Horizon Actuarial Services, LLC®

National Coordinating Committee for Multiemployer Plans

Mental Health Parity and Addiction Equity Act

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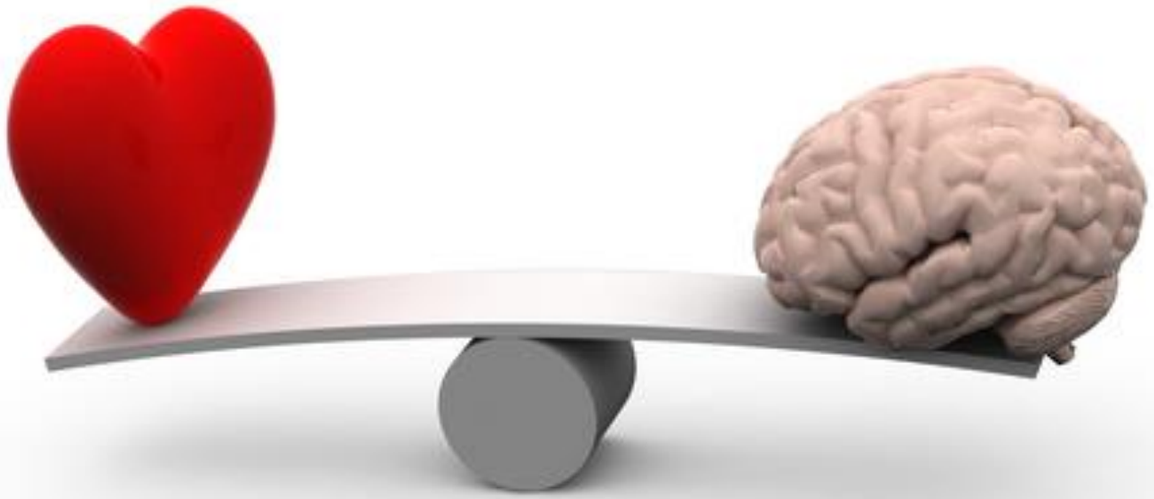
Discussion Outline

- **Prevalence of Mental Health/Substance Abuse Disorder Benefits**
- **History of Parity**
- **Requirements**
  - Financial
  - Quantitative
  - Non-Quantitative
- **NQTL Comparative Analysis Plan**
- **Implementation Process**
- **Plan Concerns**

Background

- **Why plans offer benefits?**
  - Better overall health
  - Decreased medical costs
  - Increased productivity



- **Recent impacts**
  - COVID-19 pandemic effect on stress and wellbeing
    - Gaps in screening and care
    - Access to care
    - Telehealth usage

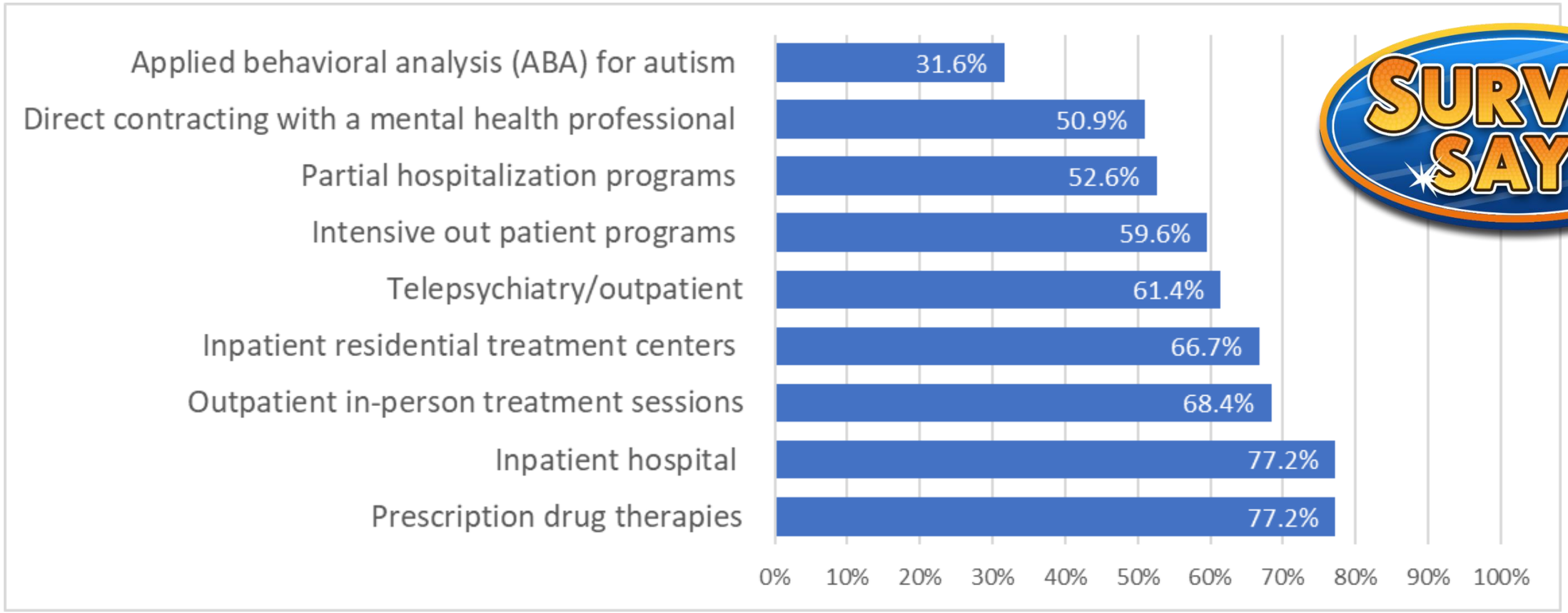
- **Plans that cover these benefits must ensure parity between medical/surgical and mental health and substance abuse**
  - Excludes retiree-only group health plans and excepted benefits only health plans

