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Mental Health Parity Update

What Must Plans Do Now?

April 28, 2022

Overview

Mental Health Parity Overview

Foundations for Compliance: MHPAEA, ACA, and the CAA

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Mental Health Parity Overview

Mental Health Parity Overview

What is Mental Health?

Mental health includes our emotional, psychological, and social well-being and affects how we think, feel, and act. Vital to our overall health, ensuring access to mental health and substance use disorder care is essential.

Mental Illness Prevalence

- In the US, more than 50% will be diagnosed with a mental illness or disorder at some point during their lifetime
- 52.9 million American adults (nearly 1 in 5), experienced a mental illness in 2020
- Estimated 40.3 million people 12 and older had a substance use disorder in 2020
- Over 27 million individuals experiencing a mental illness are going untreated

The Pandemic's Toll on Mental Health

Recent CDC data indicates that between Aug. 2020 and Feb. 2021 the percentage of adults exhibiting symptoms of anxiety or depressive disorder increased from 36.4% to 41.5%.

According to new CDC data (March 31, 2022), more than 37% of high school students reported poor mental health during the COVID-19 pandemic and 44% reported they persistently felt sad or hopeless during the past year.

According to the KFF COVID-19 Vaccine Monitor (April 6, 2022), 55% of parents say the pandemic had a negative impact on their children's mental health and 67% of young adults aged 18-29 report that the pandemic had a negative impact on their mental health, compared to 54% of 30-49 year-olds.

The Costs of Mental Health

A study from PharmacoEconomics found major depressive disorders (MDD) in 2018 affected 17.5 million adults at a total cost of $326 billion.

Costs include direct medical treatment for MDD, the costs of treating comorbidities, suicide-related costs, and workplace productivity impacts.

According to Paul Greenberg (study lead), for each dollar spent on direct costs of illness for medical expenses, an additional $2.30 went to indirect costs, including lost productivity at work, and another $5.61 went to various direct and indirect comorbidity costs.

On average (per year to manage their conditions), a patient with major depression spends $10,836, while a patient with diabetes taking insulin spends $4,800.

Mental Health Parity Overview

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

MHPAEA is a federal law that generally requires group health plans to provide coverage for mental health or substance abuse disorder (MH/SUD) benefits in parity with medical/surgical benefits.

MHPAEA imposes obligations on plans to ensure patients are not discriminated against in the way they receive benefits.

Specifically, MHPAEA prohibits coverage restrictions (i.e., higher copayments, fail first protocols, pre-certification requirements) that apply more stringently to MH/SUD benefits than for medical/surgical benefits.

Mental Health Parity Overview

MHPAEA Applicability

-fully insured plans

-self-funded plans

-grandfathered plans

-non-grandfathered plans

…that provide coverage for MH/SUD benefits

MHPAEA Exceptions, Exemptions, and HIPAA Opt-Outs*

-retiree only group health plans

-self-insured non-federal governmental plans*

-certain plans only offering excepted benefits

-small employers

-increased cost exemptions

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Mental Health Parity Overview

Group health plans must ensure the financial requirements and treatment limitations on MH/SUD benefits are no more restrictive than those on medical/surgical benefits (i.e., offered in parity). If MH/SUD benefits are provided in any benefit classification, they must be provided in every classification in which medical/surgical benefits are provided.

Parity is measured using the QTL test and NQTL test.

Examples of NQTLs	Examples of QTLs
Medical management (pre-certification, fail first protocols)	Number of visits
UCR, MAC, reimbursement calculations	Dollar limitations
Geographical or facility type limitations	Days of coverage

Foundations for Compliance: MHPAEA, ACA, and the CAA

Mental Health Parity Timeline

Sept. 1996:

Mental Health Parity Act (MHPA) signed into law

Oct. 2008:

MHPAEA signed into law

March 2010:

ACA signed into law; extended MHPAEA

April 2018/Oct. 2020:

DOL's EBSA released, and then updated, MHPAEA Self-Compliance Tool

Feb. 10, 2021:

MHPAEA provisions of CAA became effective ***Written NQTL now required!***

April 2021:

Tri-Agencies released FAQs to explain Comparative Analysis requirements added by CAA

Jan. 25, 2022:

Tri-Agencies released 2022 Annual Report to Congress

March 1, 2022:

President Biden's State of the Union addressed unprecedented mental health crisis

March 22, 2022:

