Mental Health Parity and Addiction Equity Act:

What You Need to Know - Part 2

Thursday, January 18 | 9:00am – 10:00am

The Alliance
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Introduction

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Jennifer Austin

Senior Director of Strategic Marketing
and Employer Engagement
The Alliance

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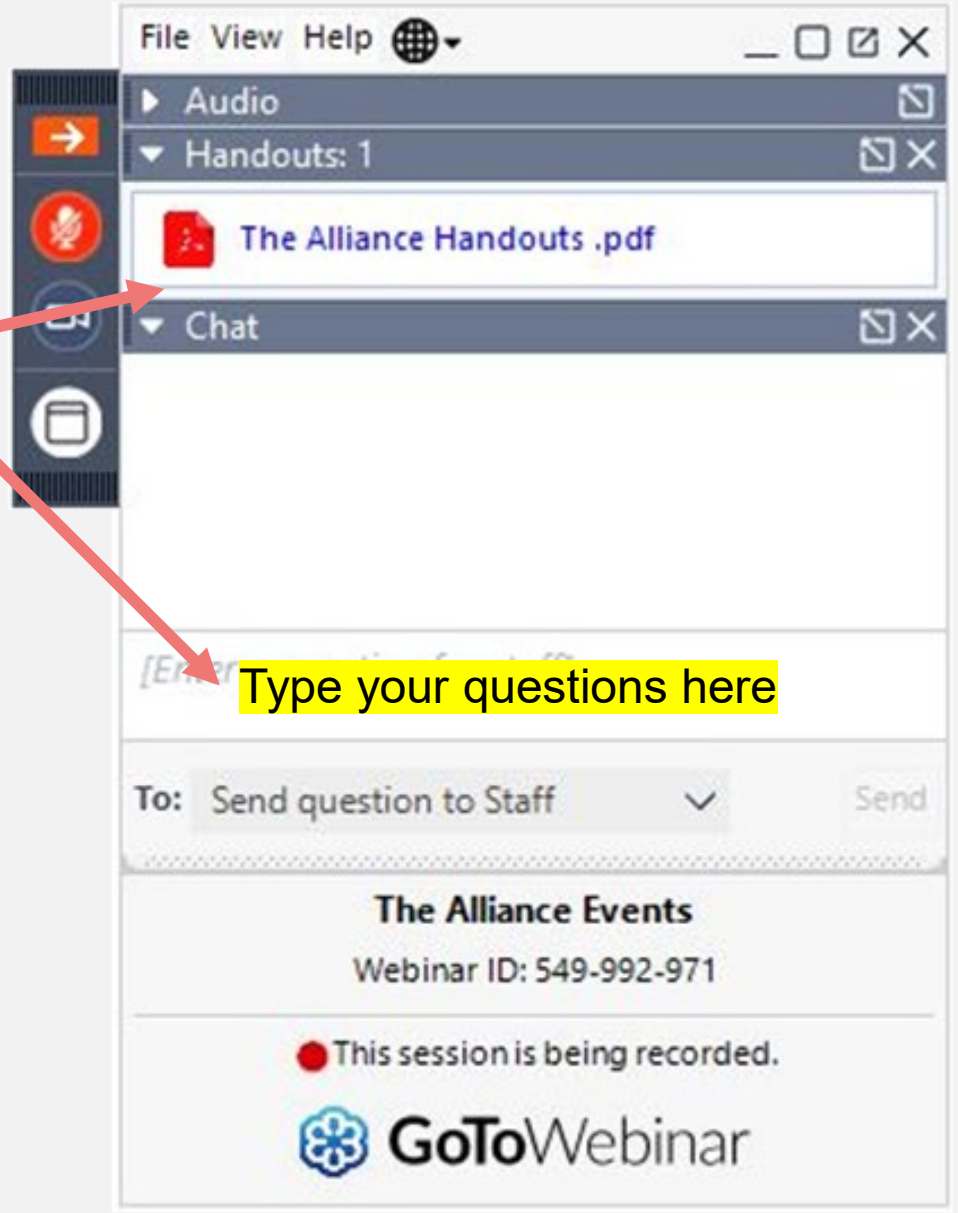

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Introduction

Reinhart

John Barlament

Shareholder
Reinhart Boerner Van Deuren s.c.