Mental Health Parity and Addiction Equity Acronyms

- **MHPAEA: Mental Health Parity and Addiction Equity Act (2008)**
- **QTL: Quantitative Treatment Limit**
- **NQTL: Nonquantitative Treatment Limit**
- **MH/SUD: Mental Health/Substance Use Disorder**
- **M/S: Medical/Surgical**
- **DOL: Department of Labor**
- **DSM: Diagnostic and Statistical Manual of Mental disorders**
- **OOPM: Out-of-Pocket Maximum**
- **UCR: Usual and customary provider reimbursement rates**

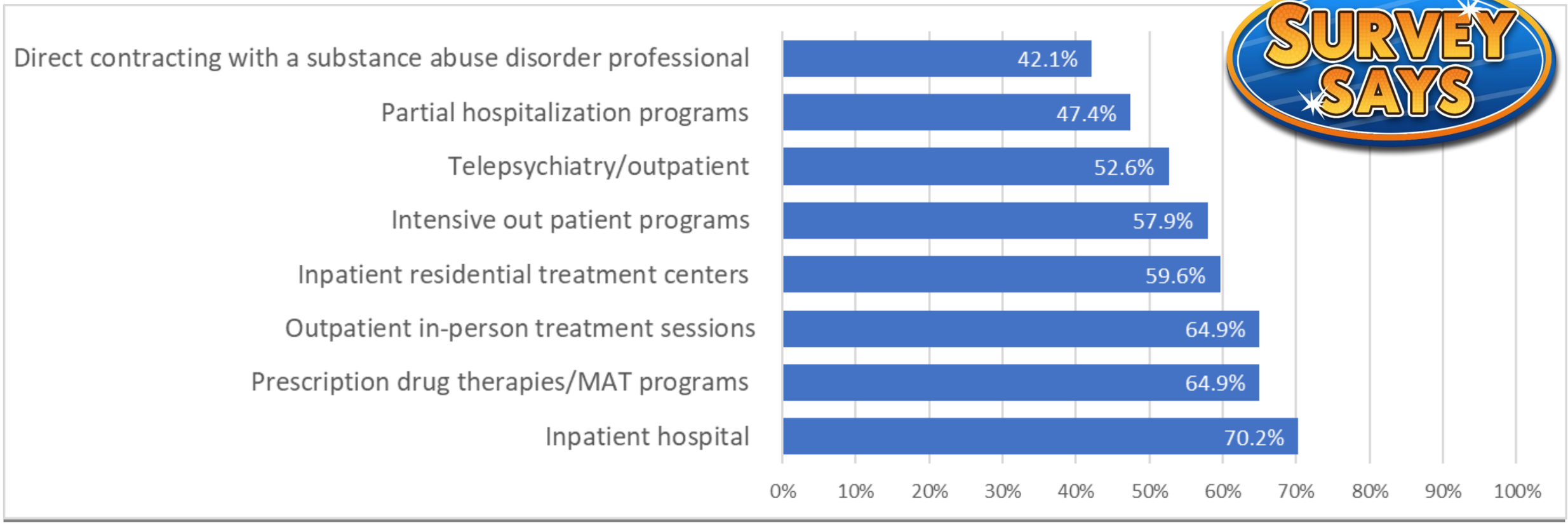
Mental Health Benefits Prevalence

- **International Foundation of Employee Benefit Plans 2021 survey of 57 multi-employer plans on the prevalence of mental health benefits:**



