Mental Health Parity and Addiction Equity Act (MHPAEA)

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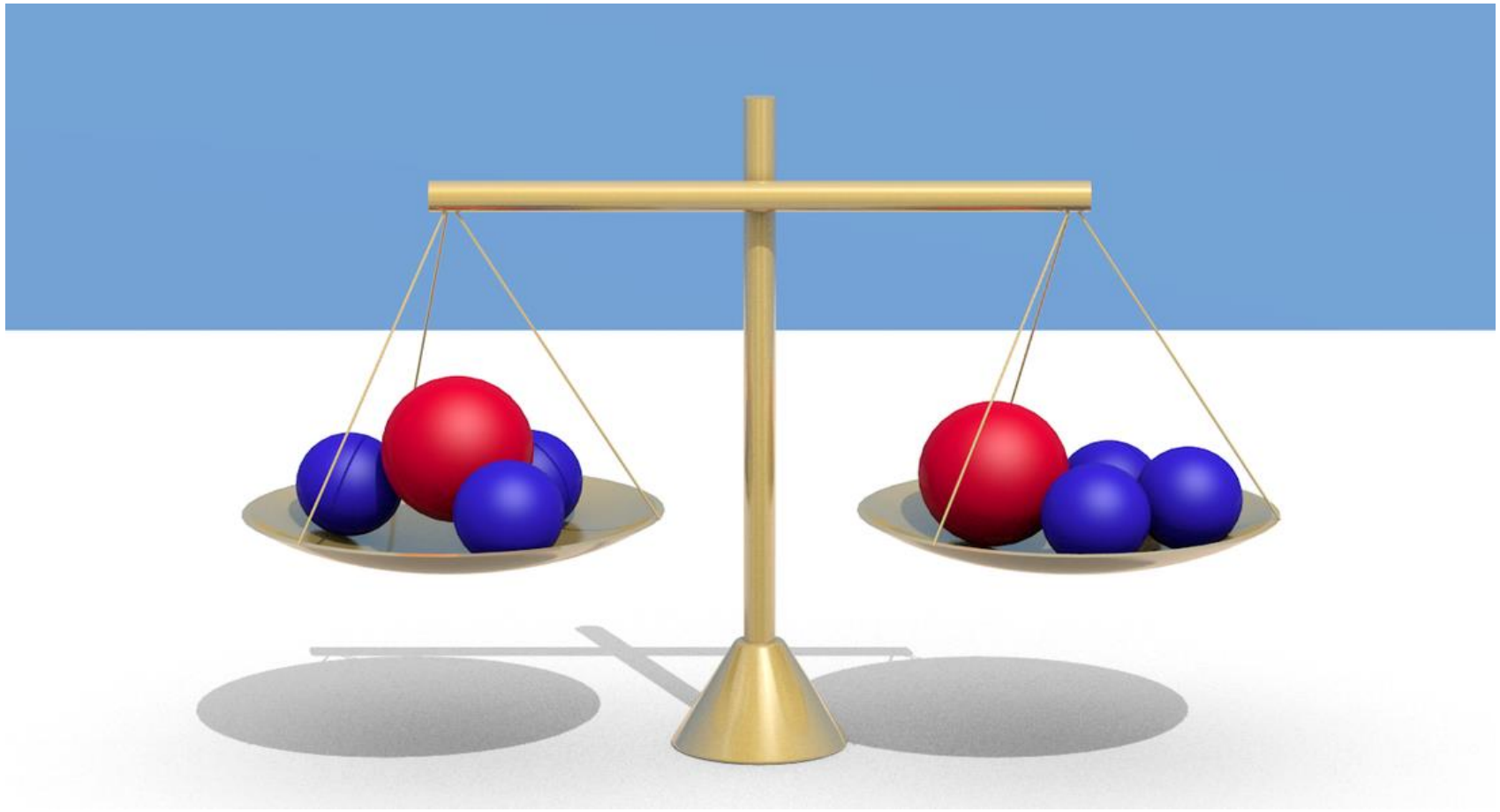
Agenda

- Comparative analysis required under the MHPAEA between MH/SUD and major medical benefits and the written report requirement.
- Best practices for responding to an agency request for MH/SUD and major medical comparative analysis and agency challenges to the information.
- The Department of Labor MHPAEA Compliance Tool that can be used to determine whether the MH/SUD benefits have parity with major medical benefits.
- Participant disclosure of parity information and delegating responsibility for disclosure to third parties.
- Enforcement actions and possible penalties for violations of the MHPAEA.

MHPAEA BACKGROUND



Mental Health Parity Regulation

- State laws beginning in the mid 1990s — over half of states have some form of parity law
- 1996 Federal Mental Health Parity Act:
  - Prohibit different annual and lifetime dollar limits
  - Did not extend to substance use
- 2008 Federal Mental Health Parity and Addictions Equity Act (MHPAEA):
  - Effective October 3, 2009
  - Regulations effective as policies renew on/after July 1, 2010
- 2010 Healthcare Reform Laws expand protections to a broader population in 2014
- 2016 21st Century Cures Act ensures additional guidance and clarification
- 2021 Consolidated Appropriations Act (CAA) adds new protections and comparative analysis documentation requirements

What Plans Does MHPAEA Cover?