Mental Health Parity & Addiction Equity Act: What You Need to Know – Part 2

John L. Barlament
Shareholder
Reinhart Boerner Van Deuren s.c.
Milwaukee, WI
jbarlament@reinhartlaw.com
414.298.8218

Reinhart

Refresher

In part 1 of the presentation, we discussed:

Which plans are subject to MHPAEA

Quantitative treatment limitation ("QTL") rules

2021 FAQs from the DOL, IRS and CMS

- Action steps employers should take to comply with those FAQs
- Need to have a written "comparative analysis" comparing how nonquantitative treatment limitations ("NQTLs") apply to medical / surgical ("M/S") benefits and mental health / substance use disorder ("MH/SUD") benefits

We did not address the 2023 guidance

New Guidance (2023)

- After industry requested additional guidance, it arrived in late July 2023 / early August 2023
- Proposed regulations (88 Federal Register 51552 (August 3, 2023))
- Technical Release 2023-01P
- 2023 MHPAEA Comparative Analysis Report to Congress

Deep Dive Into Proposed Regulations

Note that regulations are only proposed

Comments were due by 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 2024

- If they arrive much later, 1/1/2025 not likely effective date

Deep Dive Into Proposed Regulations

- Preamble of proposed regulations reveals that the 0% success rate of the industry has not improved much in the 18 months since that first report
- The regulators “found nearly all plans or issuers audited for MHPAEA compliance could not demonstrate compliance”
- “This noncompliance is especially evident with respect to the design and application of NQTLs”
- “Plans and issuers continue to fall short”
- So, industry wanted more guidance – and we got it…

Deep Dive Into Proposed Regulations

Main changes in proposed regulations:

(1) Plans would be required to collect and evaluate outcomes data and take action to address material differences in access to MH/SUD compared to M/S benefits

- To have ANY NQTL, subject to a few exceptions (e.g., for generally recognized independent professional medical or clinical standards; or for fraud, waste or abuse), need data

Deep Dive Into Proposed Regulations

(2) Would codify requirement to conduct "meaningful" comparative analyses to measure impact of NQTLs

- Includes evaluating standards related to network composition, out-of-network reimbursement rates and prior authorization NQTLs

(3) "Meaningful benefits" must be provided in some situations

Deep Dive Into Proposed Regulations

(4) Provides examples, in general, including more examples of what limits are NQTLs

(5) Implement sunset provisions for self-funded, non-Federal governmental plans with respect to opt out provisions

Deep Dive Into Proposed Regulations

(6) Plans cannot impose a financial requirement or treatment limitation applicable only with respect to MH/SUD benefits and not to any M/S benefits

(7) In general, focus not just on “process”, but on “results” and data

Deep Dive Into Proposed Regulations

"[M]any initial responders seemed unprepared to submit their comparative analyses upon request"

"[S]ome plans did not complete or start a comparative analysis until after one was requested"

- Lesson: Agencies expect plan sponsors to work on it now—Not start when a request comes in

Clarifies that a request for documents is covered under ERISA Section 104 (30 day deadline)

Proposed Definitions: Action Step

Plan likely needs a chart for each NQTL, in various settings (*e.g.*, inpatient, in-network; inpatient, out-of-network; "hospital-based" and "outside of a hospital"?)

- Chart must have columns labeled "Strategies", "Processes", "Factors" and "Evidentiary Standards"

Plan (or TPA, PBM etc.) must explain how it applies each of those to that particular NQTL

Data to Support NQTLs

All of that is a lot of work. But it's similar to what many have seen from vendors with "template" MHPAEA documents

- But . . .