Substance Abuse Disorder Benefits Prevalence

- **International Foundation of Employee Benefit Plans 2021 survey of 57 multi-employer plans on the prevalence of substance abuse disorder benefits:**



Mental Health Parity and Addiction Equity History

- **History**
  - Mental Health Parity Act of 1996
    - Impacted mental health benefits only
    - Same annual and lifetime dollar limits must apply
    - Coverage for mental health not required
  - Mental Health Parity Act and Addition Equity Act of 2008 (MHPAEA)
    - Expanded to substance use disorder
    - Full parity in all coverage areas
      - Addressed financial requirements, quantitative treatment limits and non-quantitative treatment limits
  - Final parity regulations released in 2013
    - Added detail on non-quantitative treatment limits
  - Affordable Care Act - 2009
    - Small group plans cover MH/SUD as essential health benefits
    - Preventive services covered at 100% include depression and alcohol misuse screening and counseling

Mental Health Parity and Addiction Equity History (cont.)

- 21st Century Cures Act
  - Self-compliance tools and model disclosure requests
- Consolidated Appropriations Act 2021
  - Comparative Assessment Report on Non-Quantitative Treatment Limitations
  - Make available to Secretaries of Labor, Treasury and Health and Human Services upon request
  - Requirement effective February 10, 2021
  - FAQs released in April 2021
- High priority for the current administration

"As President, I will redouble these efforts to ensure enforcement of mental health parity laws"

– President Joe Biden

Enforcement

- **If DOL finds that parity has been violated (or comparative analysis is not provided or incomplete), the Plan has 45 days to take corrective action**
- **After 45 days, if DOL finds the Plan still in violation, the Plan must notify enrolled participants of the noncompliance within seven days**
- **DOL may refer violators to the IRS, which can assess civil penalties of up to $100 per day**
- **DOL must request NQTL comparative analyses from at least 20 plans per year and provide an annual report naming plans in violation**
- **For 2020 fiscal year, DOL reported :**
  - 180 health plan investigations with 8 MHPAEA violations

Mental Health Parity and Addition Equity Act (MHPAEA) Rules

- If MH/SUD benefits are provided in one classification, they must be provided in every classification in which M/S benefits are provided.
  - No requirement to provide MH/SUD benefits but if offered must be in parity for financial requirements and treatment limits (quantitative and non-quantitative)
  - Six classifications:

	Medical/Surgical Benefits	MH/SUD Benefits
1) Inpatient; In-Network	**Covered**	**Covered**
2) Inpatient; Out-of-Network	**Covered**	**Covered**
3) Outpatient; In-Network	**Covered**	**Covered**
4) Outpatient; Out-of-Network	**Covered**	**Covered**
5) Emergency Care	**Covered**	**Covered**
6) Prescription Drugs	**Covered**	**Covered**

  - Outpatient can be split into Office Visits and Other Outpatient

Financial and QTL Limits Requirements

- **MH/SUD not more restrictive than M/S**
  - Annual and lifetime dollar limits
  - Financial requirements such as deductibles, coinsurance, copays and OOPM
    - Calculate the predominant financial requirement applied to substantially all M/S benefits in the same classification based on plan payments
      - Substantially all means the type of cost sharing or treatment limitation applies to at least 2/3rds of the M/S benefits in that classification
      - Predominant means the level of cost sharing or treatment limitation that applies to more than 50% of the M/S benefits with that type of cost sharing or treatment limitations
    - Example:
      - Coinsurance applies to all in-network inpatient M/S benefits (>66.7%), so it applies to substantially all benefits in the category
      - 80% coinsurance applies to 60% of the in-network inpatient M/S payments (>50%)
      - MH/SUD in-network inpatient benefits may use 80% coinsurance
  - Quantitative treatment limits include annual, episode and lifetime day and visits limits such as number of treatments, visits, or days of coverage

NQTL Limits Requirements

- **NQTL is a limit on the scope or duration of benefits for treatment**
  - Permanent exclusion of benefits for a condition/disorder is not a treatment limitation
  - NQTLs are processes, strategies, evidentiary standards, or other factors which must not be more stringent for MH/SUD than those applied to M/S. Examples:
    - Prior authorization requirements
    - Concurrent review
    - Medical management and necessity standards
    - Network provider reimbursement and usual and customary determinations for out-of-network benefits
    - Network adequacy and access
    - Rx formulary design
    - Step therapy protocols, including fail-first protocols
    - Experimental treatment exclusions

Timing of NTQL Comparative Analysis

- **Plans must be able to provide this documentation by <u>February 10, 2021</u>**
- **FAQ notes that participants can request an NTQL analysis**

Wasn't that months ago? What if we don't have one yet?