- Most group health plans and insurers must comply
  - No exception for church plans or grandfathered plans
- Exceptions for
  - Excepted benefits
  - Retiree-only plans (fewer than two current employees)
  - Self-funded non-federal governmental plans (can opt out)
  - Small employers (generally 50 or fewer or state small group def) – Controlled Group Basis
    - ACA effectively limits exemption by including MH/SUD in EHB definition
- Combined Plan Approach
  - Cannot evade rules by moving MH/SUD into separate plan (e.g. EAP)
  - EAPs that are excepted benefits – not combined
  - No gatekeeper requirements allowed

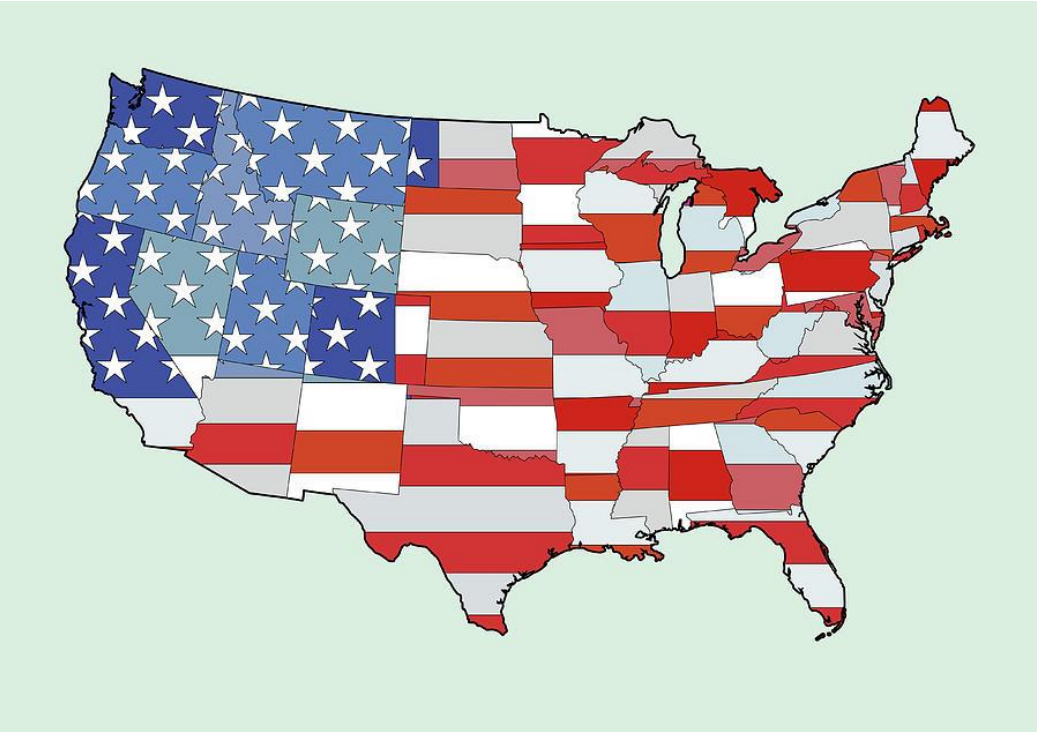
Limited Cost Exemption Available

- The law provides a possible increased cost exemption:
  - If cost is more than 2% greater in first year (generally, first plan year beginning after Oct. 3, 2009) due to parity, employer can request an exemption for the next year
  - If cost in subsequent year is 1% greater due to parity, employer can request an exemption for a further year
  - Plans applying for exemptions must show that cost increases are directly attributable to implementing the rules & maintain related documentation for 6 years

How Is Parity Analyzed?

- Coverage in All Classifications:
  - Covered plans that offer MH/SUD benefits must offer MH/SUD in 6 classifications in parity with M/S
- Requires equal application of plan terms/administration relating to:
  - Annual or lifetime limits – though generally prohibited now by ACA
  - Financial requirements (e.g., deductibles, coinsurance, co-payments)
  - Quantitative Treatment Limitations (QTL) (e.g., restrictions on the number of visits or days of coverage, annual, lifetime limits)
  - Non-Quantitative Treatment Limitations (NQTL) (e.g. application of medical management techniques)
- Stricter State laws may apply for fully-insured plans

Who Oversees MHPAEA Compliance?



