as well as mental health and substance use disorder benefits, the plan must perform a self-assessment. A plan then must make the comparative analysis and findings available to enforcement authorities to demonstrate compliance with MHPAEA parity requirements. The self-assessment must include the following information:[12]

- The specific NQTL terms and a description of the specific mental health/substance use disorder and medical/surgical benefits the terms apply to;
- The factors used in determining how the NQTLs will apply to the benefits;
- Any evidentiary standards used to identify the factors, or any other evidence relied upon in applying the NQTLs;
- A comparative analysis demonstrating that the process, strategies, evidentiary standards, and other factors used to apply the NQTLs satisfy the MHPAEA parity requirements; and
- Specific findings and conclusions, including if the plan fails to comply with any MHPAEA requirements.