How to Comply

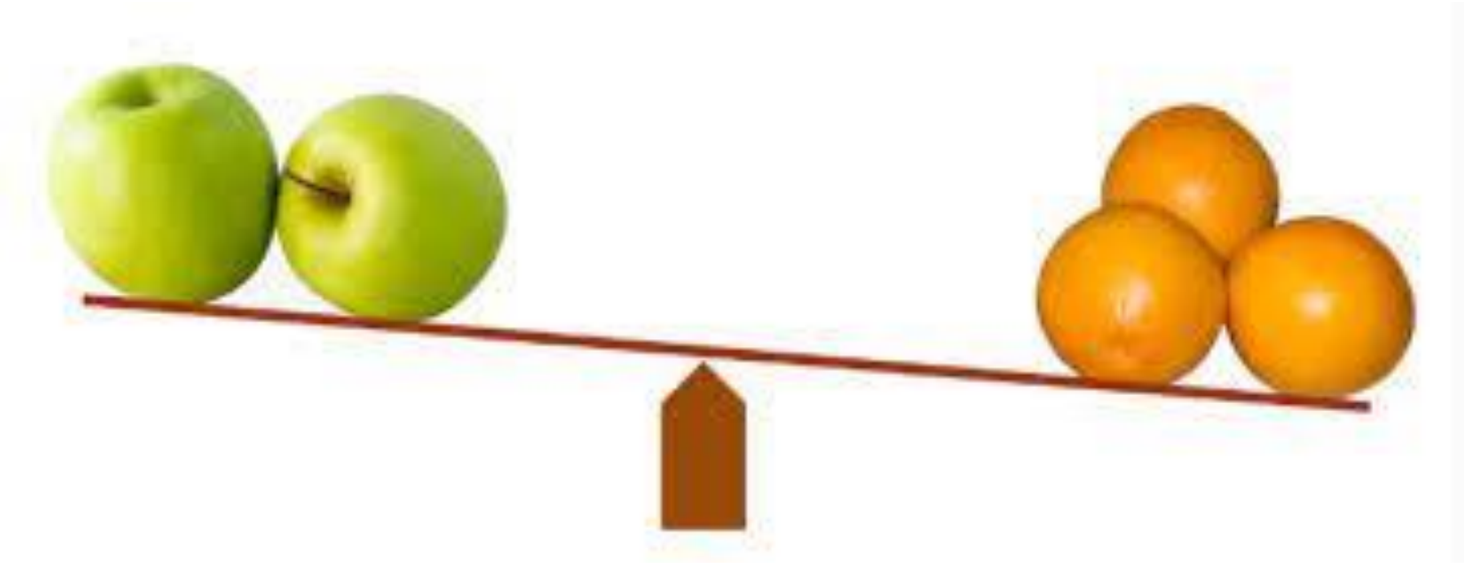
- **DOL notes that the Self-Compliance Tool provides robust guidance**
  - Outlines a process for analyzing whether a particular NQTL meets requirements
  - Examples and tips are included along with warning signs of areas of non-compliance

NQTL Comparative Analysis Requirements

- **A specific, detailed, and well reasoned written explanation of the basis for a Plan's conclusion that NQTLs comply with MHPAEA**
- **What's not enough?**
  - General statements without support or documentation
  - Mountain of paperwork without clear explanation of relevancy and applicability
  - Plan details without a comparative analysis between M/S and MH/SUD benefits
  - List of factors, standards, or strategies without supporting information on how they're defined or applied
- **Additional documents may be required, such as:**
  - Claim processing policy manuals
  - Samples of covered, denied, or appealed MH/SUD and M/S claims

Comparative Analysis Must Include

1. NQTL description
2. Benefit Application
3. Application Criteria
4. Quantitative Factors
5. Variations
6. Administrative Decisions
7. Expert Reliance
8. Findings and Conclusions
9. Analyses Details



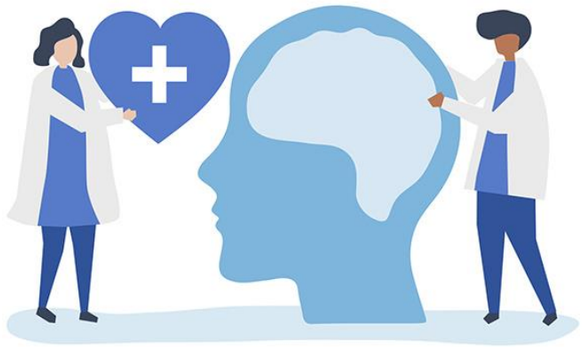
Comparative Analysis Must Include (cont.)