- The Agencies of Labor, the Treasury, and Health and Human Services (HHS) (collectively, the Agencies), administer MHPAEA together with the States
- DOL/EBSA and IRS generally enforce requirements for employer group health plans
- States generally enforce requirements for health insurance issuers
- HHS ensures State enforcement and has direct authority over non-Federal governmental plans

Enforcement

- An interagency task force was established to identify and promote best practices for federal and state agencies to better ensure compliance with requirements related to MH/SUD parity (DOL, HHS, IRS, and others)
  - 21st Century Cures Act requires the agencies to audit plans and insurers that have violated the parity rules at least five times
- ERISA has no specific penalty or enforcement rule for violations of the MHPA/MHPAEA; but participants, beneficiaries, and the DOL may use ERISA's civil enforcement provisions to file lawsuits to enforce CAAs' requirements
  - Such a lawsuit could include claims for breach of fiduciary duty, for payment of mental health benefits alleged to be due under the plan, attorney's fees, etc.
- IRS may impose excise taxes for a group health plan's failure to comply with the MHPA/MHPAEA's requirements
  - $100 per day for each individual to whom a failure relates
  - The IRS excise tax regulations provide that persons liable for an excise tax for failure to satisfy the requirements of Code §4980D (regarding mental health parity) must file IRS Form 8928

What Disclosures are Required?

- Reasons for denials of MH/SUD claims must be provided
- Criteria for medical necessity must be provided upon request
  - 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 of request
- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under an ERISA plan are being provided on par with M/S (must furnish within 30 days)
  - DOL provides model form for participants to use to request info concerning treatment limitations or denials
- GHPs may need to work with insurance issuers or TPAs to ensure that participants and beneficiaries are being provided any documents and information to which they are entitled
  - $110 per day penalty for failure to provide required documents upon request

What Disclosures are Required?

DOL Model Form: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf

Participants can use this form to request:

- **General information** about treatment limitations, preauthorization policies for both M/S and MH/SUD.
- **Specific information** about why benefits were denied.

Provides requests for:

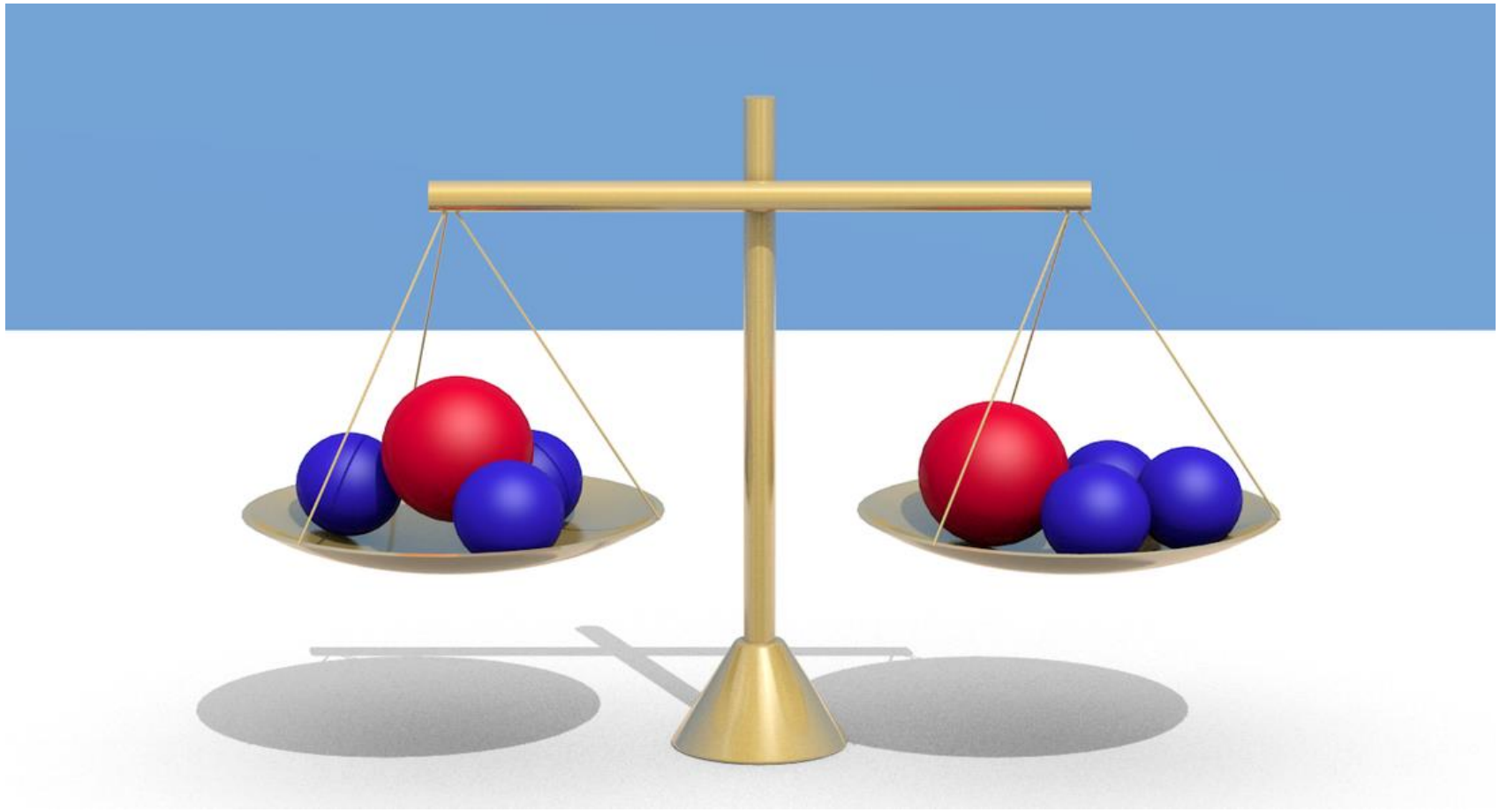
- specific plan language regarding the limitation(s) and identify the M/S and MH/SUD benefits to which it applies in the relevant benefit classification

- factors used in the development of the limitation(s) (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment)

What Disclosures are Required?

- sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above. Examples of evidentiary standards include, but are not limited to, the following:
  - Excessive utilization as defined by two standard deviations above average utilization per episode of care;
  - Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
  - High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and
  - Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish that a treatment is not experimental or investigative;
- methods and analysis used in the development of the limitation(s)
- evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits

MHPAEA BACKGROUND
Coverage in all Classifications



Coverage in All Classifications

- If offer MH/SUD benefits in any classification below, must offer in all classifications:*
  - In Network Inpatient
  - In Network Outpatient
  - Out of Network Inpatient
  - Out of Network Outpatient
  - Emergency Services
  - Prescription Drug

* *Exception if limited only to ACA mandated preventive care for MH/SUD*

Coverage in All Classifications

Parity must be met for each category and any applicable sub-classification

- Illustration: Plan covers M/S benefits in all benefit classifications, but excludes outpatient services for MH/SUD – Plan violates MHPAEA
  - May only have sub-classifications when allowed by regs
    - E.g. must compare all in-network outpatient – can't create subclassifications for primary care vs. specialists

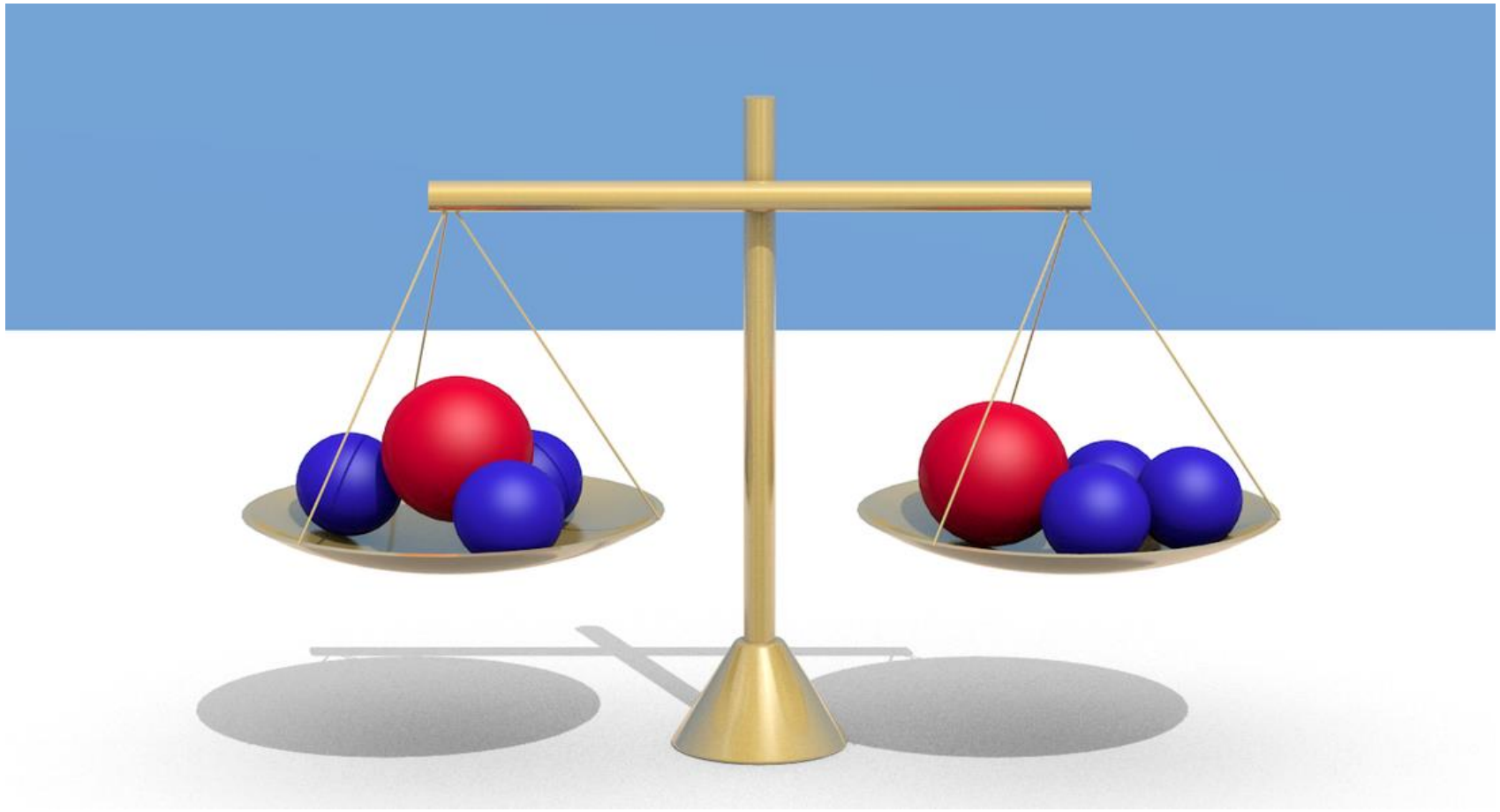
Coverage in Classifications

- Special rule for outpatient – can create sub-classifications comparing:
  - (1) office visits and
  - (2) all other outpatient items and services
- Intermediate Services must be reasonable and consistent
  - (e.g. if classify skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then residential treatment is inpatient. If classify home health care as outpatient benefit, then any covered intensive outpatient MH/SUD disorder services and partial hospitalization must be considered outpatient benefits as well)