Ninth Circuit reversed United Behavioral Health case

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MHPAEA, ACA, and the CAA

MHPAEA

- Requires employer plans provide coverage for MH/SUD benefits in parity with medical/surgical benefits

Affordable Care Act (ACA)

- Under the ACA, MH/SUD benefits are considered essential health benefits (EHBs); non-grandfathered plans must cover certain preventive services without cost-sharing (i.e., alcohol misuse screening and counseling, depression screening, tobacco cessation)

CAA

- Mandates employer plans offering medical/surgical and MH/SUD benefits provide written, documented comparative analyses and supporting documentation illustrating MHPAEA parity to the EBSA and DOL (in writing and operation)

MHPAEA, ACA, and the CAA

Pre-CAA

- MHPAEA did not specify how plans must demonstrate compliance
- Barrier for EBSA enforcement in ensuring individuals received MH/SUD benefits
- 39-page DOL Self-Compliance Tool

Post-CAA

- CAA did specify how plans must demonstrate compliance
- New enforcement authority for EBSA
- Plans must “perform and document” the comparative analysis and provide those analyses upon request

MHPAEA, ACA, and the CAA

The CAA formalized the guidance in place via the DOL's Self-Compliance Tool; converting a recommendation into a requirement.

Plans must "perform and document comparative analyses of the design and application" of NQTLs sufficient to demonstrate compliance with MHPAEA. 29 U.S.C. § 1185a(a)(8)(A)

The agencies will request a minimum of 20 analyses per year; plans must have the comparative analysis available upon request.

What changed?

- Enforcement (in practice and in operation)
- Parity is a priority and plans must **SHOW THEIR WORK*!***

The NQTL Comparative Analysis Specifications

The Specifications

The comparative analysis must be sufficiently specific, detailed, and reasoned to demonstrate whether the processes, evidentiary standards, or other factors used in developing and applying an NQTL are comparable and applied no more stringently to MH/SUD benefits than to medical/surgical benefits.

To be sufficient, the analysis – PER NQTL – must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue and include the bases for plan's conclusion the NQTL complies with MHPAEA.

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NQTL Design

Any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD benefits in a classification must be comparable to, and applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification.

An array of factors may be considered in designing NQTLs, including:

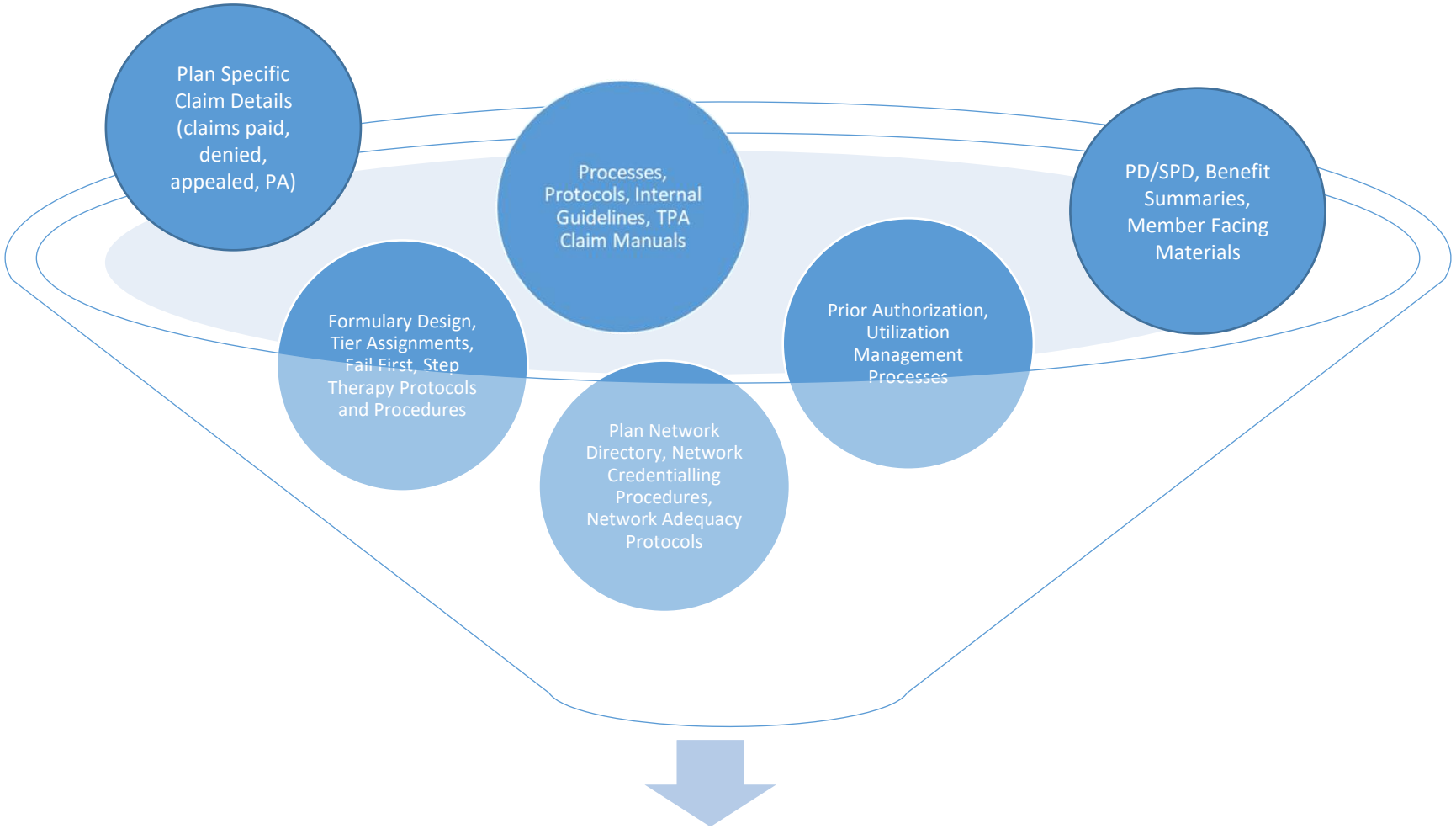
- Cost of treatment
- Variability in cost and quality
- Clinical efficacy
- Licensing and accreditation of providers
- Type or length of treatment

