education | research | information

benefits
MAGAZINE

The Mental Health Parity and Addiction Equity Act:

Does Your Plan Comply?

by | **Daniel R. Brice**

As DOL and HHS step up efforts to enforce the Mental Health Parity and Addiction Equity Act, now is a good time for plan sponsors to review their health plan design and make sure they are in compliance.

The Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires that health plans and health insurance carriers offering group or individual health coverage ensure that the financial requirements and treatment limitations imposed on mental health or substance use disorder benefits are no more restrictive than those imposed on medical or surgical benefits. This article addresses the current state of MHPAEA enforcement and the steps plans can take to confirm compliance.

Why Should Health Plan Sponsors Be Concerned?

The U.S. Departments of Labor (DOL) and Health and Human Services (HHS) have been instructed to accelerate MHPAEA enforcement efforts. As part of those efforts, DOL and HHS issued a MHPAEA compliance publication labeled *Warning Signs*.[1] In fact, in the most recent DOL audit the author was involved in, MHPAEA was a central focus of DOL fact-finding.

In addition, private litigation has served as an enforcement vehicle for participants as well as various psychiatric associations targeting health plans and insurance carriers.

Finally, ongoing legislative efforts seek to further improve and enhance MHPAEA oversight.

It is safe to say that now is a good time to review both plan design and practice to confirm MHPAEA compliance.

What Plans Are Subject to MHPAEA?

The act applies to self-insured and insured group health plans, non-federal governmental health plans and individual health insurance plans. There are some exceptions. First, it is not applicable for retiree-only plans or self-insured "small employer" plans. MHPAEA defines *small employer* as one with 50 or fewer employees.

There is also an exception for plans if the application of MHPAEA results in a plan year increase of the total cost of coverage by 1%. The value of the "increased cost" exemption is somewhat diminished by the fact that it applies for only one year.

What Does MHPAEA Require?

An important starting point is that the act does not require any plan to provide mental health or substance use disorder benefits. However, if such benefits are offered, they must be provided in parity with medical/surgical benefits.

Classifications

If offered, mental health or substance use disorder benefits must be provided in each of six classifications in which medical/surgical benefits are provided:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs.

Note that there is no MHPAEA mandate to provide a mental health/substance use disorder benefit in each classification if the benefit is provided based only on the Affordable Care Act (ACA) preventive services guidelines (e.g., screening for depression).

Financial Requirements and Quantitative Treatment Limitations

A plan that provides mental health or substance use disorder benefits may not apply any financial requirement or quantitative treatment limitation to those benefits in any of the above classifications that is more restrictive than the *predominant* financial requirement or treatment limitation that applies to *substantially all* medical/surgical benefits in the same classification.

- *Financial requirements* include deductibles, copayments, coinsurance and out-of-pocket maximums.
- A *quantitative treatment limitation* is a limit on benefits based on the frequency of treatment, number of visits, days of coverage or days in a waiting period or is a similar limit on the scope or duration of treatment that is expressed numerically.

A financial requirement or quantitative treatment limitation is considered to apply to "substantially all" plan payments for medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in that classification.

If a type of financial requirement or quantitative treatment limitation (copay, coinsurance, etc.) does not apply to at least two-thirds of all medical/surgical benefit payments in a classification, then that limitation/requirement cannot be applied to mental health or substance use disorder benefits in the classification.

If the "substantially all" test is met, the plan must look to what the "predominant" (applies to more than 50% of claims) financial requirement/limitation is in the classification (e.g., a $20 copay). The requirement/limitation on mental health/substance use disorder benefits can be no more restrictive than the predominant requirement/limitation.

Prescription Drugs

A plan may apply different levels of financial requirements to different tiers of prescription drug benefits so long as the levels are based on reasonable factors and applied without regard to whether a drug is generally prescribed for mental health/substance use disorder conditions. Reasonable factors in this context include cost, efficacy, generic versus brand name, and mail order versus pharmacy pickup.

Nonquantitative Treatment Limitations

A plan may not impose a nonquantitative (e.g., preauthorization) treatment limitation with respect to mental health or substance use disorder benefits in any classification unless:

> Under the terms of the plan or coverage, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the (nonquantitative treatment limitation) to (mental health/substance use disorder) benefits in the classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.[2]

The MHPAEA final rule included the following nonexhaustive list of nonquantitative treatment limitations:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative
- Formulary design for prescription drugs
- For plans with multiple network tiers, network tier design
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary and reasonable charges
- Refusal to pay for higher cost therapies until it can be shown that a lower cost therapy is not effective (also known as *fail-first policies* or *step therapy protocols*)
- Exclusions based on failure to complete a course of treatment
- Restrictions on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

What Are DOL and HHS Looking For?

