EMPLOYMENT SERVICES ALERT

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The Deadline for Plan Compliance with the Mental Health Parity and Addiction Equity Act Looms

The Department of Labor (DOL) has broad authority to investigate and audit employers' benefit plans for compliance with the Employee Retirement Income Security Act (ERISA). The DOL's Employee Benefits Security Administration (EBSA) performs the audits.

DOL audits often focus on violations of ERISA's fiduciary obligations and reporting and disclosure requirements. The DOL may also investigate whether an employee benefit plan complies with ERISA's protections for plan participants, such as the special enrollment rules. Traditionally, DOL audits of employee benefit plans have focused primarily on retirement plans, such as 401(k) plans. However, now that the DOL has started enforcing compliance with health care reform, or the Affordable Care Act (ACA), health plan audits, particularly those of mental health parity requirements are on the rise.

Overview

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted to ensure "parity" or fairness between mental health and/or substance use disorder (MH/SUD) benefits and medical/surgical benefits covered by a health plan. Enacted in 2008, MHPAEA does not require a plan to offer MH/SUD benefits, but if the plan does so, it must offer the benefits on par with the other medical/surgical benefits it covers. In 2010, the Departments of Treasury, Labor and Health and Human Services issued Interim Final Regulations (IFR) implementing the law. In 2013, the Departments issued a Final Rule (FR) implementing the law.

The parity law says that when health insurance plans provide coverage for mental ailments, it must be comparable to coverage for physical ailments. For instance, plans cannot set higher deductibles or charge higher co-payments for mental health visits than for medical visits, and cannot set more restrictive limits on the number of visits allowed. Additionally, plans cannot limit mental health care to a specific geographic region, if they do not do so for physical illnesses. The MHPAEA rules clarify that the law also applies to "intermediate" treatment options for mental health and addiction disorders, such as residential treatment or intensive outpatient therapy.

Insurance plans also must be consistent when deciding whether treatment for physical or mental ailments is medically necessary, and they cannot make getting prior-approval for inpatient mental health treatment more difficult than that for admission to an acute care hospital. Insurance plans under MHPAEA must also let patients and doctors know what criteria are used to make the aforementioned decisions, which can be helpful if coverage is denied and a patient wants to file an appeal.

Effective Date

In general, the Final Rule is effective for plan years beginning on or after July 1, 2014. In practice, most plan years begin on January 1, so the effective date for a majority of plans covered by MHPAEA will be January 1, 2015. With respect to the guidance in the Final Rule, plans and issuers must continue to comply with the 2010 IFR.

Financial Requirements/Quantitative Treatment Limitations Under Particular Investigative Scrutiny

Plans and issuers as of 2015 are banned from imposing a financial requirement or quantitative treatment limitation on MH/SUD benefits that is more restrictive than the "predominant" financial requirement or quantitative treatment limit that applies to "substantially all" medical/surgical benefits in the same classification.

Under the regulations, "substantially all" is defined as meaning two-thirds and "predominant" is defined as meaning more than one-half of medical/surgical benefits in the same classification.

Additionally, the regulations prohibit plans and issuers from having cumulative requirements (such as deductibles or out-of-pocket maximums) or cumulative quantitative treatment limits (such as annual or lifetime day or visit limits) on MH/SUD that accumulate separately from the cumulative financial or quantitative treatment limits for medical/surgical in the same classification. For example, a plan may not have a $500 deductible for medical/surgical services and a separate $500 deductible for MH/SUD services, which could result in an enrollee paying a $1,000 deductible. Rather, the deductible must be combined so the enrollee would only have to pay one $500 deductible.

Enforcement as of January 2015

As codified in existing federal and state law, states have primary enforcement authority over health insurance issuers. As such, states will be the primary means of effectuating the implementation of MHPAEA. However, the DOL continues to be the primary enforcer for all self-insured employer plans, which currently represent the majority of employees affected by MHPAEA.

The Department of Health and Human Services (HHS), through its Centers for Medicare and Medicaid Services (CMS), has enforcement authority over issuers in a state that do not comply. The DOL has primary enforcement authority over self-funded employer plans. The majority of beneficiaries in employer-sponsored plans are self-funded and are under the sole jurisdiction of the DOL.

With 2015 fast approaching, now is the time for plan sponsors to confirm with counsel that their health plans comply with MHPAEA.

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