The NQTL Comparative Analysis Specifications

Illustrative List of NQTLs *(29 CFR 2590.712(c)(4)(ii))*

- Medical management standards (medical necessity, E/I)
- Formulary design for prescription drugs
- Network tier design
- Standards for provider admission to participate in network, reimbursement rates
- Methods for determining UCR
- Fail-first or step therapy protocols
- Exclusions for failing to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty or other criteria limiting the scope or duration of benefits

The NQTL Comparative Analysis Specifications



Non-Exhaustive List of Required Documentation

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The NQTL Comparative Analysis Specifications

Avoid	Include
Referring to factors or evidentiary standards defined or applied quantitatively without specific definitions, data and information to assess their development or application	A "reasoned discussion" of the findings and conclusions concerning the comparability of the processes, strategies, evidentiary standards, factors, and sources for each classification (as written and applied)
Identifying processes, strategies, sources, or factors without explaining how they were defined and applied in practice	Documentation relied upon in determining NQTLs apply no more stringently to MH/SUD than medical/surgical benefits
Submitting an outdated analysis (i.e., due to passage of time, change in plan structure, or another reason)	Description of each specific NQTL, plan term and policy
Producing large volume of documents without explanation or analysis	MHPAEA compliance information pertaining to service providers
Conclusory or generalized statements without detailed analysis	Samples of MH/SUD and medical/surgical claims that were covered and denied
	Date of the analysis, name, title, and position of person or persons who performed or participated in the comparative analysis

NQTL Checklist for CAA Compliance

- ❑ Confirm NQTL comparative analysis applicability
- ❑ Identify NQTLs applied to MH/SUD benefits
- ❑ Identify factors considered in the design of the NQTL

  Medical Management/Utilization Review: excessive utilization, lack of adherence to quality standards, claim types with high percentage of fraud, high variability in cost per episode of care

  Provider Adequacy: service type, wait times, geographic market, current projected demand for services

NQTL Checklist for CAA Compliance

❑ Identify sources used to define the factors identified previously to design the NQTL

Examples of sources of factors:

- Internal claim analysis
- Authorized exception report
- Medical expert reviews
- State and federal requirements
- National accreditation standards
- Internal market and competitive analysis
- Medicare physician fee schedules
- Evidentiary standards

NQTL Checklist for CAA Compliance

- ❑ Confirm whether the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD as compared to medical/surgical benefits both as written and in operation
- ❑ Review documentation
- ❑ Reconcile gaps and revise plan language and/or policies
- ❑ Prepare written NQTL comparative analysis

Non-Compliance Consequences

Insufficient

If the Departments determine a plan has not provided enough information to review a comparative analysis, they will specify to the plan the information that must be submitted to be responsive to the request.

