Mental Health Parity and Addiction Equity Act:

What You Need to Know - Part 1

Wednesday, November 15 | 9:30am – 10:30am

The Alliance
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Introduction

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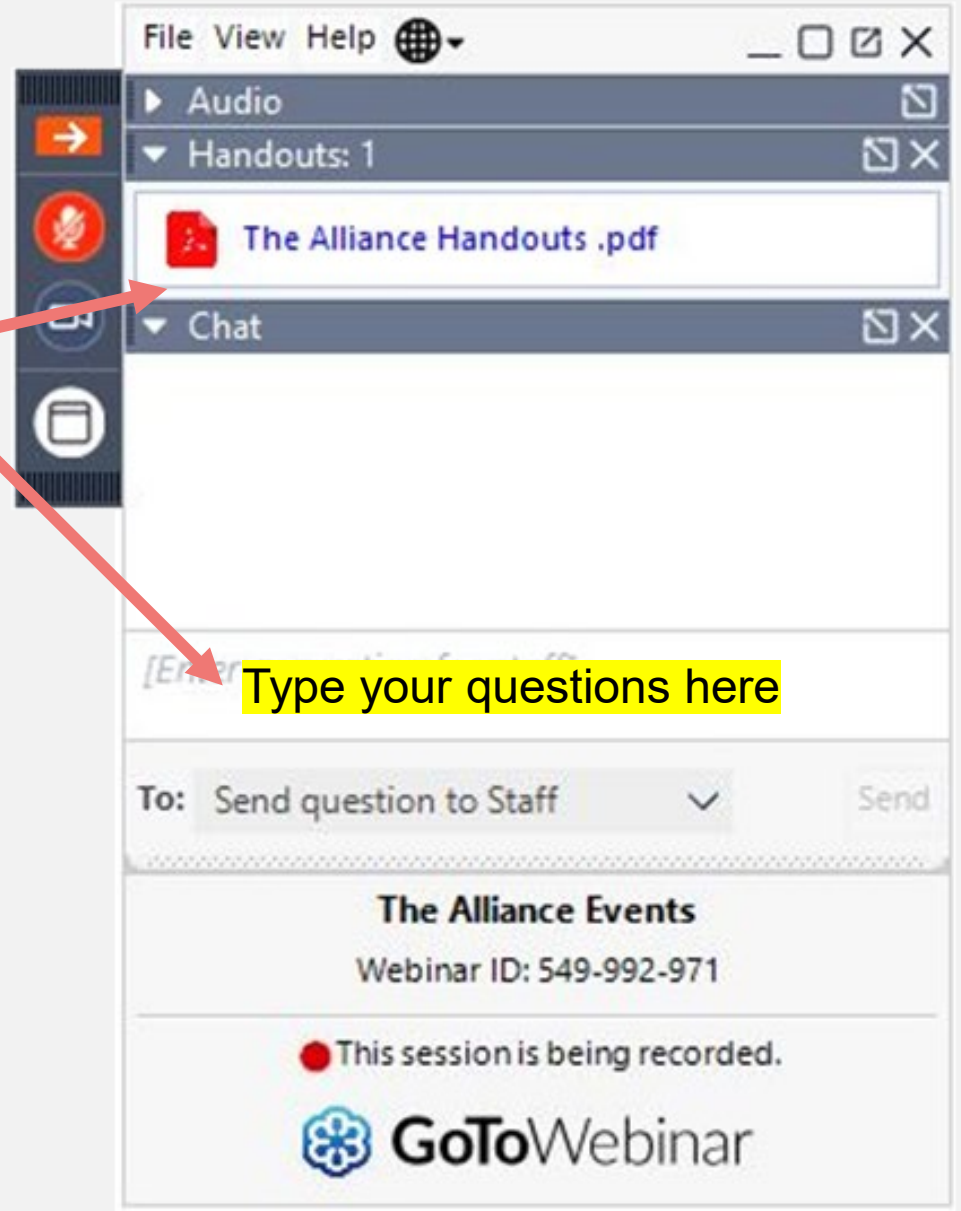

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John Barlament

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The Mental Health Parity and Addiction Equity Act: What You Need to Know

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The ABCs of Mental Health Parity

MHPA: Mental Health Parity (1996)

MHPAEA: Mental Health Parity and Addiction Equity Act (2008)

ACA: Affordable Care Act (2010)

CAA: Consolidated Appropriations Act

QTL: Quantitative Treatment Limit

NQTL: Nonquantitative Treatment Limit

MH/SUD: Mental Health/Substance Use Disorder

M/S: Medical/Surgical

DOL: Department of Labor

CMS: Centers for Medicare and Medicaid Services

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Overview

Mental Health Parity and Addiction Equity Act ("MHPAEA")

How did we get here?

