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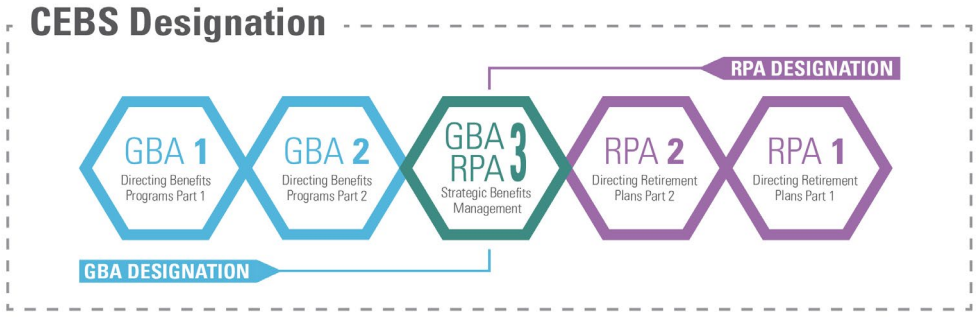

Today's Speaker & Topic

Kirsten Garcia, Counsel

Haynes Boone

Spotting Mental Health Parity Issues Before the DOL Comes Knocking

HAYNES BOONE

MHPAEA ISSUE SPOTTING AND ENFORCEMENT

Spotting Mental Health Parity Issues Before the DOL Comes Knocking

Kirsten Garcia

January 13, 2022

Agenda

- MHPAEA Compliance and Issue Spotting
  - Changes made by the CAA
- Enforcement
- Action Items for Employers

MHPAEA Compliance and Issue Spotting

- Financial requirements and treatment limitations on MH/SUD benefits are no more restrictive than those on M/S benefits
  - Coverage in all classifications
  - Financial and quantitative treatment limits
  - Nonquantitative treatment limitations (NQTLs)
- Disclosure requirements

Definitions

MHPAEA = Mental Health Parity and Addiction Equity Act

MH/SUD benefits = mental health and substance use disorder benefits

M/S benefits = medical and surgical benefits

NQTL = nonquantitative treatment limitation

Coverage in All Classifications

Cover MH/SUD benefits in every classification that covers M/S benefits

Inpatient, in-network	Inpatient, out-of-network
Outpatient, in-network •Office visits •All other outpatient	Outpatient, out-of-network •Office visits •All other outpatient
Emergency care	Prescription drugs

Classifying intermediate services

- Commonly inpatient
  - Skilled nursing facilities (M/S)
  - Rehabilitation hospitals (M/S)
  - Residential treatment facilities (MH/SUD)
- Commonly outpatient
  - Home health care (M/S)
  - Partial hospitalization (MH/SUD)
  - Intensive outpatient treatment (MH/SUD)

Issue Spotting

- Does the plan cover out-of-network MH/SUD services in the same way as out-of-network M/S services?
- Are intermediate services classified as inpatient or outpatient using a comparable methodology?
- Does the method of assigning drugs to a prescription drug tier (e.g., preferred brand vs nonpreferred brand) comply with the NQTL requirements?
  - Reasonable factors for different financial requirements include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up
- Does a plan's multiple network tiers (e.g., preferred network and participating provider network) comply with NQTL requirements in establishing its tiers? Each tier is then subject to the financial and treatment limitation requirements as its own sub-classification.

Financial and Quantitative Treatment Limits

Step 1

Identify all financial and quantitative treatment limits on MH/SUD benefits

- Ex.: $50 copay for outpatient, in-network specialist office visits for MH/SUD benefits

Step 2

What is the expected annual plan spend for that classification?

- Ex.: Plan expects to spend $1,000,000 on M/S outpatient, in-network office visits.

Step 3

Does the type of limit apply to at least 2/3 of M/S benefits in the classification?

- Ex.: Is at least 2/3 of the amount spent for M/S outpatient, in-network office visits subject to copay?

Step 4

Does the limit amount apply to more than ½ of M/S benefits in the classification that have that limit type?

- Ex.: Does a $50 (or greater) copay apply to more than ½ of the expected amount spent for M/S outpatient, in-network office visits that have a copay?

