New Law Amends MHPAEA Requirements

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Agenda

- MHPAEA – Brief Overview
- Consolidated Appropriations Act, 2021 ("CAA") MHPAEA Requirements
- Federal Compliance Tools
- NQTL Complexity Challenges
- Behavorial Health System Challenges
- MHPAEA Misconceptions
- NAIC & MHPAEA

MHPAEA – Brief Overview

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MHPAEA – Brief Overview

- Benefits under MHPAEA are analyzed based on benefit classifications
- Financial requirements and quantitative treatment limits that apply to MH/SUD benefits must be "no more restrictive than the predominant financial requirements applied to substantially all M/S benefits covered by the plan"
- Nonquantitative treatment limitations (NQTLs) affect the scope or duration of benefits under the plan and are not expressed numerically
  - Any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to M/S benefits
- MHPAEA requires certain disclosures

Consolidated Appropriations Act, 2021 MHPAEA Requirements

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Consolidated Appropriations Act, 2021 MHPAEA Requirements

- Plans and issuers must perform and document comparative analyses of the design and application of NQTLs on MH/SUD and M/S benefits
  - Beginning February 10, 2021, (45 days after enactment) analyses must be made available to regulators, upon request
- Federal Agencies must request minimum of 20 analyses per year from plans and issuers with potential violations
  - If a plan is found to be non-compliant, the plan has 45 days to correct
  - If Secretary makes a final determination of non-compliance, plan or issuer must notify enrollees of noncompliance within 7 days
- Requires information-sharing with States which will support State enforcement efforts

Consolidated Appropriations Act, 2021 MHPAEA Requirements (cont.)

- Tri-agencies must issue compliance program guidance with examples of instances of compliance/noncompliance on disclosure requirements and NQTLs, and update every 2 years
- Tri-agencies must finalize any draft or interim guidance by 6/27/2022 (18 months after enactment), including a process and timeline for consumers to file complaints
- CAA requires notice and comment prior to issuing final guidance

Federal Compliance Tools

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Federal Compliance Tools

MHPAEA guidance is released jointly by three federal Agencies: DOL, HHS and the Treasury

- Regulations
  - Interim Final Regulation
  - Final Rule
- FAQs on MHPAEA/ACA Implementation (45+) (compliance-assistance-materials-index.pdf (dol.gov))
- Warning Signs: Plan or Policy NQTLs that Require Additional Analysis to Determine MHPAEA Compliance (MHAPEAChecklistWarningsignscleared.indd (dol.gov))
- Disclosure Guide: Mental Health and Substance Use Disorder Benefits (Disclosure Guide: Making the Most of Your Mental Health and Substance Use Disorder Benefits (dol.gov))

Federal Compliance Tools (cont.)

- DOL 2020 MHPAEA Self-Compliance Tool (Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov))
- Covers MHPAEA obligations
  - Question 1: Applicability (Whether the plan is subject to MHPAEA)
  - Question 2: Does the plan cover MH/SUD benefits?
  - Question 3: Does the plan cover MH/SUD benefits in every benefit classification that M/S benefits?
  - Question 4: Does the plan comply with MHPAEA regarding lifetime and annual dollar limits?
  - Question 5 and 6: Does the plan comply with MHPAEA's financial requirements and QTLs, including requirements regarding cumulative requirements and benefits?
  - Question 7: Does the plan comply with MHPAEA's NQTL requirements (4-step test)?
  - Question 8: Does the plan comply with MHPAEA's disclosure requirements?
  - Section on Internal Compliance Plans
  - Appendix I & II: Additional Examples and Provider Reimbursement Rate Warning Signs

NQTL Complexity Challenges

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NQTL Complexity Challenges

NQTLs are the most challenging compliance issue under MHPAEA

- NQTL compliance is required both as written and in operation
- NQTLs have posed the most challenges on how to apply the rule, for example:
  - Medical management standards – Under MHPAEA regulations, a difference in what benefits are subject to medical management (e.g., prior authorization) is NOT determinative of compliance, rather the process for determining what benefits are subject to medical management is what is important
  - Provider reimbursement practices - Under MHPAEA regulations, a difference in provider reimbursement rates is NOT determinative of compliance, rather the process for determining rates is what is important

Behavorial Health System Challenges

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Behavorial Health System Challenges

There are certain factors that are outside of the control of plans:

- Mental Health Workforce Shortages
  - Nationwide, nearly 30% of Americans are in a mental health provider shortage area, and less than 30% of the need for psychiatrists is being met
  - HRSA projects there will be a nationwide shortfall of over 12,500 adult psychiatrists and over 11,500 addiction counselors by the year 2030
  - 70% of counties in the U.S. have no practicing child psychiatrist

Source: https://data.hrsa.gov/topics/health-workforce/shortage-areas

Behavorial Health System Challenges (cont.)