DOL and HHS recently issued the ominously titled *Warning Signs* publication addressing MHPAEA compliance in connection with nonquantitative treatment limitations. The publication provides examples of plan provisions that might trigger careful analysis by the agencies.

The "warning signs," reproduced in part below, are followed by the author's analysis in italics. It is important to note that the plan/policy terms listed in the *Warning Signs* do not automatically violate MHPAEA. The key compliance question remains: Is there parity?

Preauthorization and Pre-Service Notification Requirements

- **Blanket preauthorization requirement:** The plan/insurer requires preauthorization for all mental health and substance use disorder services.
- **Treatment facility admission preauthorization:** The plan/policy states that if the participant is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, he or she will be responsible for the cost of services received.
- **Medical necessity review authority:** The plan's/insurer's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for medical/surgical services

learn more

Education

Health Care Management Conference
May 1-3, New Orleans, Louisiana
Visit *www.ifebp.org/healthcare* for more information

Mental Health Parity and Addiction Equity Act: Does Your Plan Comply?
On-Demand Webcast from August 2016.

The Opioid Abuse Epidemic and Your Benefit Plan
On-Demand Webcast from December 2016
Visit *www.ifebp.org/webcasts* for more information.

From the Bookstore

Self-Funding Health Benefit Plans
John C. Garner, CEBS. International Foundation. 2015.
Visit *www.ifebp.org/selffunding* for more details.

Health Insurance Answer Book
John C. Garner, CEBS. Wolters Kluwer. 2016.
Visit *www.ifebp.org/books.asp?9069* for more details.

but conducts its own reviews for mental health and substance use disorder services.

- **Prescription drug preauthorization:** The plan/insurer requires preauthorization every three months for pain medications prescribed in connection with mental health and substance use disorder services conditions.
- **Extensive prenotification requirements:** The plan/insurer requires prenotification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment and extended outpatient treatment visits beyond 45-50 minutes.

The author suggests plans consider, to the extent not already done, maintaining the same procedures for determining preauthorization/medical necessity regardless of the type of benefit.

The author recently succeeded with a motion to dismiss a MHPAEA complaint against a plan in large part because, although the mental health benefits were denied, the plan had in place the same procedures and practices for medical necessity review whether the participant had a heart condition or suffered from depression.

Fail-First Protocols

- **Progress requirements:** For coverage of intensive outpatient treatment for mental health and substance use disorder services, the plan/insurer requires that a patient has not achieved progress with nonintensive outpatient treatment of a lesser frequency.
- **Treatment attempt requirements:** For inpatient substance use disorder rehabilitation treatment, the plan/insurer requires a member to first attempt two forms of outpatient treatment, including intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.

It is not uncommon for a plan to require outpatient program participation prior to inpatient substance use/mental health treatment. While not unlawful on its face, to remain compliant with MHPAEA, the plan must identify a similar restriction for medical and surgical benefits.

Probability of Improvement/Written Treatment Plan Requirement

- **Likelihood of improvement:** For residential treatment of mental health and substance use disorder services, the plan/insurer requires the likelihood that inpatient treatment will result in improvement. For example, the plan/policy covers only services that result in measurable and substantial improvement in mental health status within 90 days.
- **Written treatment plan:** For mental health and substance use disorder services benefits, the plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.
- **Treatment plan required within a certain time period:** The plan/insurer requires that within seven days, an individualized problem-focused treatment plan is completed, including nutritional, psychological, social, medical and substance abuse needs developed based on a complex biopsychosocial evaluation. The plan needs to be reviewed at least once a week for progress.
- **Treatment plan submission on a regular basis:** The plan/insurer requires that an individual-specific treatment plan be updated and submitted, in general, every six months.

Similar to the above comments, it is acceptable to impose these restrictions if there is parity with medical/surgical benefits. The author's firm successfully defended a self-insured plan charged with alleged MHPAEA violations based on a trustee appeal determination requiring medical necessity recertification for mental health counseling after a set period of time. The record was clear that the plan's procedures were applied uniformly regardless of the type of benefit, and the plan had in fact applied time-restricted benefits for medical/surgical claims. Thus, parity existed and no violation was found.

Other Warning Signs Raised

- **Patient noncompliance:** The plan/policy excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including the exclusion of benefits for mental health and substance use disorder services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.
- **Residential treatment limits:** The plan/policy excludes a residential level of treatment for chemical dependency.
- **Geographical limitations:** The plan/policy imposes a geographical limitation related to treatment for mental health and substance use disorder conditions.