- Congressional belief that health plans (fully-insured and self-funded) were not treating mental health ("MH") (and, later, substance use disorder ("SUD")) fairly
  - Mental Health Parity Act of 1996
    - ✓ Expanded in 2008 to MHPAEA
    - ✓ Expanded again by Consolidated Appropriations Act, 2021 ("CAA")
- When compared to medical/surgical ("M/S") benefits

Plans Subject to Law

- Generally applies to "group health plans" (typically, major medical plans)
- Excepted benefits (such as most FSAs, dental, vision, etc.) generally excluded
- No exemption for church plans
- "Small" plans / retiree-only plans generally excluded
  - Definition of "small" can be a bit confusing
  - Generally, employer had at least 2 but not more than 50 employees on business days during preceding year

Plans Subject to Law

- Can be a different rule for governmental plans (*e.g.*, public school, city or county)
- In some situations, upper boundary can be 100 employees (not 50)
- Also can be an "increased cost" exception
- If there was an increased cost of 2% in 2010 or at least 1% in any subsequent plan year
  - 2013 regulations provide some details. Cost estimate must be made by actuary and exemption only lasts 1 year

MHPAEA Overview

MHPAEA establishes three main requirements

(1) Annual/lifetime limits: If plan has annual or lifetime dollar limits for M/S benefits, must apply those same (or higher) dollar limits for MH/SUD

- *E.g.*, it would have been problematic to include a $1,000,000 lifetime limit on M/S benefits but a $500,000 lifetime limit on MH/SUD
- Really not relevant any longer, though, because ACA eliminated dollar-based annual and lifetime limits for "essential health benefits"
- In other words, the problem was basically "resolved" by ACA

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MHPAEA Overview

(2) Financial requirements (such as coinsurance, copayments, deductibles) and quantitative treatment limitations (*e.g.*, visit limits) cannot be more restrictive against MH/SUD benefits

- AND, no separate cost-sharing requirements only for MH/SUD benefits
  - *E.g.*, could not draft plan to say that there is a $1,000 deductible for M/S benefits and a $500 deductible for MH/ SUD benefits. Even though the deductible is "better", it violates MHPAEA because it is separate

MHPAEA Overview: QTL Rules

- QTL test: Identify "classifications" such as inpatient, in-network and emergency care
- Check whether the financial requirement (such as copayment or coinsurance) applies to at least 2/3 of medical/surgical ("M/S") benefits in the classification
  - If "no", cannot apply to any mental health/substance use disorder ("MH / SUD") benefits in the classification

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MHPAEA Overview: QTL Rules

- If "yes", check if there is a single level that applies to more than ½ of M/S benefits
  - If "no", aggregate them until you get to 50.01%
  - If "yes", use that limit for MH / SUD benefits

- *Example*: For outpatient, in-network M/S benefits, plan has projected benefits for next plan year as follows

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QTL Rules

Copayment amount	$0	$10	$15	$20	$50
Projected payments	$200,000	$200,000	$200,000	$300,000	$100,000 Total = $1,000,000
Percent of total plan costs	20%	20%	20%	30%	10%
Percent subject to copayments	Not applicable	25% ($200K / $1M)	25% ($200K / $1M)	37.5% ($300K / $1M)	12.5% ($100K / $1M)

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QTL Rules

- In this example, 2/3 "substantially all" test IS met because 80% of benefits are subject to a copayment
- No single level that applies to more than 50%- (highest is 37.5%)
- Combining $50 copayment (12.5%) with $20 copayment (37.5%) still is only 50.00%
- So, add in $15 copayment to be greater than 50%
- So, $15 copayment is highest copayment plan can have for outpatient, in-network MH / SUD benefits