Definitions

Financial requirements = deductibles, copays, coinsurance, out-of-pocket max

Quantitative treatment limit (QTL) = day limits, visit limits

Determined by coverage tier (e.g., employee only or employee plus family)

Issue Spotting

- Is the calculation based on the TPA's entire book of business or only plan claims?
- Is the calculation based on all plan payments in that classification for the year?
- Do not just look at "equivalent" benefits; look at the entire classification.
  - Ex: Just because the M/S specialist copay is the same as the MH/SUD specialist copay does not mean it is compliant.
  - Can find this with intermediate levels of care, like intensive outpatient treatment and home health care

Cumulative Financial and Quantitative Treatment Limits

- Any cumulative financial requirement or cumulative QTL on MH/SUD benefits cannot accumulate separately from any cumulative financial requirement or cumulative QTL on M/S benefits in the same classification
  - "Cumulative" = determine whether benefits are paid based on accumulated amounts
  - Deductibles and out-of-pocket maximums
  - Annual or lifetime day or visit limits
- Ex.: Cannot have $300 deductible on inpatient M/S benefits and separate $100 deductible on inpatient MH/SUD benefits

Nonquantitative Treatment Limitations (NQTLs)

NQTL: a non-numerical limitation on the scope or duration of benefits

- Exclusions based on medical necessity / experimental or investigative
- Prior authorization
- Concurrent review standards
- Formulary design for prescription drugs
- Network tier design (such as preferred providers and participating providers)
- Standards for provider admission to a network, including reimbursement rates
- Determining UCR charges
- Requirement to show that a lower-cost therapy is not effective (i.e., “fail-first” or “step therapy”)
- Exclusions of specific treatments for certain conditions
- Restrictions on applicable provider billing codes
- Standards for out-of-network provider access
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, or provider specialty

Nonquantitative Treatment Limitations (NQTLs)

Any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification *are comparable to*, and are *applied no more stringently than*, those used in applying the NQTL with respect to M/S benefits in the same classification

Four step process to evaluate each NQTL:

Identify all NQTLs	Identify the factors	Identify the sources	Demonstrate processes "comparable" and "applied no more stringently"

Consolidated Appropriations Act, 2021 (CAA) Changes

- Expressly requires plans to perform and document the comparative analysis of the design and application of NQTLs
- Provides additional detail regarding what must be included in the analysis
- General statements or recitations of the legal requirements is not enough
- Requires a reasoned discussion of findings and conclusions as to the comparability and stringency analysis and compliance with MHPAEA
- Date of analysis and name, title, and position of persons who performed or participated in the analysis
- Documented analysis must be available upon request to the DOL and participants
- Supporting documentation must also be provided to the DOL; e.g., claims denials

DOL Comparative Analysis Request Process

DOL makes initial request for comparative analysis, with 2-week deadline

DOL may make supplemental request after about a month of review with 1 week deadline

DOL determines compliance based on the submitted documentation

If determined noncompliant, employer has 45 days (*no extensions*) to specify the actions it will take to come into compliance and to provide additional comparative analyses to reflect such compliance

If, after the 45-day corrective action period, the DOL makes a final determination that the plan is not compliant, DOL will give a written notice of that determination, and employer will have 7 days (*no extensions*) to notify all participants and beneficiaries that the DOL has determined the plan is not complying with MHPAEA

DOL's public annual report to Congress will identify any plan or issuer the DOL determined is non-compliant with MHPAEA based on the comparative analysis, as well as the Secretary's conclusions as to whether each plan or issuer submitted sufficient information for the Secretary to review the required comparative analyses for compliance with MHPAEA

Step 1: Identify the NQTLs

Rule

- Identify NQTLs applicable to MH/SUD and M/S benefits in each classification

Issue Spotting

- NQTLs may not be apparent based solely on the SPD, the DOL expects they may be in internal guidelines and provider contracts as well
  - Are provider reimbursement rates for M/S services based on same factors and sources as for MH/SUD services?
  - What about provider admission standards? Does the network have far fewer MH/SUD providers than M/S providers?
- Ensure SPDs are up-to-date; e.g., no more treatment plan language

Step 2: Identify the Factors

Details

- What factors are used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits?
- Are any factors given more weight than others; if so, why?
- What is the threshold for any quantifiable factors?
  - E.g., what is the cost threshold for requiring prior authorization?