Non-Compliant

If the Departments conclude that a comparative analysis and supporting information are noncompliant, the plan must specify to the Departments the actions they will take to become compliant.

Non-Compliance Consequences

Corrective Action

A plan must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance.

If after the 45-day corrective action period the plan is still noncompliant:

- Plan must inform all individuals enrolled that coverage has been determined to be noncompliant with MHPAEA
- Departments will share findings of noncompliance with the state where the plan is located and will take other appropriate action, as prescribed

The NQTL Comparative Analysis

	Medical/Surgical	Mental Health/Substance Use Disorder
List of Benefits Subject to Limitation		
Inpatient INN Inpatient OON Outpatient INN Outpatient OON	Provider-administered methadone prescribed for pain management. Therapeutic & Rehab services	Provider-administered methadone prescribed as part of opioid use disorder treatment. Therapeutic & Rehab services
Prescription Drugs	Pharmaceuticals prescribed for use outside of provider setting	Pharmaceuticals prescribed for use outside of Provider setting, including methodane & related medication buprenorphine
Emergency Care	Not Applicable to the DOL Request	
Factors		
Inpatient INN Inpatient OON Outpatient INN Outpatient OON	Medically Necessary Medically Appropriate Treatment is reasonably expected to significantly improve health	Medically Necessary Medically Appropriate Treatment is reasonably expected to significantly improve health

The NQTL Comparative Analysis

	Medical/Surgical	Mental Health/Substance Use Disorder
Evidentiary Standards		
Outpatient INN Outpatient OON	**The Plan uses the following evidentiary standards to determine that care being delivered is medically necessary:**	**The Plan uses the following evidentiary standards to determine that care being delivered is medically necessary:**
	In accordance with generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors; and	In accordance with generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors; and
	Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and	Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
	Not primarily for the convenience of the patient, physician or other health care provider; and	Not primarily for the convenience of the patient, physician or other health care provider; and
	Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.	Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

The NQTL Comparative Analysis

Prior Authorization Process in Operation During The 2021 Plan Year

	Medical /Surgical	Mental Health Conditions	Substance Use Disorders
Outpatient Admissions (INN/OON) to a Facility *In practice the prior authorization NQTL does not include OP sub-classification of office visits*			
Total preauthorization request received	91	34	13
Average # of days from request to initial determination	5	8.5	2
Total preauthorization requests initially denied	23	3	2
% of Total preauthorization requests initially denied	25.3%	8.28%	15.4%
Of initial denials, total ultimately granted	21	3	1
% of initial denials, but ultimately granted	91.3%	100%	50%

The NQTL Comparative Analysis

The Plan conducted a thorough and comparative review and analysis of each of the NQTLs listed in this document**.** Based on our comparative review and analysis of the specified NQTLs, the Plan has made the following findings:

1. **Methadone is a medication that can be used as both a M/S and MH/SUD treatment.** A detailed review of all factors and evidentiary standards used to determine how Methadone and Methadone Maintenance Therapy are covered by the Plan shows that they are applied identically for both MH/SUD and M/S conditions. Coverage for Methadone and related therapies and medications is based on the necessity and appropriateness of the treatment and that the prescription is ordered and filled in accordance with the law. Examining all other NQTLs applied by the plan and their relationship to the coverage of Methadone and Methadone Maintenance Therapy also show that they apply no more stringently for MH/SUD care than they do for M/S care.

2. **The Prior Authorization requirement applies to all benefit categories except for emergency care.** A detailed review of all factors and evidentiary standards used to apply the NQTL shows they are applied identically regardless of type of condition or benefit, including to MH/SUD and M/S conditions. However, the requirement applies to some MH/SUD services when it does not apply to the same or comparable benefit for M/S. Telehealth services and psychological and neuropsychological testing are the two benefits for which this is the case.

NQTL Comparative Analysis Requests

ERISA plan participants, beneficiaries and their authorized representatives are entitled to:

- Comparative information on medical necessity criteria for medical/surgical and MH/SUD
- Processes, strategies, evidentiary standards, and other factors used to apply NQTLs

According to the Departments, this means any comparative analyses performed under the plan must be made available to participants and beneficiaries upon request.

Eligible Requestors

- Participants, Beneficiaries, Enrollees - ERISA participants entitled to information
- Authorized Representatives (AR) - Providers or others acting as patient's AR
- Claimants - Upon appeal of ABD, claimants may receive details relevant to benefit claims
- Applicable State Authority - Officials designated by the State
- EBSA

CAA-related MHPAEA NQTL Enforcement

EBSA Enforcement

Greatest Impact

EBSA enforcement focuses on compliance with ERISA and restoring benefits improperly withheld from plan participants.

