AGENDA

1. Consider Adoption of its June 24 Minutes—Katie Dzurec (PA)

2. Hear a Discussion of Mental Health Parity (MHP) Compliance Work and Activities Involving Self-Funded Group Health Plans—Henry Harbin (TBD) and Beth Ann Middlebrook (B. Middlebrook Consulting LLC)

3. Hear a Discussion of State Legislative Trends and Activity in MHP Reporting—Tim Clement (American Psychiatric Association—APA)

4. Discuss the Currently Available MHP State Resources, How the States Can Leverage These Resources, and the Working Group’s Activities to Assist the States in Utilizing These Resources—Katie Dzurec (PA)
   - Quantitative Treatment Limitation (QTL) Template Current Version
   - Non-Quantitative Treatment Limitation (NQTL) Topics and Path Forward

5. Discuss Any Other Matters Brought Before the Working Group—Katie Dzurec (PA)

6. Adjournment
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Agenda Item #1

Consider Adoption of its June 24 Minutes—Katie Dzurec (PA)
The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met via conference call June 24, 2020. The following Working Group members participated: Katie Dzurec, Chair (PA); Jane Beyer, Vice Chair (WA); Mel Heaps (AR); Erin Klug (AZ); Sheirin Ghoddoucy (CA); Cara Cheevers (CO); Kurt Swan (CT); Sarah Crittenden (GA); Andria Seip (IA); Ryan Gillespie and Erica Weyhenmeyer (IL); Julie Holmes (KS); Erica Bailey (MD); Peter Brickwedde and Grace Arnold (MN); Jeannie Keller (MT); Ted Hamby (NC); Chrystal Bartuska and Sara Gerving (NJ); Gale Simon and Ralph Boeckman (NJ); Brittany O'Dell (NM); Laura Miller (OH); Shari Miles (SC); Jill Kruger (SD); Rachel Bowden (TX); Heidi Clausen and Jaakob Sundberg (UT); Brant Lyons (VA); Barbara Belling (WI); Tim Sigman and Joylynn Fix (WV); and Denise Burke (WY). Also participating was: Laura Arp (NE).

1. **Adopted its June 5 Minutes**

The Working Group met June 5 to review and discuss the draft quantitative treatment limitation (QTL) template and instructions.

Ms. Beyer made a motion, seconded by Mr. Swan, to adopt the Working Group’s June 5 minutes (Attachment 7-A). The motion passed unanimously.

2. **Heard an Update from the DOL on the Proposed 2020 MHPAEA Compliance Tool**

Amber Rivers (U.S. Department of Labor—DOL) said the DOL’s Employee Benefits Security Administration (EBSA) released a proposed 2020 self-compliance tool on June 19 intended to help improve compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and additional related requirements under the federal Employee Retirement Income Security Act (ERISA). The EBSA is requesting public comments on the self-compliance tool proposed revisions by July 24. Ms. Rivers said the proposed revisions update the current 2018 MHPAEA self-compliance tool. She said the proposed revisions generally fall into four categories: 1) integration of recent guidance; 2) revision of compliance examples; 3) best practices for establishing an internal compliance plan; and 4) warning signs. She said the DOL is hosting an MHPAEA listening event July 16 focusing on compliance issues. She urged Working Group members to attend.

3. **Discussed the June 18 Comments Received on the Draft QTL/FR Template and Instructions**

Ms. Dzurec said the Working Group received comments on the draft QTL and financial requirement (QTL/FR) template by the June 18 public comment deadline from the Association for Behavioral Health and Wellness (ABHW); America’s Health Insurance Plans (AHIP); the American Medical Association (AMA); the Blue Cross Blue Shield Association (BCBSA); the Health Coalition in a joint comment submission from Anthem Inc., Cigna, CVS Health, Health Care Service Corporation (HCSC), and UnitedHealthcare; The Kennedy Forum; the Legal Action Center (LAC); the National Association of Health Underwriters (NAHU); the NAIC consumer representatives; the Parity Implementation Coalition (PIC); the Virginia Insurance Bureau; and URAC. She said she reviewed each comment letter, and during her review, she found that the comments generally fell into the following issue categories: 1) addressing plan networks; 2) grouping services; 3) certificate of coverage and schedule of benefits (SOB) cross reference requirements; 4) a limitation on the number of plans per template; and 5) the addition of non-quantitative treatment limitation (NQTL) elements. She discussed how she planned to address some of these issues in the next draft of the QTL/FR template and instructions, including clarifying in the instructions how plans should account for networks, such as preferred and non-preferred networks; clarifying how plans may be able to group certain services together if the elements are the same; and making the certificate of coverage and SOB cross-references optional.