NEW: NQTLs generally require data to support them – no data, no NQTL!

- Language in plan/SPD is good but not sufficient
- Language in template MHPAEA NQTL analysis is good but not sufficient
- Need more. Will vendors provide it?

Data to Support NQTLs

Without relevant data and the new analysis being done, “plans and issuers would not be permitted to impose” the NQTL

- Burden of proof on plan – does that mean TPA?
- Preamble: Agencies believes “Issuers and TPAs” are “the ones most likely, and the ones the Departments have overwhelmingly observed, performing the work to evaluate NQTLs and provide the comparative analysis and required data”
- TO DO: Plan sponsors and vendors should discuss / strategize approach

Data to Support NQTLs

NEW: Three step process to prove that data-based NQTLs are sufficiently justified

(1) NQTL is no more restrictive as applied to MH/SUD benefits than to M/S benefits

- NEW: This is called the “No More Restrictive Requirement”

(2) Plan satisfies requirements related to design and application of the NQTL

- NEW: This is called the “Design and Application Requirement”

Data to Support NQTLs

(3) (a) Plan collects, evaluates and considers the impact of relevant data on access to MH/SUD benefits relative to access to M/S benefits

- (3)(b) If there are “any material differences”, plan must take reasonable action as necessary to address the material differences
- NEW: This is called the “Relevant Data Evaluation Requirement”

All 3 must be met, generally, to impose an NQTL

(1) No More Restrictive Requirement— In Depth

NEW: Four-part test must be satisfied to demonstrate that the No More Restrictive Requirement is met (and, therefore, your plan meets part (1) of the (3)-part test so you can impose that particular NQTL)

(a) First, determine the portion of plan payments for M/S benefits expected to be subject to the NQTL for the plan year

- Will your TPA / PBM do this for you? Every year?

(1) No More Restrictive Requirement – In Depth

(b) Determine whether NQTL applies to "substantially all" M/S benefits in the classification

- Based on the plan payments for M/S benefits subject to an NQTL as a portion of the dollar amount of all plan payments for M/S benefits in classification expected to be paid under the plan for the plan year

(1) No More Restrictive Requirement

NQTL must apply to at least 2/3 of M/S benefits in order to be allowed

DOL notes concern that this data is not really tracked by TPAs

- They request comments on whether vendors “maintain systems capable of making such determinations and the potential administrative burdens” of gathering this data
- TO DO: Plan sponsors, discuss with vendors. Vendors, determine what you track/don’t track. Both: Discuss whether to wait until final regulations issued/push back through comment process

(1) No More Restrictive Requirement

(c) Plans must determine the “predominant variation” of the NQTL that is applied to substantially all M/S benefits

“Predominant” means the “most common or most frequent variation of an NQTL within a benefit classification”

(1) No More Restrictive Requirement

(d) NQTL applied to MH/SUD cannot be more "restrictive" than the predominant NQTL applied to "substantially all" M/S benefits in the same classification

- "Restrictive" means the NQTL imposes terms, conditions, or requirements that limit access to benefits under the terms of the plan or coverage

(1) No More Restrictive Requirement

Detailed example: Medical necessity determination is used under the plan for all inpatient, in-network benefits (M/S or MH/SUD). For all benefits in that classification, prior authorization is granted for 1 day, 3 days or 7 days

- Similar numbers as the concurrent review NQTL on prior slides

(1) No More Restrictive Requirement

For M/S benefits, approval for 7 days is the most common number. For MH/SUD, 1 day is the most common number of days approved as medically necessary

- After time period is over, plan requires a treatment plan

Time periods (7 days v. 1 day) are not the result of independent professional medical or clinical standards

- Or standards used to detect or prevent fraud, waste or abuse
- These are two “exceptions” which are now important

(1) No More Restrictive Requirement

Does the plan comply under the new regulations?

