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Mental Health Parity Enforcement Efforts Likely to Continue but With New Focus

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The general concept of mental health parity is that insurers should provide the same coverage benefits for mental health and substance use disorder treatments as they do for medical and surgical treatments. This has become a hot topic in the health-care industry due to recognition of the ''opioid epidemic'' and the impact of behavioral health issues on medical outcomes. The enforcement of mental health parity generally has bi-partisan support. While efforts to enforce mental health parity rules are likely to continue, these efforts may look different over the coming years under a Trump administration.

Mental Health Parity Requirements

In October 2008, President Bush signed into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). This bipartisan legislation went beyond existing Mental Health Parity Act requirements (enacted in 1996) restricting large group health plans from imposing annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits. MHPAEA prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. The Patient Protection and Affordable Care Act of 2010 (ACA) further expanded the reach of MHPAEA by mandating that MH/SUD treatment services (including behavioral health treatment) be provided as part of an essential health benefits (EHB) package that individual, small group plans and Medicaid nonmanaged care Alternative Benefit Plans must provide. All plans required to cover EHBs, including MH/SUD benefits, must do so in compliance with MHPAEA.

Under the MHPAEA mental health parity rules, group health plans and health insurance issuers that provide both medical/surgical benefits and MH/SUD benefits must ensure that: (1) the financial requirements (i.e., deductibles and copayments) applicable to MH/SUD benefits are no more restrictive than the predominant financial requirements applied to substantially all medical/surgical benefits covered by the plan; (2) there are no separate cost sharing requirements that are applicable only with respect to MH/SUD benefits; (3) the treatment limitations applicable to MH/SUD benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical/surgical benefits covered by the plan; and (4) there are no separate treatment limitations that are applicable only with respect to MH/SUD benefits. MHPAEA, among other things, also requires disclosure of the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services made under the plan with respect to MH/SUD benefits and requires the plan to provide out-of-network coverage for MH/SUD benefits if the plan provides coverage for medical/surgical benefits provided by out-of-network providers.

Current Enforcement Landscape

The Obama administration has taken numerous steps to implement these requirements and to establish the role of the federal government in enforcement of mental health parity, through the publication of commercial and Medicaid managed care regulations and subregulatory guidance to further direct health plans on compliance with the mental health parity rules, as well as providing grant funding to states to assist with mental health parity implementation and enforcement.

However, enforcement is complicated and has been slow to get underway. Enforcement authority is not un-

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der one agency's control but rather is split between the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury as well as state insurance commissioners. Further complicating the landscape is the fact that MHPAEA does not preempt state mental health parity laws that are more stringent than MHPAEA. State mental health parity laws have been enacted in all 50 states plus the District of Columbia but vary widely in scope. To date, enforcement actions have only been pursued in a small number of states, with New York and California leading the way through settlements against plans for federal and state mental health parity law violations (primarily related to a plan's application of nonquantitative treatment limitations (NQTLs) causing greater denials for MH/SUD services than for medical/surgical benefits) and through the issuance of guidance to help insurers demonstrate compliance with the federal and state laws. The federal agencies responsible for mental health parity compliance have largely addressed complaints regarding mental health parity violations through voluntary compliance efforts. The types of violations identified by federal agencies are predominantly related to the application of more restrictive NQTLs, but also include the application of separate cumulative requirements or limitations; not offering sufficient benefits in all service classifications (including out-of-network benefits); the application of more restrictive quantitative treatment limitations, higher financial requirements, and lower annual dollar limits on benefits; and noncompliance with disclosure requirements.

The ability to impose sanctions is complicated as well, as primary enforcement resides with the states (each with varying authority to impose fines). The HHS has the authority to impose civil monetary penalties (CMPs) for violations, and the Treasury Department may impose excise taxes. The DOL is limited to investigating violations and suing for equitable relief. Accordingly, a recent report issued by the Mental Health & Substance Use Disorder Parity Task Force recommends allowing the DOL to assess CMPs for violations in order to increase the DOL's enforcement impact. Individuals also have a private right of action through the Employee Retirement Income Security Act of 1974. Such private lawsuits against health plans related to denied MH/SUD benefits are steadily increasing.

What the Future Holds

While it is unlikely that enforcement efforts will stop under the new Trump administration, there are overarching Republican principles that could impact how enforcement looks. The primary goal of Republicans right now is to repeal the ACA, and much of mental health parity is tied to mental health as an EHB under the ACA. At this time, it is unclear whether provisions of the ACA establishing EHBs or expanding the scope of mental health parity will be repealed. Since Republicans generally dislike federal requirements that dictate what an insurer covers, the required coverage of EHBs, including MH/SUD treatment services, is in question, making it unclear which plans will be subject to mental health parity enforcement under the new administration. Further, there are persistent concerns with implementation of the mental health parity rules, in particular related to NQTLs and disclosure requirements, which could be addressed under the Republican-led administration and Congress. A Trump administration may be more willing to engage with industry stakeholders on relaxing the regulatory environment for mental health parity to make compliance less burdensome and treatment more accessible. Finally, under the principle of promoting ''states rights,'' Republicans would likely prefer that enforcement occur at the state level rather than at the federal level.

On the campaign trail, President-elect Trump mentioned his support for mental health reforms being developed in Congress. Reform provisions included in the Helping Families in Mental Health Crisis Act of 2016 were included in the 21st Century Cures Act, which was signed into law on Dec. 13, 2016. The bill, among other mental health-related initiatives, requires the HHS, DOL and Treasury to enhance mental health parity compliance by releasing compliance program guidance with examples of past findings of compliance and noncompliance with the existing mental health parity rules, including NQTLs and disclosure requirements; issuing new guidance documents on mental health parity compliance that are subject to a public comment period; and issuing annual reports summarizing the results of closed federal investigations with findings of noncompliance with the mental health parity rules. The bill also requires HHS to convene a public meeting and produce an action plan for improved federal and state coordination related to mental health parity enforcement, including the identification of specific, strategic objectives regarding how the various federal and state agencies charged with mental health parity enforcement will collaborate to improve enforcement.

Conclusion

While we do not know at this time if expansion in the scope of plans subject to the mental health parity rules under the ACA will continue, the mental health parity provisions included in the 21st Century Cures Act provide a framework for the Trump administration to shape the enforcement strategy going forward, in particular by requiring the administration to seek industry input and address persistent implementation concerns through the issuance of new guidance. Accordingly, mental health parity enforcement is sure to continue but likely with a new focus.

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