EBSA prioritizes investigations that may result in large recoveries or affect many participants and will work with plan service providers (i.e., TPAs) to obtain broad correction and increase authority.

EBSA has primary enforcement jurisdiction over 2 million group health plans covering approximately 137 million Americans.

EBSA Enforcement

Biden-Harris Administration Top Enforcement Priority

- EBSA formed MHPAEA NQTL Task Force
- Expanded staff, new tools, new programs, new funding, new contractor support
- EBSA selected 'Focus' NQTLs and evaluated existing investigations to identify NQTLs for comparative analysis requests, including compliance with requirements for reimbursement rates for the treatment of MH/SUD conditions, autism treatment limitations, and denials of claims for emergency services

DOL Red Flags *(DOL MHPAEA FAQ #8, Part 45, April 2, 2021)*

- Prior authorization requirements for IN and OON inpatient services
- Concurrent review for IN and OON inpatient and outpatient services
- Standards for provider admission to participate in a network, inc. reimbursement
- OON reimbursement rates (method for determining UCR)

EBSA Strategy

- EBSA issued 156 letters to plans requesting comparative analyses for 216 unique NQTLs across 86 investigations (between 2/10/2021 and 10/31/2021)
- EBSA issued 80 insufficiency letters covering 170 NQTLs
- EBSA issued 30 initial determination letters that identified 48 impermissible NQTLs
- EBSA primarily chose to request NQTLs where EBSA had previously developed specific investigative leads
- EBSA received corrective action plans from 19 plans
- 26 plans agreed to make prospective plan changes

EBSA Conclusions

- Plans were unprepared; approximately 40% responded with an extension request
- Comparative analyses were all initially insufficient

Plans Must "Show Their Work" *(29 U.S.C. Section 1185a(a)(8)(A))*

- Requirements for both design and application (in writing and operation)
- Focus on underlying processes, strategies, evidentiary standards and factors

Deficiency Themes

- Failure to document CA before designing NQTL
- Conclusory assertions lacking specific supporting evidence or detailed explanation
- Lack of meaningful comparison, analysis
- Non-responsive CA that did not address the specific NQTL
- Failure to identify all factors, lack of sufficient detail about factors
- Failure to demonstrate application of factors in design of NQTL or as applied
- Generally (generically) prepared by a service provider and not specific to plan at issue

EBSA Initial Determination Letter NQTLs at Issue

- Limitation or exclusion of ABA or other services to treat autism
- Billing requirements where licensed MH/SUD providers can bill the plan only through specific types of other providers
- Limitation or exclusions of medication-assisted treatment for opioid use disorder
- Preauthorization
- Limitation of nutritional counseling for MH/SUD conditions
- Provider experience requirement beyond licensure
- “Effective treatment” requirement applicable only to SUD benefits
- Treatment plan required

EBSA Recommendations to Congress

Authority for DOL to assess civil monetary penalties for parity violations has potential to strengthen protections of MHPAEA

Amend ERISA to expressly provide authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans (including TPAs)

Amend ERISA to expressly provide that participants and the DOL may recover amounts lost by participants who wrongly had their claims denied in violation of MHPAEA

Permanently expand access to telehealth and remote care services

DOL MHPAEA Investigations

EBSA Investigations

Fiscal Year 2021 EBSA (Non-CAA) Enforcement Efforts

- FY 2021 MHPAEA reporting does not capture EBSA increased CAA-related activity since the investigations are ongoing and not yet closed during FY 2021
- EBSA closed 148 investigations in FY 2021; 74 involved plans subject to MHPAEA
- EBSA advisors answered 175 public inquiries related to MHPAEA in FY 2021, including 144 complaints

EBSA Regional Office	Focus Project
Boston	Nutritional counseling initiative: Focus on self-funded plans that exclude coverage for nutritional counseling for behavioral health conditions and NQTLs
	Taft-Hartley initiative: Focus on Taft-Hartley plans that exclude treatment for opioid use disorder
Kansas City	Opioid parity initiative: Focus on disparity of MH/SUD benefits compared to medical/surgical, barriers to overcome addiction
Philadelphia	Network accuracy and adequacy: Test accuracy and adequacy of networks for MH/SUD providers, ensure advertised benefits reflect availability
EBSA 2020 Staffing: 364 investigators, 108 benefit advisors and 20 specialists	

Exclusion of Applied Behavior Analysis (ABA) Therapy

Question: Our TPA offered the option to exclude coverage for ABA therapy, primarily for autism. Is that compliant with the MHPAEA requirements?