Ms. Dzurec said some commenters also requested clarification on the states’ use of the proposed QTL/FR template. She said Pennsylvania uses the template for market conduct examinations. However, she said the analysis needed to determine MHPAEA plan parity compliance is the same regardless of whether the template is used for form review or market conduct examinations. Kris Hathaway (AHIP) asked about the Working Group’s timeline for completing the template. She noted that the states have other tools and templates to use to determine MHPAEA mental health/substance use disorder (MH/SUD) parity compliance, such as the MHPAEA chapter and tool in the NAIC Market Regulation Handbook (Handbook). She also expressed concern with the time it will take for a plan to complete the proposed QTL/FR template. Randi Reichel (Health Coalition)
expressed support for Ms. Hathaway’s comments concerning the potential time needed for a plan to complete the proposed template. Ms. Reichel explained that plans are currently doing the analysis to comply with the MHPAEA MH/SUD parity requirements, but operationally the proposed template will require plans to manually input the required information, which could take a lot of time because it cannot be automated.

Ms. Arp discussed her work in developing the MHPAEA chapter and tool in the Handbook. She discussed how she envisioned the proposed QTL/FR template working with the MHPAEA chapter and tools and the merits of having such a template particularly for those states with limited resources to resolve red flags. Ms. Dzurec agreed that the states can use the draft QTL/FR template for that purpose and any other purpose a state feels is appropriate. She noted that she personally would like to use such a template at the beginning of any MHPAEA MH/SUD plan parity analysis because she has seen a lot of violations. She expressed concern that plans are not getting it right and consumers are being harmed.

Ms. Dzurec emphasized that consistent with the Working Group’s charge, the draft QTL/FR template is meant to be supplemental to existing compliance tools. It is not intended to replace any of these existing compliance tools, including the MHPAEA chapter in the Handbook. She asked for comments.

Tim Clement (American Psychiatric Association—APA) said he understands industry concerns. However, he does not believe the draft QTL/FR template is overly burdensome. John Troy (BCBSA) expressed support for AHIP’s and the Health Coalition’s comments regarding their operational concerns with the draft QTL/FR template and its potential to be administratively burdensome for plans to complete. Pamela Greenberg (ABHW) reiterated the ABHW’s concerns with the draft QTL/FR template outlined in its comment letter, including its use, the Working Group’s process, flexibility in its use, and benefit services classifications. David Lloyd (The Kennedy Forum) agreed with Ms. Dzurec’s comments concerning the errors that plans continue to make in their MHPAEA MH/SUD parity analyses and the impact of such errors on consumers.

Ms. Hathaway suggested that the draft QTL/FR template should be something the Market Regulation and Consumer Affairs (D) Committee should be involved in given the year-long project conducted by one of the Committee’s working groups with respect to developing the MHPAEA chapter and tool in the Handbook. Ms. Dzurec explained the Working Group’s next steps with respect to the draft QTL/FR template and the template’s connection with the MHPAEA chapter and tool in the Handbook. She said after the Working Group completes its work on the template, it will not be formally voted on by the Regulatory Framework (B) Task Force or the Health Insurance and Managed Care (B) Committee. She reiterated that, consistent with the Working Group’s charge, the template would be an additional resource the states can use, if they choose to do so, to determine MHPAEA MH/SUD plan parity compliance. The template would not supplant the MHPAEA chapter and tool in the Handbook. Ms. Dzurec said the draft template is just a deeper dive into the analysis required to determine MHPAEA plan parity compliance. She also explained that the template was never meant to be an NAIC supported or endorsed product. However, she cautioned that even it is not an NAIC supported or endorsed product, some states will still use it, and are currently using it, as part of their processes to determine MHPAEA plan parity compliance.

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Ms. Beyer said the MHPAEA is a complex law and the analysis necessary to determine MHPAEA plan parity compliance is complex as well. She said state insurance regulators feel that they have a responsibility to consumers to ensure that they have access to the services they need. Ms. Cheevers expressed support for Ms. Dzurec’s and Ms. Beyer’s comments with respect to the proposed QTL/FR template being an additional tool states can use to dig deeper, particularly when there are red flags.