- Provider Networks
  - High percentages of mental health specialists are out-of-network, opting not to participate in contracts with health plans for a multitude of reasons: administrative simplicity; preference for patients who can pay out of pocket
- Shortage of Licensed Inpatient Facilities to Treat Mental Health
  - An additional 123,300 psychiatric hospital beds are needed to adequately care for the mentally ill
- Quality measures and clinical and evidence-based treatment for behavioral health services

MHPAEA Misconceptions

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MHPAEA Misconceptions

- NQTLs must be the same for MH/SUD and M/S benefits
  - **MHPAEA does NOT require NQTLs to be the same**. It is the processes, strategies, evidentiary standards, and other factors used to determine and define those NQTLs that must be comparable, and no more stringent for MH/SUD benefits
- Outcomes are determinative of compliance
  - **Under MHPAEA, outcomes are NOT determinative of compliance**. Disparate results alone do not mean that the NQTL in use does not comply with MHPAEA
- All MH/SUD benefits must be provided
  - **MHPAEA does NOT require all MH/SUD benefits to be provided**

NAIC & MHPAEA

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NAIC Compliance Tool

- NAIC Market Conduct Handbook Section for Mental Health Parity
  - a general guidance document addressing mental health parity review, which includes a series of questions to be posed to health carriers by examiners; and
  - a regulator data collection tool for mental health parity analysis

MHPAEA – Looking Forward

- The new law requires plans to conduct and document NQTL comparative analyses and establishes a framework for enforcement, including information sharing with States
- The federal guidance required by the new law will
  - establish a uniform standard, and assist plans with MHPAEA compliance
  - be an important tool that can be used by States in reviewing for MHPAEA compliance

Appendix: MHPAEA Overview

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MHPAEA Overview

- Generally, MHPAEA requires most health plans (there are a few exceptions) to apply *comparable* rules to MH/SUD benefits as they do for M/S benefits
- Parity means that financial requirements (such as copayments, coinsurance, and deductibles) and QTLs (such as visit limits) must be comparable for M/S and MH/SUD services
- Parity also applies to NQTLs, or rules on how services are accessed and under what conditions services are covered (such as prior authorization requirements)

MHPAEA Overview: Benefit Classifications

- Benefits under MHPAEA are analyzed based on benefit classifications required by the rule:
  - Inpatient, in-network
    - Sub-classification for multiple network tiers
  - Inpatient, out-of-network
  - Outpatient, in-network
    - Sub-classification for office visits
    - Sub-classification for multiple network tiers
  - Outpatient, out-of-network
    - Sub-classification for office visits
  - Emergency care
  - Prescription drug

MHPAEA Overview: Financial Requirements and QTLs

- MHPAEA requires that financial requirements that apply to MH/SUD benefits be "no more restrictive than the predominant financial requirements applied to substantially all M/S benefits covered by the plan"
  - Financial requirements include deductibles, copayments, coinsurance and out-of-pocket maximums
- MHPAEA also requires that QTLs are subject to the same predominant and substantially all test as financial requirements
  - QTLs are expressed numerically
  - Examples are day and visit limits
  - MH/SUD QTLs cannot accumulate separately from M/S QTLs

MHPAEA Overview: Non-quantitative Treatment Limits

- NQTLs are limitations that affect the scope or duration of benefits under the plan that are not expressed numerically
  - Any processes, strategies, evidentiary standards *or* other factors used in applying the NQTL to MH/SUD benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to M/S benefits in the same "classification"

MHPAEA Overview: Required Disclosure

- MHPAEA requires the following disclosures:
  - plan information on medical necessity criteria must be disclosed to contracting providers;
  - the reason for denial of a claim for MH/SUD services must be disclosed to the participant, or the participant's authorized representative (including authorized providers); and
  - information on medical necessity criteria for MH/SUD benefits (and processes, strategies, evidentiary standards, and other factors used to apply non-quantitative treatment limits) are considered plan documents under which the plan is "established or operated" that must be furnished to plan participants under section 104 of ERISA

MHPAEA Overview – Federal and State Enforcement

- MHPAEA may be enforced by both public and private parties
- *Public Enforcement* (Federal and State)
  - State Insurance regulators (against issuers)
  - HHS (against issuers and nonfederal governmental plans)
  - DOL (against group health plans)
  - IRS (against group health plans and church plans)
- *Private Litigation*
  - Class actions by individual and group policyholder subscribers
  - Individual lawsuits by individual and group policyholders (including employers as plan fiduciaries)
  - Associations of providers and advocacy groups

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