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Heads Up, Employers!

Mental Health Parity is on the Front Burner

August 10, 2021 | 12:00 - 1:00PM

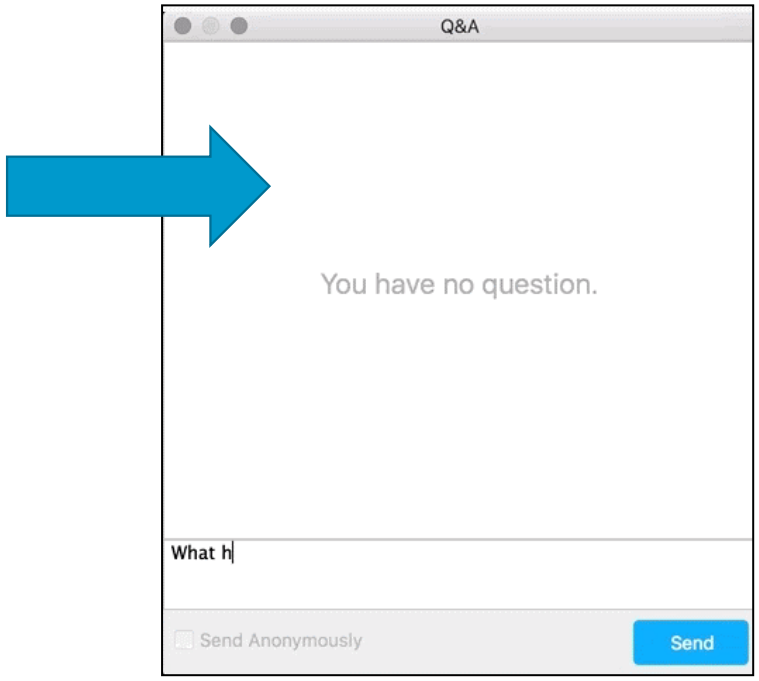
Webinar Procedures

All lines will be muted

Please submit all questions using the “Q&A” dialog box

Email Diane Engel at dengel@nebgh.org with any issues during this webinar

The recording and a PDF of the slides will be shared



Speakers

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Mental Health Parity and Addiction Equity Act (MHPAEA)

- Requires that beneficiaries have access to benefits that are designed and delivered in a manner that doesn't discriminate against individuals with mental health conditions or substance use disorders.
- Is fundamentally a consumer-protection anti-discrimination statute
  - More similarities to the Civil Rights Act and ADA than to most forms of managed care and insurance regulations.
- Regulations and sub-regulatory guidance effectuate this anti-discrimination requirement through a complex series of tests.

Oversight and enforcement have steadily increased over the years and are now requiring comprehensive, organizational culture changes

Key Terms and Specific Requirements

Financial requirements ("FRs") and quantitative treatment limitations (QTLs)

- MHSU benefits must be no more restrictive than the predominant type of financial requirements applied to substantially all medical/surgical ("M/S") benefits

Aggregate lifetime dollar limits and annual dollar limits (AL/ADLs)

- May not be applied to MHSU benefits unless they apply to at least one-third of M/S benefits, *AND*
- Limits for MHSU benefits accumulate jointly with, or are no more restrictive than, the limits for M/S benefits

Non-Quantitative Treatment Limits (NQTLs)

- Processes, strategies, evidentiary standards or other factors used to apply MHSU and M/S ***NQTLs must be comparable and no more stringent***

Strengthening Parity in MHSU Benefits

- Signed into law on December 27, 2020
- Requires group health plans to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs)
- Plans must be prepared to make these comparative analyses available to the DOL and/or HHS upon request beginning 45 days after the date of enactment (February 10, 2021)

The new amendments also include requirements related to:

- Updated compliance program guidance
- An approach to corrective action
- Annual reporting by the Departments regarding noncompliance
- Guidance regarding participant and beneficiary complaints
- Promotion of Federal and State information sharing

Plan Sponsor Compliance Efforts

Plans (plan sponsors) will need to work with benefit administrators to gather information so that the NQTL comparative analyses can be performed and documented

- DOL, HHS, and Treasury issued initial guidance regarding the new requirements on April 2, 2021 under FAQ Set 45

- Additional guidance is expected. Once issued, plans may need to work to comply with any requirements clarified by the Departments

Failure to Comply

Consequences of failure to satisfy the comparative analysis requirements include:

- The plan or issuer must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance.
- Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer is still not in compliance
- The plan will then have seven days to notify covered individuals that the plan is not in compliance.