Ms. Dzurec said within the next few weeks, she will revise the draft QTL/FR template and instructions based on the comments received requesting clarity in some areas. She reiterated that after the Working Group completes its work, it will report on its work to the Regulatory Framework (B) Task Force and the Health Insurance and Managed Care (B) Committee for informational purposes only. Currently, she said the Working Group does not foresee the template being an NAIC supported or endorsed product. However, if the Task Force or the Committee decides that it should be, then the Working Group would go back to the beginning and use the NAIC’s traditional process to work on it. Ms. Dzurec said after the Working Group completes its work on the QTL/FR template, it will begin work on the NQTL models determining what NQTL topics to include.

Having no further business, the MHPAEA (B) Working Group adjourned.
Agenda Item #2

Hear a Discussion of Mental Health Parity (MHP) Compliance Work and Activities Involving Self-Funded Group Health Plans—*Henry Harbin (Adviser to the Path Forward and former CEO of Magellan Health) and Beth Ann Middlebrook (B. Middlebrook Consulting LLC)*
Presentation for
2020 NAIC Virtual Summer
National Meeting

By The Bowman Family Foundation and its tax-exempt subsidiary,
The Mental Health Treatment and Research Institute LLC

Henry T. Harbin, M.D.
Advisor to
The Bowman Family Foundation

Beth Ann Middlebrook, J.D
Consultant to
The Mental Health Treatment and Research Institute
Mental Health & Substance Use: A Public Health Crisis

FIVE INTER-RELATED OPPORTUNITIES TO STEM THE TIDE OF ACCESS ISSUES

**A BROKEN SYSTEM**
- Phantom networks – difficult to get timely appointments
- Provider shortages, low participation rates
- Most mental health medications prescribed by primary care
- No accountability for quality of treatment
- Growing concerns and enforcement of mental health parity

**A REFORMED SYSTEM**
- Reverse declining network participation rates of mental health professionals
- Improve quality of care provided and patient outcomes
- Integrate behavioral health screening, coordination and referrals from primary care
- Reduce legacy mental health disparities and friction
- Supplement access and integration with virtual care

**Societal Impact**
- Suicide rates at record levels
- Opioid deaths up 400%
- Acceptance improving, access declining

**Workforce Impact**
- Direct impact on performance
- Leading cost of disability
- Multiplier effect on co-morbidities

The Path Forward for Mental Health and Substance executes a disciplined approach to affect market-driven change.
The Path Forward for Mental Health and Substance Use

The Path Forward is a 5 year initiative undertaken by its partners, National Alliance of Healthcare Purchaser Coalitions, American Psychiatric Association (APA), American Psychiatric Association Foundation (APAF) Center for Workplace Mental Health, The Bowman Family Foundation and Meadows Mental Health Policy Institute.

Employers overwhelmingly identify the need to improve access to effective, affordable, and timely behavioral healthcare as a top priority. Five evidence-based reforms can dramatically improve early detection and access to more effective behavioral healthcare. The Path Forward’s goal is implementation of these reforms:

1. **Improve in-network access to behavioral health specialists:** Inadequate or “phantom” networks lead to a false sense of access for lower paid workers and a two-tiered system.

2. **Expand screening and testing for MH/SUD:** Evidence clearly shows that consistent use of MH/SUD symptom measurement tools (quantitative assessments) improves outcomes by a remarkable 20% - 60%.

3. **Expand integration of behavioral health into primary care:** “Collaborative Care” (as defined in the CoCM reimbursement codes) is a proven and scalable solution that improves access and outcomes, and reduces costs, by integrating the support of psychiatrists (virtually) and MHSUD care managers into primary care settings – where the majority of people receive behavioral care.

4. **Improve tele-behavioral health:** Tele-behavioral health has grown dramatically since the onset of Covid-19 as barriers to implementation have been addressed overnight. These gains must be “locked in” while standards are established to support populations with disparate needs, capabilities, and access to technology.