QTL Rules

- Note: Result is that MH/SUD gets treated "better" than M/S benefits
- In the example, of benefits with a copay, 37.5% of M/S benefits have a $20 copay and 12.5% of M/S benefits have a $50 copay – and that is ok
- But MH/SUD copays are capped at $15
- Unless you have only a single level of copays, coinsurance, etc., no way to know if you pass by only looking at SPD
  - Must do the test to see if you pass

  - It's not "parity", it's "super-parity": MH/SUD benefits can, in some situations, be treated much better than M/S benefits

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NQTL

A NQTL is a non-numeric limit on the scope or duration of benefits for treatment.

Examples include:

- Medical management standards limiting/excluding benefits based on medical necessity or appropriateness, or whether treatment is experimental or investigative
- Formulary design for prescription drugs
- Network tier design (*e.g.*, preferred and participating providers)

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NQTL

Additional types of NQTLs:

- Standards for provider admission to participate in a network (*e.g.*, reimbursement rates)
- Plan methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher cost therapies unless lower cost therapies are not effective (*e.g.*, step therapy protocols)
- Exclusions based on failure to complete a course of treatment
- Restrictions on the scope or duration of benefits that are based on geographic location, facility type, provider specialty or other criteria

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NQTL

Any processes, strategies, evidentiary standards or other factors ("Processes") used in applying the NQTL to MH/SUD benefits within a classification must be comparable to, and applied not more stringently than, the processed used in applying the NQTL to M/S benefits in the same classification (we refer to this requirement as the "Comparable Processes Rule")

NQTL

- Cannot have separate NQTLs that are applicable only with respect to MH/SUD benefits
  - But not required to have same NQTLs for MH/SUD and M/S benefits
  - Application of Comparable Processes Rule can have disparate results
- Each NQTL for MH/SUD benefits within a classification must comply with the plan as written and in operation

NQTL

- Appears that a two-part analysis is required:
  1. The Processes used in applying any NQTL to MH/SUD benefits must be identified and compared to Processes used for M/S benefits
  2. If comparable, must "dig deeper" to make sure that the Processes are not applied in a more stringent manner for MH/SUD benefits than for M/S benefits
- Review of plan documents is not enough

NQTL

- Risk of deficient SPD is small and fixed relatively easily
- Risk of deficient vendor practices is larger; more difficult to identify; more difficult to "fix"

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NQTL Under April 2021 FAQs

- CAA did not require a change in coverage, but did add to documentation requirements of the plan
- Plans must be able to provide a comparative analysis of NQTLs if requested by the DOL or plan participants (or state regulator / CMS for non-ERISA plans)
- A specific, detailed and well-reasoned written explanation of the basis for a plan's conclusion that NQTLs comply with parity law
  - General statements without support or documentation is not enough

NQTL| Comparative Analysis Requirements

1. NQTL Description

- Description of each specific NQTL
- Plan terms and any relevant policies related to each NQTL
- Plan sponsor would have some of this information, but not all of it. For example, many TPAs have "medical policies" (hundreds of them) for specific conditions

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NQTL| Comparative Analysis Requirements

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

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NQTL| Comparative Analysis Requirements

3. Benefit 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
- This is information a plan sponsor would not typically have. Need to go "beyond the SPD"

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NQTL| Comparative Analysis Requirements

4. Quantitative Factors

- Definitions used by the plan that incorporate a quantitative component into factors, standards, or processes
  - *Example*: medical necessity review after 30 visits for M/S, 10 for MH/SUD
  - Supporting sources for these definitions should be provided
- DOL has gone back and forth on how much "quantitative" information a plan sponsor should obtain

NQTL| Comparative Analysis Requirements

5. Variations

- Identify any variations in how a standard is applied between MH/SUD benefits and M/S benefits
- Explanation of process and factors considered in determining the variation
- Question: How are plans supposed to determine whether their TPAs and PBMs have any such "variation"?

