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Building a sustainable mental health parity compliance program

By Jeffrey A. Smagula, Esq., and Victoria Larson

Jeffrey A. Smagula (jsmagula@verrilldana.com) is Counsel and **Victoria Larson** (vlarson@verrilldana.com) is 2021 Summer Associate in the Boston office of Verrill Dana LLP.

- linkedin.com/in/jeffrey-a-smagula/
- linkedin.com/in/larson-victoria/

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.

Who is subject to mental health parity requirements?

After the passing of the MHPAEA and subsequent amendments, most health insurers and group plans must meet the parity requirement, with a few exceptions. (Plans that are exempt from meeting MHPAEA parity requirements include retiree-only group health plans, Federal Employees Health Benefits Program, TRICARE, grandfathered small-group health plans, Medicare, and Medicaid fee-for-service.) Plans that must comply with MHPAEA parity requirements include large-group fully and self-insured plans that offer mental health and substance use disorder benefits. After the passing of the ACA, individual health plans and non-grandfathered small-group health plans—an employer with fewer than 50 employees with a health plan that came into effect after March 23, 2010—must also meet MHPAEA requirements. Other health plans that are subject to parity requirements include state employee plans and Medicaid insurance (managed care organizations, alternative benefit plans, and Children's Health Insurance Program).

Over the past decade, as society's understanding of mental health and substance use disorders has evolved, so have the laws regulating health plans, leading to the mental health parity laws we see today. With the Consolidation Appropriations Act provisions coming into effect, the recent Supreme Court decision to uphold the ACA in June 2021,[13] and the increase in DOL and state audits, mental health parity enforcement continues to be a top issue in 2021. It is imperative that health plans and third-party administrators prioritize mental health parity compliance and implement best practices to avoid violations and to prepare for an inevitable audit.

Best practices for ensuring compliance and preparing for a potential audit

A robust mental health parity compliance program is critical to prevent, detect, and correct potential violations; to survive audits; and, ultimately, to do the right thing for those who need mental health and substance use disorder services. The following best practices can help improve and strengthen your existing program.

Make mental health parity a year-round activity

Mental health parity requires an ongoing and dynamic review of the operations of a health plan or third-party administrator, rather than a stagnant annual test conducted to complete a product filing or to submit an affidavit of compliance. Annual training must emphasize that every time there is change or update to a benefit, member cost share, or other operational process, functional and operational teams should ask themselves (and their colleagues), "What are the mental health parity implications of this change?" Even better, requiring an internal mental health parity check and sign-off before a team or department makes a change or update will help ensure that employees consider mental health parity compliance as an ongoing part of their day-to-day job, rather than an annual activity.

Use and build on published tool kits

Federal regulators have created tool kits that provide detailed technical guidance and tools to perform parity analysis. For example, the DOL has published a tool kit for self-insured group health plans,[14] and the Centers for Medicare & Medicaid Services has published guidance for commercial insurance products.[15] It is critical to first review the applicable guidance and tools published by the regulator(s) responsible for the product at issue to ensure that your organization has a deep understanding of the regulatory landscape. Armed with the knowledge, teams can design enhanced policies, procedures, and monitoring to be conducted regularly throughout the year.

Document your methodology

The oft-quoted saying "if it isn't documented, it didn't happen" rings true in dealing with auditors and regulators on mental health parity issues. Demonstrating compliance with mental health parity is required, but often not sufficient, to satisfy an auditor or regulator seeking evidence of a sustainable compliance framework that will persist following the conclusion of an audit. Further, as noted above, regulators like the DOL are now auditing *documentation of plan self-assessments* of mental health parity. While there are multiple stakeholder teams involved in mental health parity, and department-specific policies and procedures are critical, it is helpful to develop enterprise-wide policy and procedure templates. This will allow your organization to describe a single, common approach to any inquiring regulator or auditor, while still allowing departments the opportunity to tailor the documents to their own specific areas of responsibility.