Coverage in All Classifications

- Special rule for prescription drug benefits:
  - Can have tiered Rx benefits if can show that the different financial levels are reasonable and established without regard to whether a drug is generally prescribed for M/S or MH/SUD benefits
    - Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up
- Special rule for multiple network tiers

MHPAEA BACKGROUND
Financial Limitations and QTLs



Financial Limitations and QTLs

- Prohibits application of more restrictive financial requirements or QTLs to MH/SUD
- No separate cost-sharing requirements only for MH/SUD
  - E.g. no separate, but equal deductibles
- Must compare benefits within the 6 separate coverage classifications
  - Apples to apples

Financial Limitations and QTLs

Plan offering M/S and MH/SUD may not apply any financial requirement or QTL to MH/SUD benefits in any "classification" that is more restrictive than the "predominant financial requirement" or "treatment limitation" of that type applied to "substantially all" M/S benefits in the same classification.

*A financial/QTL requirement is **"predominant"** if it applies to more than one-half of M/S benefits in a classification*

*A financial requirement or treatment limitation is considered to apply to **"substantially all"** M/S benefits if it applies to two-thirds or more of the M/S benefits for the same classification and coverage unit.*

The determination is based on the dollar amount of all plan payments for M/S benefits expected to be paid for the year

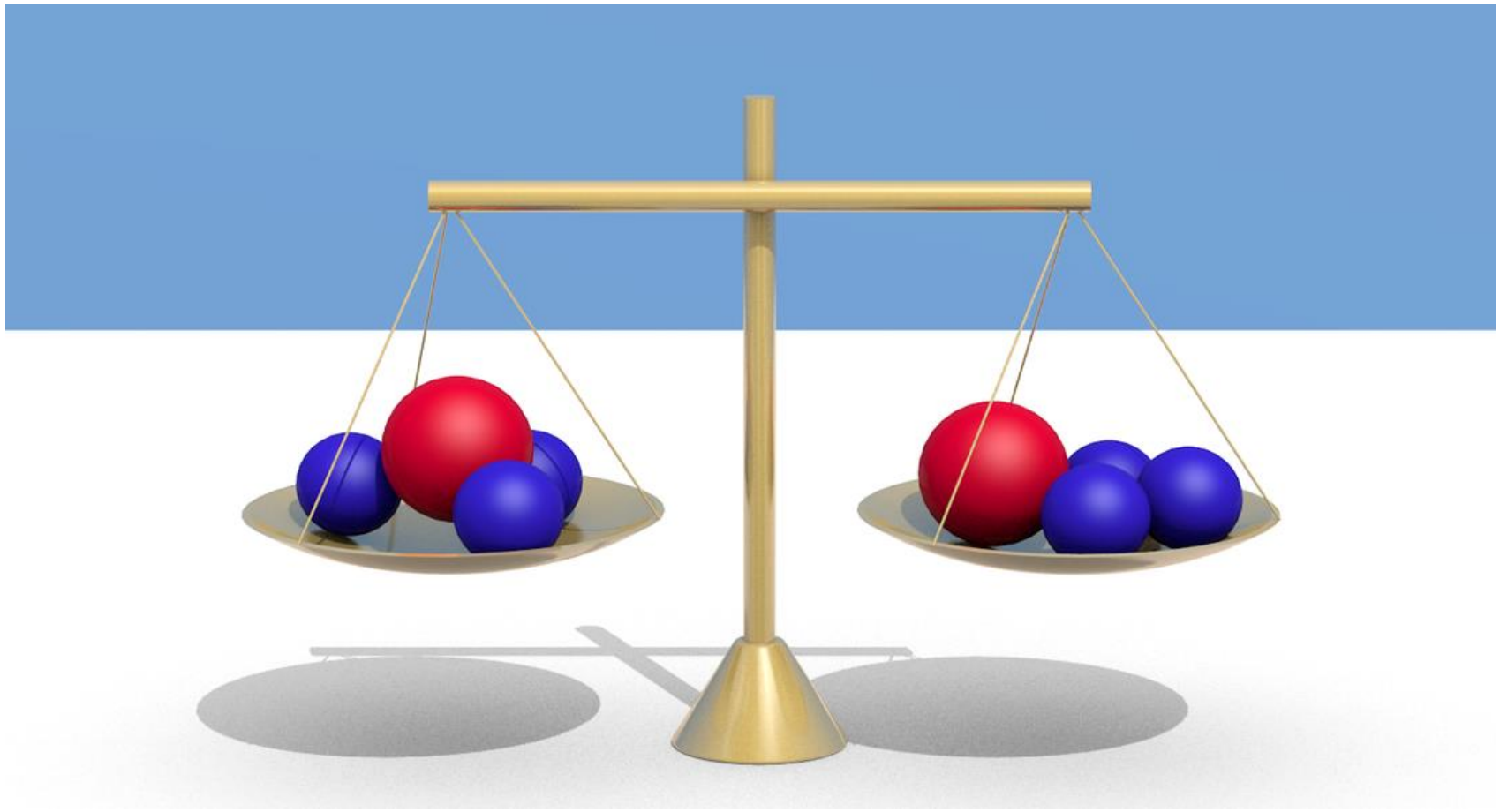
Financial Limitations and QTLs

- Illustration: Plan Z requires copayments for outpatient, in-network MH/SUD benefits. To determine if the plan meets the parity requirements:
  - STEP ONE: Determine if copayments apply to 2/3 of M/S benefits in the relevant classification (substantially all test)