Phia Interpretation: This should be revisited. A FY 2021 EBSA investigation of a large TPA resulted in the TPA changing their self-funded plan to default to cover ABA therapy. This change eliminated the exclusion of ABA therapy for autism for nearly a million participants.

Exclusion of Therapy to Treat MH/SUD Conditions

Question: Our plan excludes speech therapy to treat MH/SUD conditions and learning disorders. Is that compliant with the MHPAEA NQTL requirements?

Phia Interpretation: Imposition of medical necessity requirements on speech therapy to treat medical/surgical benefits is not comparable to a complete exclusion of speech therapy for MH/SUD conditions and learning disorders.

Exclusion of Out-of-Network Facility

Question: Our plan excludes out-of-network residential treatment for MH/SUD. Is that compliant with the MHPAEA requirements?

Phia Interpretation: No. A FY 2021 EBSA investigation resulted in a plan re-processing claims totaling over $88,000 for residential treatment and agreeing to amend its plan language to eliminate the exclusion and modify the claims processing procedures to prevent this from happening in the future.

Drug Testing

Question: Our service provider denied coverage for urine drug testing related to SUD benefits. Is that compliant with the MHPAEA NQTL requirements?

Phia Interpretation: Probably not, as this is often required as part of SUD treatment and often required to continue residential treatment. This would require a detailed NQTL analysis to review factors and evidentiary standards to support that this would be applied substantially similarly to MH/SUD and medical surgical benefits.

As it relates to outpatient care, a FY 2021 EBSA investigation found the denial of claims for outpatient drug testing was impermissible because the plan failed to establish medical necessity. This investigation resulted in 250 re-processed claims and $175,000 in payments to providers.

Preauthorization

Question: Our plan requires preauthorization for all inpatient MH/SUD benefits, but only for certain inpatient medical/surgical benefits. Is that compliant with the MHPAEA NQTL requirements?

Phia Interpretation: This would require a detailed NQTL analysis to review factors and evidentiary standards to support that this would be applied substantially similarly to MH/SUD and medical surgical benefits.

Access to MH/SUD Benefits

Question: Our plan does not allow access to EAP MH/SUD benefits for COBRA beneficiaries. Is that compliant with the MHPAEA requirements?

Phia Interpretation: This should be reviewed and updated. A FY 2021 EBSA investigation resulted in a correction of this error and allowing the individual access to MH/SUD benefits. Pursuant to this investigation, the EBSA benefits advisor identified an SBC NQTL pre-authorization issue.

Plan Language vs. Plan Policy

Plaintiffs were participants in ERISA covered plan administered by UBH. Participants sought MH/SUD benefits. UBH denied coverage based upon internal medical necessity guidelines. Plaintiffs argued there was a breach of fiduciary duty as UBH was arbitrary and capricious in denying benefits based on its guidelines instead of evaluating generally accepted standards of care.

District Court found UBH's guidelines deviated from generally accepted standards and remanded for re-processing.

Ninth Circuit reversed the order and held the District Court misapplied the abuse of discretion by substituting its interpretation of the plan for UBH's and it was not unreasonable for UBH to decide on the standards.

Recommended Next Steps

Cost Considerations

Employee Assistance Programs

Utilization Management

Pharmacy Benefits

Plan Design

Hands-on assessments with licensed clinicians in private practice (face-to-face and telehealth video)

Compliance Considerations

Perform a NQTL comparative analysis:

- Review relevant plan documents, procedure manuals, etc.
- Identify any NQTLs applied to mental health benefits
- Analyze whether the use of NQTLs is compliant
- Produce a report detailing the results of that analysis
- Recommend and adopt changes to achieve compliance

Future MHPAEA Reforms

Expanded Coverage and Reduced Costs for Mental Health

The Budget would require all health plans to cover MH/SUD benefits and ensure an adequate network of behavioral health providers, including three behavioral health visits each year without cost-sharing.

The Budget would integrate MH/SUD treatment into primary care settings.

The Budget would expand access to telehealth and virtual mental health options.

Anticipated June 27, 2022 Clarifying MHPAEA Guidance

"Not later than 18 months after December 27, 2020, the Secretary shall finalize any draft or interim guidance and regulations …."


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