Examples of Factors

- Excessive utilization
- Treatment cost
- High cost growth
- Variability in cost and quality
- Elasticity of demand
- Provider discretion in determining diagnosis, or type or length of treatment
- Clinical efficacy of a treatment or service
- Licensing and accreditation of providers
- Claim types with a high percentage of fraud

Step 3: Identify the Sources

Details

- Identify the sources used to define the factors
- Are there any variations in the application of a guideline or standard?
  - What are the process and factors relied upon for establishing that variation?
  - Is there discretion?
- If experts are relied upon, what are their qualifications for M/S vs MH/SUD and to what extent are the expert evaluations or recommendations relied upon for each?
- Define what evidentiary standards, if any, are used: e.g., medical literature, professional standards and protocols, comparative effectiveness studies, clinical trials, published research studies

Examples of Sources for Factors

- *Internal claims data* shows medical cost for specific service increased 10% or more per year for two years
- Deviation from *generally accepted national quality standards* for a specific disease category occurs more than 30% of the time based on *clinical chart reviews*
- *Claims data* shows that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care
- More than 50% of outpatient episodes of care for specific diseases are not based on evidence based interventions (as defined by *nationally accepted best practices*) in a *12- month sample of claims data*

Step 4: Comparability and Stringency

Rule

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD benefits and M/S benefits as written and in operation?
- A separate NQTL that applies only to the MH/SUD benefits in a classification does not comply

Examples

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization) were implicated for all MH/SUD and M/S benefits subject to the NQTL
- Review of published literature on rapidly increasing cost for services for MH/SUD and M/S conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and M/S benefits subject to the NQTL
- A consistent methodology for analyzing which MH/SUD and M/S benefits had "high cost variability" and were therefore subject to the NQTL
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and M/S benefits were the same, both as developed and applied
- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and M/S benefits, demonstrating that the research was utilized similarly for both MH/SUD and M/S benefits

Step 4: Comparability and Stringency

Issue Spotting

- If utilization review is conducted by different entities for M/S and MH/SUD, ensure comparable application of utilization review policies
  - E.g., is separate MH/SUD carve-out provider administering prior authorization for MH/SUD in a comparable way to the TPA administering prior authorization for M/S benefits?
- Are there any exceptions or discretion at any step?
- Do decision-makers have comparable expertise with respect to MH/SUD and M/S benefits?

Step 4: Comparability and Stringency

Compliance must be demonstrated in operation as well

Example From a DOL Supplemental Request

- Provide an in operation comparative analysis of:
  - prior authorization denial and approval rates and appeal rates, including the reasons for the denials and the rate of overturned appeals
  - frequency of prior authorization reviews
  - the initial duration of treatment authorized on prior authorization reviews
  - prior authorization turnaround review times
- For each of the above, provide an explanation of the methodology and source for the data (i.e., UR database, claims database, etc.) used to develop these rates and explain how the results were derived
- Address and discuss the reasons for any discrepancies between the MH/SUD and M/S rates

NQTL Examples: Medication Assisted Treatment

- Coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services. Is a comparable process used to determine whether this limit applies to M/S benefits?
- Exclusion of methadone for opioid addiction, but coverage of methadone for pain management
- Plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat M/S benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. Plan deviates from such standards for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations.
  - Does the P&T committee have comparable expertise in MH/SUD conditions as it has in M/S conditions?
  - Is the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions comparable to and no more stringent than the processes it follows for M/S conditions?

Enforcement: Comparative Analysis

- The DOL will request the comparative analysis for an NQTL that is the subject of a complaint or potential violation
- CAA provides the DOL may request the comparative analysis in any other appropriate instance, and must request at least 20 per year
- Near term, the DOL expects to focus on the following NQTLs:
  - Prior authorization requirements for in-network and out-of-network inpatient services
  - Concurrent review for in-network and out-of-network inpatient and outpatient services
  - Standards for provider admission to participate in a network, including reimbursement rates
  - Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).
  - CAA initial request also asks for a list of all other NQTLs for which the plan prepared a comparative analysis, the conclusion of the analysis, and any service provider relied on. A plan may be required to submit analyses for these additional NQTLs.

