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MHPAEA (B) Working Group
Conference Call
March 9, 2020

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call March 9, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Mel Heaps (AR); Catherine O'Neil (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Howard Liebers (DC); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie (IL); Julie Holmes (KS); Erica Bailey (MD); Sherri Mortensen-Brown and Peter Brickwedde (MN); Jeannie Keller (MT); Rosemary Gillespie (NC); Chrystal Bartuska and Sara Gerving (ND); Maureen Belanger (NH); Gale Simon (NJ); Paige Duhamel (NM); Marie Ganim (RI); Shari Miles and Kendell Buchanan (SC); Jill Kruger (SD); Rachel Bowden (TX); Tanji Northrup (UT); Yolanda Tennyson (VA); Jane Beyer (WA); Barbara Belling (WI); Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Tashia Sizemore (OR).

1. Discussed the Working Group's 2020 Activities

Ms. Dzurec said the purpose of the Working Group's conference call is to discuss how the Working Group plans to proceed with its work and how it will operate moving forward. She said she anticipates the Working Group operating similarly to the ERISA (B) Working Group. The Working Group's main activity will be to review and develop tools for the states to use with respect to plan compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Ms. Dzurec requested suggestions from Working Group members and other stakeholders on what they believe the Working Group should focus on short-term and long-term consistent with the Working Group's 2020 charges.

Ms. Dzurec described some of the tools and resources currently available to the states to assist in MHPAEA plan compliance, including the U.S. Department of Labor's (DOL's) MHPAEA self-compliance tool and the MHPAEA chapter in the NAIC *Market Regulation Handbook*. She explained that the MHPAEA is not a mandate, but if a plan covers mental health and substance use disorder (MH/SUD) benefits, then the plan is prohibited from imposing limitations on such benefits that are less favorable than the limitations imposed on medical/surgical (M/S) benefits. She said that to determine plan compliance with this parity requirement, state insurance regulators are required to conduct a comparability analysis both at inception and in-operation.

Andrew Sperling (National Alliance on Mental Illness—NAMI) expressed support for the Working Group's appointment and its 2020 anticipated work. Tim Clement (American Psychiatric Association—APA) also expressed support for the Working Group's 2020 work, particularly its anticipated work related to in-operation plan parity compliance.

Ms. Dzurec requested comments on issues the states have encountered with plan parity compliance. Ms. Sizemore said Oregon has been having problems with third-party administrators (TPAs) not disclosing their underlying algorithms to support their assertions of parity and compliance with the MHPAEA. Health Insurance Commissioner Ganim said the Rhode Island Office of the Health Insurance Commissioner (OHIC) recently completed three market conduct examinations related to behavioral health coverage. She also said that state departments of insurance (DOIs) welcome input from providers related to parity issues they have encountered with plans. Ms. Dzurec agreed. She said the Working Group might want to consider developing some best practices for ways providers can provide such information to DOIs in such a manner that it is not burdensome to providers. Daniel Blaney-Koen (American Medical Association—AMA) expressed support for any efforts the Working Group undertakes related to provider reporting of plan parity compliance issues.

Ms. Bailey said there is a bill currently pending in the Maryland Legislature to establish reporting requirements related to non-quantitative treatment limits (NQTLs) and associated data. She suggested that the Working Group might want to consider developing best practices related to such reporting requirements. Several Working Group members noted passage of or consideration of legislation like Maryland's pending legislation, and they expressed support for the Working Group's efforts to develop resources for the states in this area as Ms. Bailey suggests. Mr. Clement said he would provide the Working Group with a copy of the APA's tracking of such legislation. Uma Dua (Dua Enterprises, Limited) suggested that the Working Group include a review of pharmacy benefits, particularly concerning pharmacy NQTLs and Pharmacy & Therapeutic (P&T) Committee actions in this area. Jeffrey M. Klein (McIntyre & Lemon) said the American Bankers Association's (ABA's) Health Savings Account (HSA) Council has been tracking state legislation related to behavioral services, and he warned the Working Group about potential compliance issues with high deductible health plans (HDHPs) and first dollar coverage for such services. Kris Hathaway (America's Health Insurance Plans—AHIP) expressed support for the Working Group's potential

 

work to develop best practices related to what data elements are most helpful to state insurance regulators to determine NQTL plan compliance.

Ms. Dzurec outlined the Working Group's potential short-term goals for further discussion during the Working Group's meeting at the Spring National Meeting. She volunteered to develop basic assumptions for the Working Group to use as it moves forward. She said the Pennsylvania DOI created an automated tool for the testing of quantitative treatment limits (QTLs) that she will share for discussion as another potential resource for the states in their analysis to determine plan parity compliance. Ms. Cheevers expressed support for having a uniform QTL tool for use among the states. Ms. Dzurec agreed, but reminded Working Group members that the intent is for the Working Group to develop resources and tools as an option for the states to use to supplement what they are already doing.

Ms. Dzurec said another short-term goal for the Working Group is to develop an NQTL process for the states to use when conducting their analyses to determine what red flags to look for, how to find them, what to do, and what questions to ask when a state finds them. She explained that the Working Group's options are limitless in this area, and she suggested that the Working Group select a few NQTLs to start with that are already under review and look for best practices. She said she anticipated each NQTL would be a separate document. She suggested the following NQTLs to review first: 1) reimbursement for MH/SUD providers; 2) fraud, waste and abuse actions that have resulted in NQTLs, such as substance use disorder laboratory work; 3) pharmacy; and 4) soft caps; i.e. not actual visit limits. Working Group members expressed support for Ms. Dzurec's suggested Working Group short-term goals. Ms. Sizemore said Oregon has been doing some work related to MH/SUD NQTL provider reimbursement that she would be happy to share with the Working Group when it is complete in a few months.

Having no further business, the MHPAEA (B) Working Group adjourned.

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