Non-Quantitative Treatment Limits (NQTLs)

NQTLs include any policies or processes that serve to limit the scope or duration of benefits

- The federal rules provide a non-exhaustive list of examples
- Broad enough that almost any policy or procedure that limits access to MHSU benefits differently than M/S benefits can potentially be subject to the NQTL analysis

Plans may not impose NQTLs on MH/SUD benefits unless any *processes, strategies, evidentiary standards, or other factors* used in applying the NQTL are

- Comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits
- In the same classification

Analytic Framework for NQTLs

A variety of different "tests" or analytic frameworks have been developed for NQTLs, but none are defined in regulation. However, the types of questions that regulators tend to ask include:

- Is a ***reasonable rationale*** provided for applying the NQTL to M/S and MH/SUD benefits, and is it applied consistently to all relevant benefits?
- Are differences in the application of the NQTL to MH/SUD benefits as compared to M/S benefits arbitrary, or ***supported by evidence***?
- Are differences in the application of the NQTL to MH/SUD benefits ***consistent with practice guidelines***?
- Is it ***harder to "pass"*** the NQTL for MH/SUD benefits than it is for M/S benefits?
- Are the ***consequences*** more severe for failing to meet the NQTL requirements as they apply to MH/SUD benefits?
- Is there a ***disparate impact*** on MH/SUD benefits as compared to M/S benefits?

Coverage Policy and Medical Management NQTLs

Examples of common product/benefits NQTLs include:

- Medical necessity definitions
- Utilization management processes, such as prior authorization and concurrent review, step therapy, “soft limits” (numerical limits that can be exceeded for medical necessity)
- Restrictions based on facility location or type
- Limits based on clinical status of the patient (e.g., failure to complete a course of treatment, court-ordered treatment, admission standards based on danger to self or others)

Common coverage policy NQTL concerns include:

- Application of prior authorization to all benefits in a classification for MH/SUD but not for M/S
- Quantity limits on services that are not grounded in medical evidence
- Exclusions for wilderness therapy or other residential treatment settings

Provider Network NQTLs

Examples of common network NQTLs include:

- Provider network development strategies
- Network admission standards
- Reimbursement rate-setting strategies and methodologies

Common network-related concerns include:

- Using Medicare rates as an anchor for M/S, but not for MH/SUD (or systematically applying a lower percentage for MH/SUD)
- Restrictions on scope of practice for non-physician MH/SUD providers but not for non-physician M/S providers
- Quantitative metrics for network development for M/S but not for MH/SUD

Pharmacy NQTLs

Common pharmacy NQTLs include:

- Formulary design and tiering
- Prior authorization, step therapy, and other utilization management
- Restrictions or exclusions based on formulation or mode of administration
- Exclusions of coverage for MH/SUD drugs or drug classes
- Restrictions on off-label prescribing
- Dosage limits

Common violations:

- Requiring a greater number of steps or “failures” for MH/SUD drugs vs. M/S
- Disparities in timeline or criteria (e.g. age or safety) for prior authorization
- Considerations applied non-uniformly for drug tiering
- Dosage limits below FDA approved levels
- Application of prior authorization in practice (though not stated in policy)

Key Themes in Compliance Risk

Missing foundational elements

- Documentation of definitions, classifications, FR/QTLs, etc.

Lack of analysis and documentation regarding key NQTLs

- Limits or requirements related to the clinical status of the patient
- Provider network and reimbursement strategies
- Pharmacy benefit management
- Exclusions or limits related to specific treatments, conditions, or provider or facility types

“Per se” violations

Lack of parity compliance governance and oversight

- Process = Compliance

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