Ensure collaboration between operational groups and teams

Mental health parity compliance requires communication and collaboration across health plan or third-party administrator functions or teams that might not ordinarily work together. For example, a team managing visit limits and prior authorizations for physical and occupational therapy might not normally work with a behavioral health team managing visit limits and prior authorizations for psychotherapy. To overcome this lack of coordination, each team or department should maintain a written policy and procedure that requires a check with partner department(s) before implementing a change, such as a revised visit limit or a new prior authorization requirement. This approach requires teams to think critically about how mental health parity considerations cut across the enterprise, while still allowing for innovation and the successful completion of

internal team goals and strategies.

Implement an enterprise-wide governance model

It is sometimes easy to point to your compliance or legal department as responsible for mental health parity issues. While compliance and legal must and do play an important role in providing guidance and ensuring completion of required tasks and submissions, sustainable compliance requires that functional and operational teams take accountability for mental health parity. Functional and operational teams are in the best position to be aware of, assess, and coordinate new or changed member services or functionality. To facilitate discussion and mutual accountability across an organization, health plans should gather key business stakeholders several times per year to review and update policies and procedures, to understand upcoming benefit or operational changes, and to discuss and resolve challenging mental health parity issues and questions.

Corrective action plans (if needed)

Mental health parity issues can arise in many contexts, even from seemingly member-friendly benefit or operational changes. A robust, continuous effort to manage mental health parity will undoubtedly reveal gaps and problems that must be fixed promptly. Health plans (and third-party administrators) should follow well-defined corrective action plan processes. Corrective action plans are important to ensure that the root cause is identified and remedied with a sustainable solution in a reasonable period of time. If needed, corrective action plans also help define the steps needed to make the member whole. This documentation will likely be invaluable in the event of an audit.

Build and maintain a culture of compliance

As with every compliance program, success is largely determined by an organization's culture of compliance. Do employees or team members look beyond their immediate tasks and think critically about how their work relates to the work of others? Are team members recognized and rewarded by peers and leaders for flagging potential issues and questions? Do employees engage with legal and compliance teams to solve compliance issues and problems quickly and effectively? A culture of compliance engages employees in critical thinking, collaboration, issue spotting, and problem solving. A strong compliance environment and mindset translates to risk mitigation, audit readiness, and ultimately benefits those who need mental health and substance use disorder services.

Takeaways

- Mental health parity audits and enforcement activities are accelerating in 2021.
- Documentation of annual self-assessment is now required for most health plans.
- An effective compliance program requires a year-round organizational commitment.
- Consistent and clear documentation of compliance activities is a must.
- A strong culture of compliance will engage your employees and help mitigate risk.

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2 Linda Borg, "Blue Cross & Blue Shield to pay $5 million for mental health services after audit," *Providence Journal*, September 18, 2018, https://bit.ly/3wEoYs2.
3 "Delaware's First Mental Health Parity Examinations Complete," Delaware.gov, November 19, 2020,

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4 Sara Hansard, "Mental Health Insurance Parity Gets Aggressive Focus Under Biden," Bloomberg Law, May 25, 2021, https://bit.ly/2UKUZla.
5 Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (1996).
6 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (2008).
726 C.F.R. § 54.9812-1(c)(2)(ii)(A) .
8 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).
945 C.F.R. § 156.115(a)(3) .
10 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016) (codified as amended at 42 U.S.C. § 300gg-26).
11 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 (2020) (codified as amended at 42 U.S.C. § 300gg-26(a) ; 29 U.S.C. § 1185a(a) ; I.R.C. § 9812(a)).
12 I.R.C. § 9812(a)(8)(A)(i)–(iv); 29 U.S.C. § 1185a(a)(8) ; 42 U.S.C. § 300gg-26 .
13 California v. Texas, 593 U.S. _____ (2021).
14 U.S. Department of Labor, *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, accessed July 12, 2021, https://bit.ly/2SDAB4s.
15 U.S. Centers for Medicare & Medicaid Services, "FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45," April 2, 2021, https://go.cms.gov/3wByaNZ.