5. **Ensure mental health parity compliance:** Evidence clearly shows the need to revamp those “non-quantitative treatment limitations” that create disparities in access and outcomes.
The Path Forward for Mental Health and Substance Use

**Network Access**
- Measurement-based care
- Collaborative care
- Mental health parity compliance
- Tele-behavioral health

**NATIONAL STEERING COMMITTEE**
- National Alliance of Health Care Purchaser Coalitions, American Psychiatric Association, American Psychiatric Association Foundation’s Center for Workplace Mental Health, The Bowman Family Foundation, and Meadows Mental Health Policy Institute

**LEAD**
- National Technical Resource Team
  - Education to national stakeholders (consultants, industry groups)
  - Advise and support coalitions
  - Website/tools/speakers bureau

**LEVERAGE**
- Eight RESET Regions Multi-Stakeholder Change Initiative
  - Establish regional baseline
  - Foster stakeholder plan
  - Project management/problem resolution

**LOCALIZE**
- 30 Non-RESET Coalitions Purchaser Engagement Initiative
  - Educate consultants/employers
  - Enlist purchaser “sign-on” to initiative
  - Execute 10 universal action steps

**BEHAVIORAL HEALTH SUPPLY CHAIN**
- Benefits Consultants
- Employers/Plan Sponsors
- Health Plans/Third Party Administrators
  - Pharmacy Benefit Mgrs
- Health Systems
  - Primary Care
  - MH/SUD Specialists

**RESET**
- Regional
- Employer
- Stakeholder
- Engagement
- Team
RESET Regions and Coalitions

- California – Pacific Business Group on Health and Silicon Valley Employers Forum
- Florida – Florida Alliance for Healthcare Value
- Kansas – Kansas Business Group on Health
- Maryland, DC and Northern VA – MidAtlantic Business Group on Health
- Minnesota – Minnesota Health Action Group
- NYC metro area including northern NJ and southern CT – Northeast Business Group on Health
- Tennessee – Memphis Business Group on Health and HealthCare 21 Business Coalition
- Texas – DFW Business Group on Health and Houston Business Coalition on Health

For More Information
https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward
Network Adequacy & Access to Care

eValue8 MH Deep Dive Data collected from 7 health plans in MN, CA, TN, CO, PA

% of in-network psychiatrists* with 0 to 4 unique claims in a calendar year:

- 1 health plan: >80% of psychiatrists
- 3 health plans: 60-80% of psychiatrists
- 1 health plan: 40-50% of psychiatrists
- 2 health plans: 20-30% of psychiatrists

*including child psychiatrists

eValue8 data showed the % of out-of-network claims was much higher for MH/SUD (median of 13.6% for office visits) than for medical/surgical (median of 5.1%), across office visits, outpatient facilities and inpatient care.

Health Plan provider directories and networks should accurately reflect professionals available for appointments.
Network Adequacy & Access to Care

Opportunities:

- Remove financial and administrative barriers:
  - Implement reimbursement strategies that reflect “supply and demand” realities
  - Implement reimbursement strategies that reward timely & high-quality care
  - Streamline credentialing process
  - Engage the provider community on strategies to reduce burdens and hassle factors

- Employers should use the MDRF to collect data on network adequacy & reimbursement.

- Health plans should be required to conduct satisfaction surveys for plan members that go out-of-network for MH & SUD care.

- Employers should request that health plans provide a detailed plan for improving networks, including setting targets for reducing OON care.

- Health plans should be required to reach out to psychiatrists, especially child psychiatrists, to join their networks.

- Track wait times for appointments.
Measurement of claims data from 37 million employees and their dependents from 2013-2017 reflect a stark and growing increase in disparities between physical and behavioral healthcare.

- **Out-of-network use:** disparities in out-of-network use between medical and behavioral health
  - Inpatient out-of-network for behavioral health worsened from 2.8 times (280%) more likely in 2013 to 5.2 times (520%) more likely in 2017—an **85% increase**.
  - Out-of-network disparities for **all levels of care worsened from 2013 to 2017**.
  - Out-of-network office visits for substance use care was **9.5 times (950%) more likely** than primary care office visits in 2017.
  - In 2017, a child’s Out-of-network office visit for behavioral healthcare was **10.1 times (over 1000%) more likely** than for out-of-network primary care office visits.
• Reimbursement rates: disparities in payment levels between medical and behavioral health providers

  • In 2017, primary care office visit reimbursement rates were on average **23.8% higher** than behavioral health office visit reimbursement rates compared to Medicare fee schedule amounts.

  • During the five-year period (2013-2017) average reimbursements remained **below Medicare allowed amounts**.

  • Disparities in substance use office visit reimbursement rates were lower than mental health.
Model Data Request Form

MHTARI has funded the development of the “Model Data Request Form” (“MDRF”) as a tool for the collection of key data on certain parity compliance and network access issues that may exist for MH/SUD health care.