NQTL| Comparative Analysis Requirements

6. Administrative Decisions

- If the application of the NQTL is based on specific decisions in the administration of the benefits, the plan must be able to identify:
  - Nature of the decisions
  - Decision maker(s)
  - Timing of the decisions
  - Qualifications of the decisionmakers
- Again, not information that an employer would have access to, unless employer asks for the information

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NQTL| Comparative Analysis Requirements

7. Expert Reliance

- If the plan relies on any experts, the following should be available 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

NQTL| Comparative Analysis Requirements

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**

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NQTL| Comparative Analysis Requirements

9. Analyses Details

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

All need to be included and be thoughtful – just a "pile of papers" is not sufficient to give to the DOL

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NQTL| Comparative Analysis

DOL 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 the DOL finds that the Plan is still in violation, the Plan must notify enrolled participants of the noncompliance within seven days
- DOL must provide an annual report naming plans in violation.
- In addition, the DOL may refer violators to the IRS, which can assess civil penalties of up to $100 per day
- DOL could bring lawsuit and force a change too

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

—President Joe Biden

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Implementing NQTL Comparative Analysis

- What does all that mean in the "real world"? What would a sufficient comparative analysis look like?
- Good question. But no answer. And in DOL Report to Congress from January 2022, we learned that no one knows
- During that time period, DOL issued 156 letters to plans and insurers, requesting comparative analyses for 216 NQTLs

Implementing NQTL Comparative Analysis

- "None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt"—*i.e.*, the entire industry failed
- But, industry pushed back
  - If every student in a classroom fails, arguably the problem might be with the teacher
- Industry pushed for more guidance
  - CAA required agencies to "finalize any draft or interim guidance and regulations" within 18 months of CAA—*i.e.*, by about June 2022

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New Guidance (2023)

- Finally, in late July 2023 / early August 2023 we received additional guidance
- Proposed regulations (88 Federal Register 51552 (August 3, 2023))
- Technical Release 2023-01P
- 2023 MHPAEA Comparative Analysis Report to Congress
  - Showed similar results, although apparently not 100% of industry failed (maybe only 90%+?)

Proposed Regulations

- Note that regulations are only proposed
- Comments were due mid-October, 2023
- Regulators hope to have final regulations be effective for plan years starting 1/1/2025
- Regulators will want to provide sufficient time for plans to comply before 1/1/2025
- Suggests that final regulations might be released 1st quarter of 2024
- We will do a "deep dive" into these proposed regulations in our January 2024 presentation

Practical Considerations

Practically speaking, the above likely means:

- No plan sponsor can do the analysis alone. Third party administrators ("TPAs") and pharmacy benefit managers ("PBMs") are the experts hired by the sponsor to make plan decisions
  - *e.g.*, when a particular brain surgery for an infant is "medically necessary" or is "experimental/investigational"
- And, trying to determine compliance "in operation" means that sponsor cannot just look at plan document/SPD

Practical Considerations

- Also, that legal review may be necessary
  - Key terms not defined; lots of legal ambiguity; "facts and circumstances" tests
  - May also help shield some from disclosure because of attorney-client privilege
  - Fiduciary who signs may require this also
- DOL had published a "Self-Compliance Tool". But many questions that the DOL asks in private letters to employers / TPAs / PBMs go well beyond the Tool
  - In other words, it's helpful but not sufficient

Practical Considerations

What steps should plan sponsors, TPAs and PBMs take now?

- Wait until regulations are finalized before implementing them? Will that provide enough time to comply by (before?) 1/1/2025?
  - "Before": If a problem is spotted under final regulations, will the plan need to be amended in 2024, to be compliant by 1/1/2025? Or will plan have all of 2025 to become compliant by 2026?

Practical Considerations

- Typically advise clients NOT to wait because DOL is still likely to audit under 2021 regulations
  - Plan enrollees can still ask for the written analysis
- Doing the analysis can be expensive. We have been able to divide cost among clients when common TPA or PBM is used
  - *E.g.,* suppose cost to create / review / question ABC TPA's document is $20,000 and four clients use ABC. $20,000 cost often can be split by 4 (i.e., $5,000 for the review). Each client's SPD must be separately reviewed also (that cost cannot be split)

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Practical Considerations

- Sponsors should start/finalize/refresh analysis based on "current" guidance, at a minimum
  - Maybe start game-planning what would be required if regulations are finalized as is
- But lot of industry pushback. Perhaps the regulations will be completely overhauled?

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Questions?