Enforcement

ERISA

- Participants may sue for fiduciary breach or payment of benefits
- DOL investigations can result in corrections (and publicity)
- DOL litigation

Internal Revenue Code

- Excise tax of $100 per day for each individual affected by the failure
  - Noncompliance period begins date the failure first occurs and ends on the date the failure is corrected
- File Form 8928 to self-report failures

Enforcement

DOL Litigation

- DOL sued United Healthcare and affiliates as fiduciary under 502(a)(2) and (5) for violating the MHPAEA and breaching their fiduciary duties in connection with discounted reimbursements for out-of-network outpatient MH services provided by psychologists or masters level counselors/social workers and more restrictive concurrent review for MH benefits. Also alleged UHC's disclosures failed to discuss the NQTL or its application to individual participants.
  - United Healthcare paid $13.6 million to affected participants and $2,084,279 in penalties and took corrective actions

DOL Investigation – Example Enforcement Action

- Plans contracting with a service provider imposed a medical necessity review requirement on outpatient MH/SUD benefits after 30 visits.
- Although the service provider indicated there was a similar medical necessity review requirement for comparable M/S benefits, EBSA discovered that the plans permitted 52 visits before requiring any additional medical necessity review for M/S services. Additionally, the service provider could not show that it applied comparable factors in establishing these two requirements.
- Service provider agreed to increase the threshold for medical necessity review of MH/SUD services from 30 to 52 visits, and reprocess 198 claims, which resulted in $19,744 in MH/SUD benefits recovered for 29 participants.

Enforcement

EBSA FY 2020 MHPAEA Enforcement Fact Sheet

- 180 health plan investigations
  - 56 Insured, 103 self-funded, 21 both
- 8 MHPAEA violations in 4 investigations of self-funded plans
  - 4 QTLs, 2 NQTLs, 2 coverage in all classifications
- 92 complaints related to MHPAEA
  - Benefits advisors seek voluntary compliance before referral to formal investigation

DOL 2020 Report to Congress

- "Vigorous enforcement of MHPAEA has been one of the agency's top enforcement priorities."
- EBSA will create a new national MHPAEA enforcement project for FY 2021

EBSA

350 - 400 investigators

100 benefits advisors pursue voluntary compliance

2020 Fiscal Year = Oct 1, 2019 – Sept 31, 2020

Enforcement

DOL Statements

"We have made it clear that enforcement of the Mental Health Parity and Addiction Equity Act is among the highest, if not the highest, areas of focus for our health enforcement," said Ali Khawar, EBSA's acting assistant secretary and principal deputy assistant secretary.

President Joe Biden's proposed Fiscal 2022 budget also includes $37 million for EBSA, which would be a very significant increase for the agency, Khawar added. "Because mental health parity is one of our highest priorities, you can expect that if we get more resources as a result of the budget process, we are using those to enhance our enforcement," he said.

Potential Civil Penalties

Build Back Better Act amends ERISA to add civil monetary penalties on plan sponsors and plan administrators for MHPAEA violations of $100/day per participant

Action Items for Employers

- Obtain NQTL comparative analysis from health, mental health, and prescription drug administrators
- Especially for self-funded plans, review the comparative analysis for compliance
  - Counsel, some also using specialized consultants
- Conduct MHPAEA compliance review for financial and other requirements
- Contact TPAs to ensure MHPAEA disclosure requests are being handled appropriately
- Ensure SPDs / Booklets are up-to-date and accurately reflect compliant benefits

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Reminders

- Like and Follow our new LinkedIn Page
https://www.linkedin.com/company/dfw-iscebs-chapter/

- ISCEBS is still accepting session proposals thru Friday, January 14th for the 2022 Symposium in Toronto!

- Join our 2022 Board! We have our Technology / Administration Committee Chair open

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