1. NQTL description

- Description of each specific NQTL
- Plan terms and any relevant policies related to each NQTL

2. Benefit Application

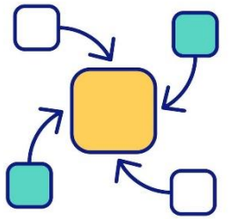
- Identify the specific MH/SUD and M/S benefits to which each NQTL applies within each benefit classification:
  - In-network inpatient
  - Out-of-network inpatient
  - In-network outpatient
  - Out-of-network outpatient
  - Emergency care
  - Prescription drugs



- Must clearly indicate which benefits identified are treated as MH/SUD and which are treated as M/S

Comparative Analysis Must Include (cont.)

3. Application Criteria



- Criteria used in designing and applying the NQTLs, including:
  - Factors
  - Evidentiary standards or sources
  - Strategies
- Weighting of certain criteria above others should be explained and justified

4. Quantitative Factors

- Definitions used by the Plan that incorporate a quantitative component into factors, standards, or processes
  - Supporting sources for these definitions should be provided

5. Variations

- Identify any variations in how a standard is applied between MH/SUD benefits and M/S benefits and process and factors considered in determining the variation

Comparative Analysis Must Include (cont.)

6. Administrative Decisions

- If the application of the NQTL is based on specific decisions in the administration of the benefits, the Plan must identify:
  - Nature of the decisions
  - Decision maker(s)
  - Timing of the decisions
  - Qualifications of the decision makers

7. Expert Reliance

- If the Plan relies on any experts, the following should be provided for each expert:
  - Assessment of each expert's qualifications
  - Extent to which the Plan ultimately relies on each expert's recommendations in setting both MH/SUD and M/S benefits

Comparative Analysis Must Include (cont.)

8. Findings and Conclusions

- Reasoned discussion on comparability of:
  - Processes
  - Strategies
  - Evidentiary standards
  - Factors
  - Sources

Used to design and apply NQTLs, both as written and as applied

9. Analyses Details

- Date of analyses
- Name, title, and position of person performing analyses
- Name, title, and position of others participating in the analyses

Areas of Concern

- **DOL's Self-Compliance tool highlights these situations:**
  - Plans that generally exclude benefits for a particular MH/SUD condition, but cover prescription drugs for that condition – MH/SUD coverage required in other categories
  - Medication Assisted Treatment where methadone cannot be excluded for opioid addiction unless processes, strategies, and evidentiary standards are comparable
  - Inequitable provider reimbursement rates for MH/SUD compared to M/S
  - Exclusions for out-of-network MH/SUD benefits
  - Plans cannot impose financial requirements, QTL, or NQTLs that are applicable only to MH/SUD benefits
  - Differentiation between specialist and PCP copays for MH/SUD
  - Differences in operation as well as in documents
  - Medical necessity review requirements and appeals and denials review criteria
  - Evaluation of experimental coverages related to Autism Spectrum Disorder (ASD) such as Applied Behavioral Analysis (ABA) therapy

Areas of Concern (cont.)

- **DOL fact sheet violations (2019 and 2020) include:**
  - Inappropriate financial requirements on MH/SUD outpatient office visits
  - Waiting period for MH/SUD claims
  - Greater cost sharing for MH/SUD than allowed
  - Annual limit on number of MH/SUD visits
  - Differentiation in processes, strategies, and evidentiary standards for medical necessity between MH/SUD and M/S benefits
  - Coverage of treatment for autism spectrum disorder
  - NQTLs related to network adequacy, including:
    - Precertification standards and medical necessity definitions
    - Utilization review policies
    - Provider network admission criteria
  - Coverage for residential treatment facilities
  - Prior authorization and clinical review processes