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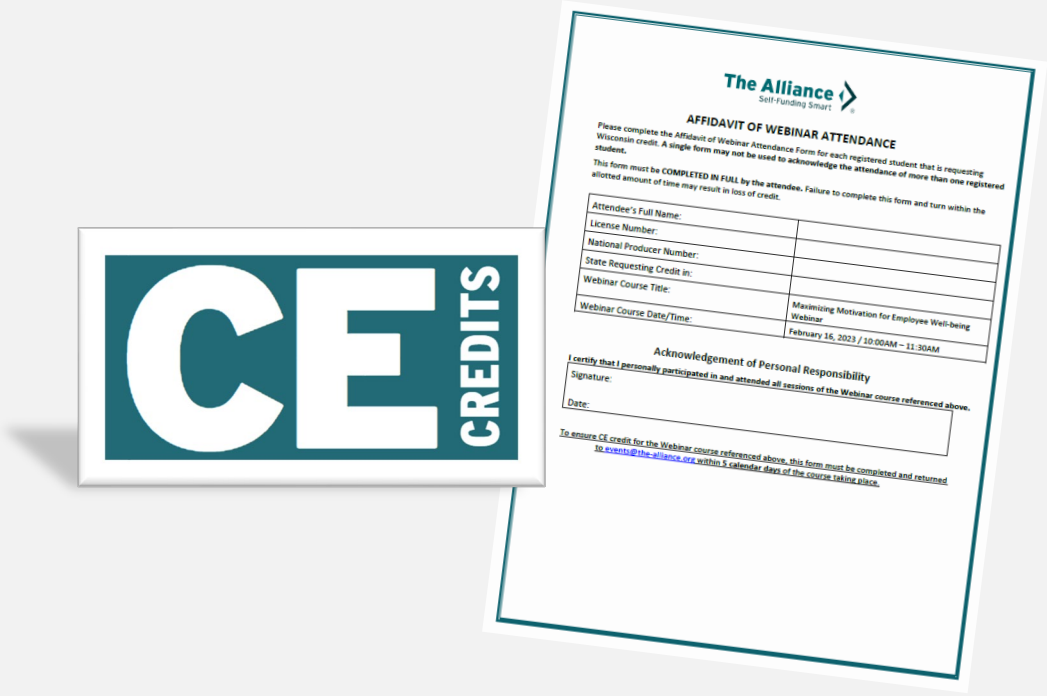

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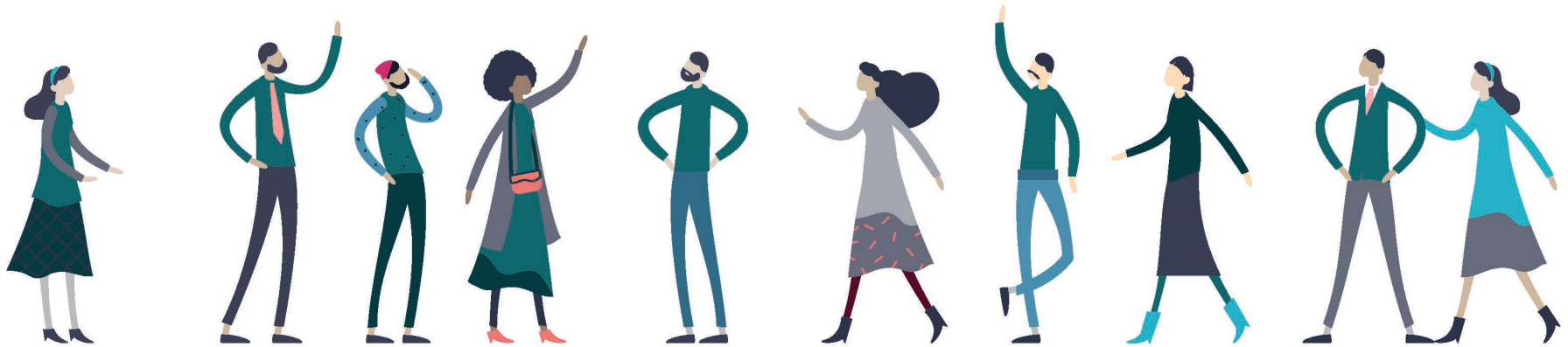

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