First, check if 2/3 test is met

- It is, as the medical necessity determination applies to 100% of the benefits in the classification

Second, identify the most common or frequent variation of the NQTL

- 7 days for M/S
- 1 day for MH/SUD

(1) No More Restrictive Requirement

1 day is more stringent than 7 days

Thus, the “predominant” NQTL is applied more stringently to MH/SUD benefits compared to M/S benefits

Thus, “the plan violates the rules” of MHPAEA

What must plan do?

Presumably plan must approve MH/SUD in that classification for 7 days; or limit M/S to 1 day

(1) No More Restrictive Requirement

That was only the FIRST test (i.e., test 1 of 3). The same NQTL must ALSO be run through the Design and Application Requirements (next slide) and the Relevant Data Evaluation Requirements (future slides)

And, again, you will want to document this step-by-step process

(2) Design and Application Requirements

Plan cannot impose an NQTL with respect to MH/SUD in a classification unless plan, as written and in operation, its processes, strategies, evidentiary standards and other factors used in designing and applying the NQTL to MH/SUD benefits is “comparable to” and “applied no more stringently than”, factors with respect to M/S benefits

(2) Design and Application Requirements

How do we determine that?

Those factors, etc., must be “applied no more stringently” than those used with respect to “generally comparable” M/S benefits

Wait, what are “generally comparable” M/S benefits?

- Proposed regulations are unclear. It’s similar to current difficulty of MHPAEA regulations. Very unclear how to “match up” a MH benefit with a “comparable” M/S benefit
- So, new, proposed regulations still leave this legally ambiguous and fail to “fix” this issue

(2) Design and Application Requirements

While the regulations do not define this key term, they do add a different requirement

If any factor or evidentiary standard relies upon “information, evidence, sources or standards” which discriminate against MH/SUD benefits, then cannot use those factors or standards

(2) Design and Application Requirements

Information is “discriminatory” if it is “biased or not objective, in a manner that results in less favorable treatment” of MH/SUD

- Or, if the difference is “without legitimate justification”
- Or, if the information “is otherwise not objective”
- Or old, in some situations (*e.g.*, from when plan was not subject to MHPAEA)

“Independent professional medical or clinical standards” are in a “not discriminatory” safe harbor

Same is true for certain fraud, waste and abuse standards

TO DO: Sponsors will likely ask TPAs / PBMs if any source is “discriminatory”. TPAs / PBMs: analyze your sources

(3) Relevant Data Evaluation Requirements

To refresh your recollection, this is the 3rd requirement you must meet to impose an NQTL

Plan must "collect and evaluate relevant data in a manner reasonably designed to assess the impact" of the NQTLs on "access" to MH/SUD benefits

Not clear what this means; some references to state data sources

- If you identify a problem, need to address it

(3) Relevant Data Evaluation Requirements

Relevant data: Network composition standards

- In-network and out-of-network utilization rates (including data related to provider claim submissions); network adequacy metrics (including time and distance data, and data on providers accepting new patients); and provider reimbursement rates (including as compared to billed charges)
  - TPAs often have some of this data now, so perhaps it won't be too much additional work
  - But, minimum time and distance standards from 3rd party or Federal or State programs not necessarily sufficient (only a "helpful starting point")

(3) Relevant Data Evaluation Requirements

Agencies believe this is especially important with respect to provider networks

- Seek industry input on how to measure network parity
- They recognize “that there is no one set of metrics for determining the parity of networks”

Actions plans MUST take could include “authorizing greater compensation or other inducements” to bring more MH/SUD providers in-network

- That is, plans may need to pay MH/SUD providers more than what they do now . . . What is the cost impact of that?