The MDRF contains specific, detailed instructions and definitions developed to elicit targeted, consistent and reliable responses from plans on quantitative measures for determining outcomes disparities related to network adequacy and other NQTLs The MDRF requests data that measures the following:

1) Disparities in Out-of-Network Use for MH/SUD vs. medical/surgical
2) Disparities in Reimbursement Rates for MH/SUD vs. medical/surgical providers
3) Disparities in Denial Rates for MH/SUD vs. medical/surgical services
4) Accuracy of Network Provider Directories

The MDRF can be downloaded at: http://www.mhtari.org/
The **MDRF** has been tested and retested in multiple analyses including the national **Milliman Disparities Reports in 2017 and 2019** and the **National Alliance of Health Care Purchaser Coalitions audit of 8 large commercial health plans** which used several of the data analytics contained in the **MDRF**.

The **MDRF** has been **adopted by the eValue8 assessment tool** to measure network adequacy and access. Further, a number of national large private employers are using the MDRF with their third-party administrators to assess network provider access disparities and parity compliance. **URAC’s Parity Accreditation Standards** recognize and endorse the **MDRF** as a best practice.

Absent specific definitions and methodology for analysis incorporated in the **MDRF**, plans are simply not able to test or report disparities in outcomes in a consistent, reliable or meaningful manner.

**Washington State Office of Insurance Commissioner developed its Model Data Definitions and Methodology form (MDDM) utilizing the **MDRF** as its source document.**
Agenda Item #3

Hear a Discussion of State Legislative Trends and Activity in MHP Reporting
—Tim Clement (American Psychiatric Association—APA)
State Trends in MHPAEA Implementation

Tim Clement, MPH - Director of Legislative Development

July 28, 2020
State Legislative Action

- There have been significant and growing legislative efforts to improve MHPAEA compliance at the state level

- Virtually every piece of legislation has focused on nonquantitative treatment limitations (NQTLs)
  - Nearly all have featured stepwise NQTL compliance analyses for issuers to submit
  - PA Insurance Department has spreadsheet that is designed to collect the stepwise compliance analyses

- Some state legislation has required market conduct exams as well
States That Have Passed Legislation Since 2018 (all require stepwise analyses unless italicized)

- AZ: **SB 1523/HB 2764** (2020)
- CO: **HB 19-1269** (2019)
- CT: **HB 7125** (2019)
- DC: **B22-0597** (2018)
- DE: **SB 230** (2018)
- IL: **SB 1707** (2018)
- IN: **HB 1092** (2020)
- MD: **SB 334** (2020)
- NJ: **A 2031/S 1339** (2019)
- NY: **A 3694** (2018) (*issuers report data on denials, prior authorization, etc*)
- OK: **SB 1718** (2020)
- TN: **SB 2165** (2018)
- WV: **SB 291** (2020)
- VA: **SB 280** (2020) (*data about denials, prior authorization, out-of-network*)
States with Legislation Introduced/Pending This Year (All Require Stepwise NQTL Analyses)

- FL: HB 939/SB 706
- KY: HB 543
- MA: S 588/H 910 – This was folded into S 2546
- MI: HB 5617, 5618, 5619, 5620
- MO: HB 2137
- NH: SB 620
- OH: HB 443/SB 254
- PA: HB 1696
Be Prepared For Legislation

- Just this year 14 states introduced legislation, with 13 requiring stepwise analyses

- Make sure that you are ready for legislation that could be introduced

- *Make legislation work FOR you instead of putting more work ON you*

- Be ready with technical suggestions/amendments regarding:
  - Effective date
  - Reporting submission date
  - Defining terms
  - Specifying that NQTL reporting can be staggered and NQTLs reported on can be selected by department
  - Do you want QTL/FR reporting too?
Talk to Your Peers

- You can learn from other departments that are implementing, or have undertaken, significant MHPAEA activities
  - CO, CT, IL, KY, MA, MD, MN, MS, NC, NH, NJ, NY, OR, PA, RI, WA, TX
  - Others as well (apologies if I have missed you, the above are simply states I have worked with or have direct knowledge of work taking place)
Contact Information

- Tim Clement, Director of Legislative Development
  - tclement@psych.org
Agenda Item #4

Discuss the Currently Available MHP State Resources, How the States Can Leverage These Resources, and the Working Group’s Activities to Assist the States in Utilizing These Resources—Katie Dzurec (PA)

- Quantitative Treatment Limitation (QTL) Template Current Version
- Non-Quantitative Treatment Limitation (NQTL) Topics and Path Forward
Agenda Item #5

Discuss Any Other Matters Brought Before the Working Group—Katie Dzurec (PA)