Implementation Process

Process Steps	Process Actions
1. Determine if MHPAEA applies to the Plan	Certain plans such as retiree-only and excepted benefit plans are exempt
2. Determine if the Plan provides MH/SUD benefits	Check all kinds of coverage, including prescription drug and emergency coverage
3. Check if the Plan covers MH/SUD benefits in every classification where M/S benefits are provided	Six classifications: 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. Outpatient benefits may be split for office visits and other outpatient items

Implementation Process

Process Steps	Process Actions
4. Review any annual and lifetime limits on MH/SUD benefits	These limits may not be lower than those imposed on M/S benefits
5. Review financial requirements (examples: deductibles, copays) and QTLs (examples: day or visit limits)	Within each of the classifications, determine financial requirement or QTL that applies to substantially all (2/3) M/S claims. Using that subset of claims, determine the exact financial requirement or QTL that applies predominantly (>50%) of the claims. MH/SUD benefits within that classification may not have financial requirements or QTLs that are more restrictive than that standard. Alternatively, MH/SUD benefits may apply the least restrictive financial requirement or QTL that applies to M/S within each classification

Implementation Process

Process Steps	Process Actions
6. Review cumulative financial requirements or QTLs	Cumulative financial requirements determine whether or to what extent benefits are provided based on accumulated amounts. Examples: deductibles and out-of-pocket maximums Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts. Examples: annual or lifetime day or visit limits Plans cannot apply cumulative financial requirements or QTLs that are separate for M/S and MH/SUD. This is true even if the separate requirements are equal.

Implementation Process

Process Steps	Process Actions
7. Review NQTLs	A list of NQTLs must be compiled looking at rules both as written and in operation. Accumulating the list of NQTLs and determining if they are applied no more stringently for MH/SUD as they are for M/S benefits will require work with multiple entities, including: • Eligibility Administrator • Claims Adjudicator (Medical and MH/SUD) • Utilization Review Vendor • Network Vendor • Out-of-Network Savings Vendor • Medical Consultant/External Medical Review Vendor • Prescription Drug Benefit Manager

Sub-steps for NQTL Comparisons

1. **Identify NQTL**
2. **Identify the factors considered in the design of the NQTL**
   - Examples of factors:
     - Excessive utilization;
     - Recent medical cost escalation;
     - Provider discretion in determining diagnosis;
     - Lack of clinical efficiency of treatment or service;
     - High variability in cost per episode of care;
     - High levels of variation in length of stay;
     - Lack of adherence to quality standards;
     - Claim types with high percentage of fraud;
     - Current and projected demand for services.

Sub-steps for NQTL Comparisons

3. Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL

- Examples of sources of factors:
  - Internal claims analysis;
  - Medical expert reviews;
  - State and federal requirements;
  - National accreditation standards;
  - Internal market and competitive analysis;
  - Medicare physician fee schedules;
  - Evidentiary standards, including any published standards as well as internal Plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits

Sub-steps for NQTL Comparisons

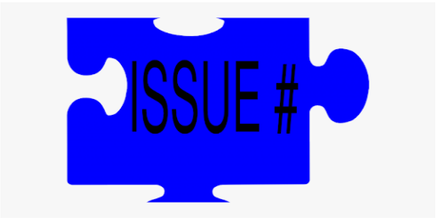
4. Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

- Examples of sources of requirements:
  - Internal claims analysis;
  - Published literature on key factors for rapidly increasing cost;
  - Methodology for determining which benefits are subject to the NQTL;
  - Methodology for setting UCR rates;
  - Internal quality control reports;
  - Summaries of medical research considered in designing NQTLs demonstrating similar utilization for both MH/SUD and M/S

Implementation Process

Process Steps	Process Actions
8. Review disclosure requirements	Plan must provide the following available upon request: • the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider • the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee If coverage is denied based on medical necessity, medical necessity criteria for the MH/SUD benefits at issue and for M/S benefits in the same classification must be provided within 30 days

Plan Concerns



- **Issues and roadblocks that plans may face:**
  - Who takes the lead on this project (consultant, counsel, third party administrator) and time to compile and complete the analysis
  - How to obtain a full list of potential NQTLs to review – so far the DOL has only provided examples

  - Multiple vendors used for administration means that compiling NQTLs requires coordination from many entities and cooperation by vendors
  - Some NQTLs are based on processes that may not be documented and will therefore be difficult to assess without first documenting the process
  - The DOL has not provided an example of a written comparative analysis; you have to rely on the tips, examples and warning signs of noncompliant NQTLs
  - Keeping up with claim-review criteria/medical necessity standards and claims litigation
  - Obtaining written certification from fully insured carriers
  - Ensuring ongoing compliance with training, document retention and updates

Questions