Recent court cases show how participants and psychiatric associations have used litigation to try to enforce mental health and substance abuse disorder parity.

- **Licensure requirements:** The plan/policy requires that mental health and substance use disorder facilities be licensed by a state.

Plans historically have excluded out-of-state substance use disorder treatment. These provisions were put in place to protect against participants from New Hampshire heading to Malibu for drug treatment by the ocean. Plans may no longer impose such blanket exclusions on out-of-state care unless similar exclusions are imposed on medical benefits. Regardless, plans can still uniformly apply "usual, customary and reasonable" rules as well as "medically necessary" restrictions. Out-of-state facility claims will continue to be a growing issue because of the current opioid epidemic.

Plans often impose licensure requirements for mental health service providers. A plan recently reviewed by the author contained an explicit licensure requirement for mental health counselors. However, there was also a global plan exclusion for any services not provided by a properly licensed practitioner. Thus, listing the specific mental health licensure requirement was redundant; all that it accomplished was planting a red flag in the middle of the plan. Red flags lead to questions from investigators and litigation complications; life tends to be easier without questions from investigators and litigation complications. If red flags can be removed, plans should consider removing them.

Court-Ordered Treatment Exclusions

Although not listed in the *Warning Signs* publication, plans generally exclude reimbursement for any services mandated by a court. While some states prohibit such exceptions for insured plans, there is nothing in MHPAEA that explicitly restricts such exclusions. However, care should be taken in drafting these exclusions so that the restriction is not limited to mental health/substance use disorder benefits. Of course, the reality is that, in practice, court-ordered treatment is directed 99% of the time to substance use treatment or mental health evaluations; courts generally are not ordering knee replacements. The act, however, provides that disparate results alone will not cause a provision to be unlawful.

What Are the Courts Saying?

Recent court cases show how participants and psychiatric associations have used litigation to try to enforce mental health and substance abuse disorder parity.

A.F. v. Providence Health Plan

A federal district court in Oregon granted the plaintiffs' partial motion for summary judgment, finding that Providence Health Plan's *developmental disability exclusion,* which excludes coverage for services "related to developmental disabilities, developmental delays, or learning disabilities," violated both MHPAEA and the Oregon Mental Health Parity Act.

The plaintiffs alleged that, under the developmental disability exclusion, Providence routinely denied coverage for applied behavior analysis therapy for participants and beneficiaries diagnosed with autism spectrum disorders, a covered condition under the plan.

Because the exclusion applied to services related to developmental disabilities (which are considered mental health conditions), yet did not apply to services related to medical or surgical conditions, the court found that the exclusion is prohibited by the plain text of MHPAEA.[3]

Once a plan chooses to provide coverage for a mental health condition, here autism, it must take great care in carving out benefits for the condition via exclusion and ensure that parity is present.

Craft et al. v. Health Care Service Corporation

The participant in a group health benefits plan and the participant's daughter filed suit under the Employee Retirement Income Security Act (ERISA) after the plan administrator denied a request for preauthorization for inpatient residential treatment care for the daughter, who suffered post-traumatic stress disorder, severe major depressive disorder and anorexia nervosa.

The court denied the defendant health plan's motion to dismiss and found that a plan, which categorically excluded expenses for residential treatment centers for mental health services but not for other medical conditions, arguably would violate a MHPAEA requirement that "treatment limitations" for mental health treatment be in parity with those for medical/surgical conditions.[4]

Exclusions for residential treatment facilities for mental health/substance use disorder benefits are not allowed if similar exclusions (e.g., a skilled nursing facility for physical rehabilitation) are not present for other medical conditions.

Tedesco v. I.B.E.W. Local 1249 Insurance Fund et al.

The fund initiated a review of the plaintiff's claims for treatment for severe obsessive-compulsive disorder. After a review by multiple doctors and relying on two independent experts, the trustees concluded that continued visits with one of the plaintiff's providers were not medically necessary and that treatment by her psychiatrist was medically necessary for 16 weeks with additional treatment conditioned on an updated showing of medical necessity.

The plaintiff challenged the denial, arguing that the defendants' requirement that she recertify the need for continued visits with her psychiatrist violated MHPAEA.

The court dismissed the complaint, finding that the plaintiff did not show a genuine issue of material fact on the MHPAEA claim, as she did not demonstrate how defendants treated her differently than other participants and violated the statutes.[5]

takeaways

- In light of recent increased MHPAEA enforcement efforts, it is important to review and evaluate plan compliance.
- Examine the terms of the plan to determine if they should be amended because language is "stale" or terms don't reflect current practices or are no longer compliant.
- Review internal practices and procedures to make sure they are consistent with MHPAEA.
- Self-insured plans should coordinate with their third-party administrator to confirm its compliance.
- Conduct a self-audit using a recent DOL information request form as a guide.