Meaningful Benefits

- Regulations propose that if a plan provides any benefits for MH/SUD in any classification, plan must provide “meaningful benefits” for treatment for that condition or disorder in each classification
- Would prevent a plan from providing a range of M/S benefits, but “only one limited benefit” for MH/SUD

Fiduciary Certification

- For plans which are subject to ERISA, a plan fiduciary would be required to certify in writing that they reviewed the analysis
- Fiduciary would state whether they believe the plan is in compliance with the regulations
- This is a surprising requirement
- Puts lot of personal pressure on plan fiduciaries to ensure that everything is legally correct

Notice of Noncompliance

- Not new, exactly, but the regulations provide additional detail on how enrollees must be informed of plan noncompliance in some situations
- This would follow a situation where the regulator notified plan of noncompliance and plan failed to correct it in 45-day corrective action period
- Notice to enrollees must be stand-alone and provided in 7 calendar (not business) days

Technical Release

Technical Release discusses various information that plans (and plan vendors) may need to gather

Out-of-Network Utilization—*e.g.*, Utilization data from the two most recent calendar years

- *e.g.*, for plan year beginning 1/1/2026, use data from 2024 and 2025
- TPAs may want to be prepared to gather this data as of 1/1/2024, if they do not already

Technical Release

- Percentage of in-network providers actively submitting claims
- Time and distance standards
- Reimbursement rates
- Aggregate data collection

Technical Release

Agencies specifically say that plan sponsors of self-funded plans “would work with their TPAs and other service providers” to “obtain these data”

- TO DO: Consider updates to service agreements, to clarify that vendors will provide information needed by plan sponsor

Goal of agencies is to create “safe harbor”

MHPAEA Litigation

- MHPAEA litigation has been an active area
- August 2021: UHC agreed to pay $15 million to settle DOL lawsuit
- Wit v. United Behavioral Health case remains ongoing
- Many individual lawsuits related to denials, often denials of long-term stays in substance use disorder facilities

Practical Considerations

Practically speaking, the above likely means:

- No plan sponsor can do the analysis alone. TPAs and PBMs are the experts hired by the sponsor to make plan decisions
  - So, sponsors will put pressure on TPAs and PBMs to help
- Trying to determine compliance “in operation” means that sponsor / TPA / PBM cannot just look at plan document/SPD
  - Need to look at underlying processes and, assuming regulations are finalized as written, data

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

Someone needs to “crunch the numbers” (assuming the regulations are finalized as is)

Penalties can include lawsuits, court orders and possibly ERISA monetary relief and IRS penalties of $100 per day per individual

Practical Considerations

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

- Update / finalize / start 2021 analysis
- Probably wait until 2024 to see what final regulations say for that “piece”
- Update contracts with TPAs and PBMs? Clarify who will do these things?

Summary

- Identify “gaps” in both QTL and NQTL approaches
- Get 2021-based NQTL analysis going / finished
- Talk to TPAs and PBMs on what, if anything, they can provide
- Consider what you would need to do under 2023 proposed regulations

Presenter Information

John Barlament / Reinhart Boerner van Deuren / 414.298.8218 / jbarlament@reinhartlaw.com

“Group” analysis and cost-sharing available

Questions?