    - Based on its prior claims experience, Plan Z expects $1 million in M/S benefits to be paid in the outpatient, in-network classification and $700,000 of those benefits are expected to be subject to copayments. Because the amount of M/S benefits expected to be subject to a copayment, which is $700,000, is at least 2/3 of the $1 million total M/S benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits

Financial Requirements & QTLs

- STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than 1/2 the M/S benefits subject to the financial requirement in the relevant classification)
  - Out of the $700,000 in M/S claims subject to copays, Plan Z expects that 25% will be subject to a $15 copayment and 75% will be subject to a $30 copayment. Since 75% is more than half, the $30 copayment is the predominant level
- THUS: Plan Z cannot impose a copayment to MH/SUD benefits in this classification that is higher than $30

MHPAEA BACKGROUND
Non-Quantitative Treatment Limitations



Non-Quantitative Treatment Limitations

- A NQTL is generally a limitation on the scope or duration of benefits for treatment that is unrelated to a dollar or numerical limitation

- MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage **as written and in operation**, 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 limitation with respect to M/S benefits in the same classification

Illustrations of Non-Quantitative Treatment Limitations

- Agency Examples of NQTLs:
  - Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
  - Formulary design for prescription drugs;
  - Standards for provider admission to participate in a network, including reimbursement rates;
  - Plan methods for determining usual, customary, and reasonable charges;
  - Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
  - Exclusions based on failure to complete a course of treatment;
  - Standards for access to out-of-network providers
  - Network tier design, for plans with multiple network tiers (such as preferred providers and participating providers); and
  - Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan

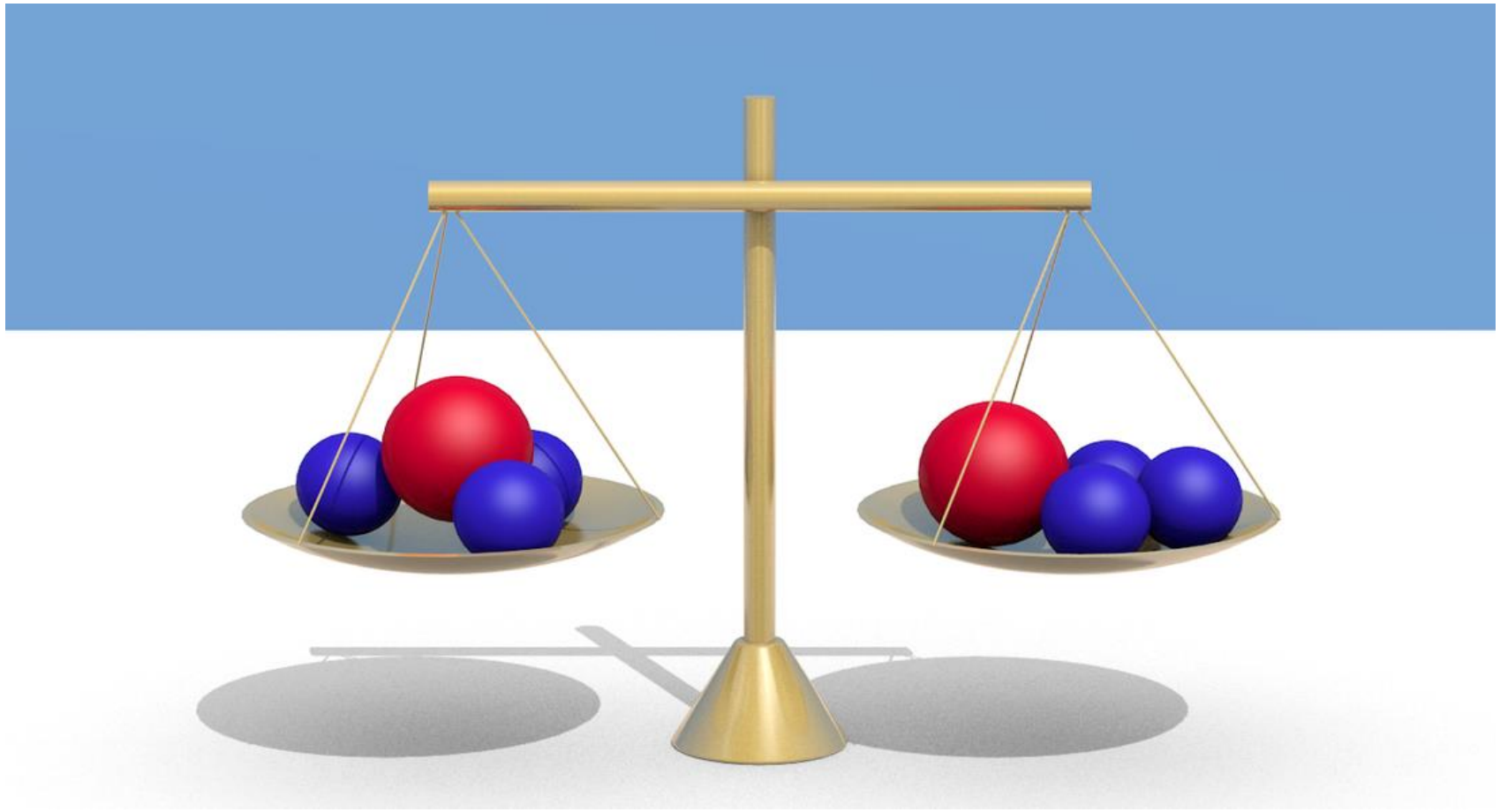
Non-Compliant Non-Quantitative Treatment Limitations