This case is an example that the focus of MHPAEA is parity, and there is no mandate for unlimited mental health/substance use disorder benefits. Here, the court allowed the plan to rely on its uniform "medically necessary" procedures in determining which of the plaintiff's mental health claims were covered.

New York State Psychiatric Association, Inc. v. UnitedHealth Group

The association sued the insurance company, claiming violation of MHPAEA by treating medical/surgical care claims more favorably than claims for mental health services. Specifically, the association alleged that a more restrictive "medical necessity" standard was applied to psychotherapy claims.

The court found that that the association had standing as an assignee of ERISA benefits.[6]

Psychiatric associations are targeting certain plans and carriers for MHPAEA violations, sometimes out front, as was the case in this litigation, and sometimes in the background, sponsoring lawsuits.

K.M. et al. v. Regence BlueShield

The plaintiffs—children enrolled through their parents in health plans underwritten and administered by the defendants—brought suit alleging that the defendants failed to comply with Washington's Mental Health Parity Act and MHPAEA. The parents of one plaintiff submitted claims to the defendants for coverage of his speech and occupational therapies in connection with his autism, but the defendants denied coverage because B.S. was "over the age of six and did not meet the age limit set by his contract for this benefit."

The plaintiffs argued that the health care plans underwritten by the defendants did not provide coverage for plaintiffs' medically necessary neurodevelopmental therapy, violating MHPAEA mandates.

The court granted the plaintiffs' preliminary injunction prohibiting the defendants from denying coverage for neurodevelopmental therapy to treat mental health conditions based on the age exclusion in the defendants' plans.[7]

Plans, of course, may contain exclusions. However, if those exclusions specifically target mental health/substance use disorder benefits, a violation is present. In this case, an age-specific exclusion was present in the plan for certain autism therapies, and the plan could not cite similar types of exclusions for medical/surgical benefits.

bio

Daniel R. Brice is a partner at Blitman & King in Syracuse, New York. He represents benefit funds in complex ERISA litigation and counsels sponsors of multiemployer and single employer plans, tax-exempt entities and executives on all matters of ERISA and employee benefits including Affordable Care Act compliance. Brice advises on the design, operation and qualification of pension and welfare benefit plans. He has represented clients in front of the Pension Benefit Guaranty Corporation, Internal Revenue Service, DOL, National Labor Relations Board, New York State Public Employment Relations Board, New York State Division of Human Rights, Equal Employment Opportunity Commission and state and federal courts. Brice obtained his B.A. degree in communication from the State University of New York at Oswego and his J.D. degree from the State University of New York at Buffalo School of Law.

Compliance Steps

Given the recent MHPAEA enforcement activity, plan sponsors should engage in a tune-up/review. Insured plans can seek written compliance confirmation from their carrier.

For a self-insured plan, there are more steps. First and foremost, the plan sponsor should review the plan. How are mental health/substance use disorder benefits treated (copays, deductibles, exclusions, etc.)? Are there differences from medical/surgical benefits, and are those differences a violation?

Second, the sponsor should reexamine plan practice. Have historical plan practices distinguishing mental health/substance use disorder benefits from medical/surgical survived the passage of MHPAEA? Are changes necessary?

Further, it's important to coordinate with the third-party administrator (TPA), if applicable, to ensure that reimbursement and claim practices comport with the act. Information regarding reimbursement amounts and how those compare across providers is data that the plan often cannot access.

Finally, a formal self-audit can be a valuable exercise. To assist in the audit, a plan should coordinate with service providers to obtain a recent (preferably 2016) copy of a DOL welfare plan audit information request and work through it question by question. Audits are much less stressful when a government investigator is not involved. If there are any issues, it is always best to address them as part of internal efforts as opposed to in response to an enforcement action.

Endnotes

1. Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, DOL and HHS; available at www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.
2. Ibid.
3. *A.F. v. Providence Health Plan,* 35 F.Supp.3d 1298 (D.Or. 2014).
4. *Craft et al. v. Health Care Service Corporation,* 84 F.Supp.3d 748 (N.D.Ill. 2015).
5. *Tedesco v. I.B.E.W. Local 1249 Insurance Fund et al.,* 2015 U.S. Dist. LEXIS 146247 (S.D.N.Y. 2015).
6. *New York State Psychiatric Association, Inc. v. UnitedHealth Group,* 798 F.3d 125 (2d Cir. 2015).
7. *K.M. et al. v. Regence BlueShield,* 2014 U.S. Dist. LEXIS 27685 (W.D.Wash. 2014).

pdf/1216