Questions

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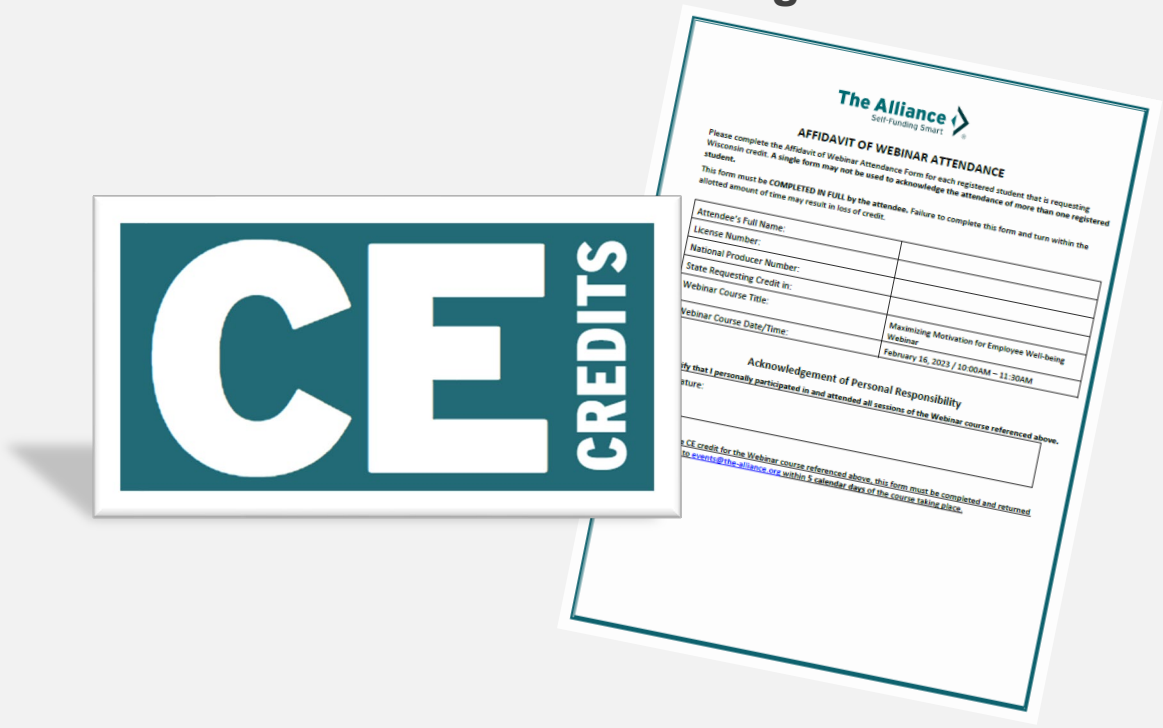

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Webinar | Tuesday, February 27 | 10:00am – 11:00am CT

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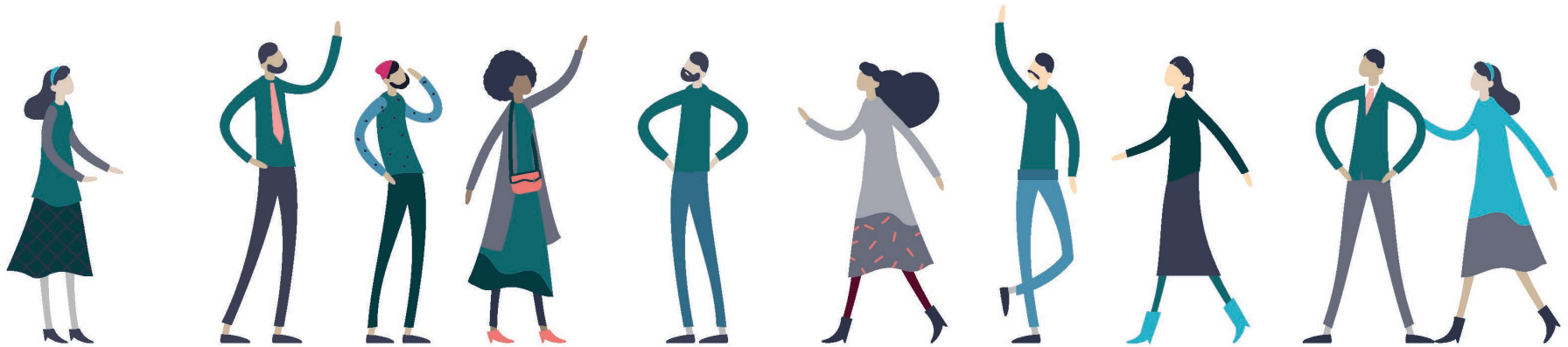

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