- Examples of NQTLs that do not comply with parity laws:
  - Penalty for failure to obtain prior approval for MH/SUD treatment
  - Exclusion of all anti-depressant prescription drugs with “black box” warning
  - Requirement for prior authorization for MH/SUD benefits
  - Requirement for in-person utilization-review for MH/SUD benefits
  - “Fail-First” requirement for inpatient treatment of SUD due to lack of geographical access
  - Exclusion of all court-ordered treatment for substance use disorder benefits
  - Developmental disability exclusion limitation

Enforcement Focus NQTLs

- 2021 focus of DOL:
  - 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 in-network, including reimbursement rates
  - Out-of-network reimbursement rates, including plan methods for determining usual, customary, and reasonable charges

Consolidated Appropriations Act, 2021 Updates



CAA Overview

- The Consolidated Appropriations Act, 2021 (CAA):
  - provides additional funding for mental health and substance abuse services
  - imposes public reporting requirements on DOL/IRS/HHS regarding compliance of group health plans and insurers with NQTLs
  - expressly requires group health plans and health insurance issuers offering group or individual health insurance coverage that offer both M/S benefits and MH/SUD benefits and that impose NQTLs on MH/SUD benefits to perform and document a comparative analyses of the design and application of NQTLs
  - beginning 45 days after the date of enactment of the CAA, the comparative analyses available to the Agencies or applicable State authorities, upon request
  - Requires Agencies to create a complaint process for MHPAEA violations

Comparative Analysis

The comparative analysis must contain the following:

i. The specific plan terms or other relevant terms regarding the NQTLs and a description of all MH or SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;

ii. The factors used to determine that the NQTLs will apply to MH or SUD or substance use disorder benefits and medical or surgical benefits;

iii. The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits;

iv. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification; and

v. A disclosure of the specific findings and conclusions reached by the group health plan, including any results of the analyses described in the above, that indicate that the plan is or is not in compliance with the MHPAEA.

When is the Comparative Analysis due?

FEBRUARY 10, 2021

- Accordingly, plans and issuers should now be prepared to make their comparative analyses available upon request.
- The Agencies must request comparative analyses from plans with potential violations or complaints regarding non-compliance, or other circumstances as determined appropriate by the Agencies or State.
- Agencies will be required to request no fewer than 20 of these comparative analyses per year.

Requests by States and Participants

- For plans subject to ERISA and the ACA claims procedures, the Agencies take the view that ERISA plan participants, beneficiaries, and their authorized representatives are entitled to:
  - Comparative information on medical necessity criteria for M/S and MH/SUD benefits.
  - The process, strategies, evidentiary standards, and other factors used to apply NQTLs concerning M/S and MH/SUD benefits.
- This means that any comparative analyses performed under the plan and other applicable information under the CAA must be made available to participants and beneficiaries on request.
- Plans and health insurers also must make available their comparative analyses and related information to state authorities on request.

Next Steps

- Fully-Insured: confirm your carrier is in compliance with the CAA's comparative analysis requirements
- Self-Insured: coordinate with TPA to ensure that comparative analyses in compliance with CAA are being conducted in a sufficient manner (e.g. no refusal to provide analyses based on proprietary data)
- Review contract language to properly delegate responsibility for future preparation of comparative analysis and compliance with participant/State disclosure requests
- If TPA refuses to prepare comparative analysis, take steps to demonstrate good faith attempt at compliance using DOL guidelines in Self-Compliance Tool and FAQ, Part 45 https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
- Follow MHPAEA lawsuits and enforcement efforts to stay apprised of new developments

Preparing the Comparative Analysis Self-Compliance Tool

- Comparative analysis must be specific, detailed, and reasoned -- a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient according to DOL
- DOL strongly encourages use of updated MHPAEA Self-Compliance Tool: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf
  - Includes robust guidance related to requirements for NQTLs and outlines a process for analyzing whether a particular NQTL meets those requirements
  - Includes potential warning signs that may be indicative of noncompliance and warrant further review
  - Outlines four steps that plans and issuers should take to assess their compliance with MHPAEA for NQTLs
  - For each step, the Self-Compliance Tool also identifies certain information to support the analysis and the conclusions reached about whether the plan or coverage complies with MHPAEA
  - The information outlined in each step closely aligns with the information required to be provided in the comparative analyses

Preparing the Comparative Analysis Self-Compliance Tool – 4 Step Process

- Step One: Identify the NQTL (plan documents, internal guidelines and provider contracts)
  - Analyze the NQTL under each classification based on which benefits are M/S and MH/SUD
- Step Two: Identify the factors considered in the design of the NQTL. Factors, include, but are not limited to:
  - 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; and
  - Current and projected demand for services.

Preparing the Comparative Analysis Self-Compliance Tool – 4 Step Process

- Step Three: Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL. Sources of factors include, but are not limited to:
  - Internal claims analysis;
  - Medical expert reviews;
  - State and federal requirements;
  - National accreditation standards;
  - Internal market and competitive analysis;
  - Medicare physician fee schedules; and
  - 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.
- Step Four: Confirm and demonstrate that any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and M/S services.

Preparing the Comparative Analysis Self-Compliance Tool – DOL Tips

- Look for MHPAEA compliance as written AND IN OPERATION.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and M/S benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and M/S benefits.
- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and M/S benefits.
- Document your comparative analysis – DOL clarifies in a recent FAQ that no longer a best practice as indicated in the Tool, it is mandated by CAA.

Per DOL "plans and issuers that have carefully applied the guidance in the Self-Compliance Tool should be in a strong position to comply with CAA comparative analysis requirement.

Preparing the Comparative Analysis DOL Guidelines in FAQ, Part 45 (2021)

At a minimum, sufficient comparative analyses must include a robust discussion of all elements listed below:

- A clear description of the specific NQTL, plan terms, and policies at issue.
- Clear statement identifying the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification.
- Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in the determination of which benefits are subject to the NQTL.
    - Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
- The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation.

Preparing the Comparative Analysis DOL Guidelines in FAQ, Part 45 (2021)

At a minimum, sufficient comparative analyses must include a robust discussion of all elements listed below:

- If the application of the NQTL turns on specific administrative decisions, the plan or issuer should identify
  - the nature of the decisions,
  - the decision maker(s),
  - the timing of the decisions, and
  - the qualifications of the decision maker(s).

- If the plan's or issuer's analyses rely upon any experts, the analyses should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and M/S benefits.

- A reasoned discussion of the plan's or insurer's findings/conclusions concerning the comparability of the above-referenced processes, strategies, evidentiary standards, factors, and sources for each classification—including their relative stringency (as written and applied). This topic should include:
  - citations to any specific evidence considered; and
  - any conclusions of an analysis indicating that the plan or coverage is (or is not) MHPAEA-compliant..

- The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses

Preparing the Comparative Analysis
What Not to Do

DOL has identified the following issues with many prior MHPAEA audits and requests for information.

- Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis
- Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations
- Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis
- Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice
- Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

Make sure your comparative analysis avoids these issues or DOL may reject it as insufficient.

Preparing the Comparative Analysis Supporting Documents

The 2020 MHPAEA Self- Compliance Tool highlights the following types of documents and relevant information that a plan or issuer should have available to support its NQTL comparative analyses.

- Records documenting NQTL processes and detailing how the NQTLs are being applied to both M/S and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under State law.

- Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to M/S benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support its rationale.

- Samples of covered and denied MH/SUD and M/S benefit claims.

- Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

The precise information needed to support an NQTL analysis will vary depending on the type of NQTL

Insufficient Information - Noncompliance

- If the Agency concludes that the group health plan has not submitted sufficient information for the Agency to review the comparative analyses, the Agency will then specify the information the plan must submit to be responsive.
- If the Agency concludes the group health plan is not in compliance, within 45 days of that finding, it will require the group health plan to provide the Agency an action plan to bring the plan into compliance, as well as additional comparative analyses.
- Following the 45-day corrective action period, if the Agency makes a final determination that the plan is still not in compliance, it will, not later than 7 days after such determination, notify all plan participants that the plan has been determined to not be in compliance with the NQTL requirements of the MHPAEA.
- The CAA also requires the applicable Agency to submit to Congress, and annually **make publicly available, a report that contains the identity of those group health plans and issuers that are not in compliance with the MHPAEA**
- The Agency is required to share information on its findings of compliance and noncompliance with the states where the group health plan and/or issuer is located.

Final Questions

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HRCI –

SHRM –

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Thank You

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