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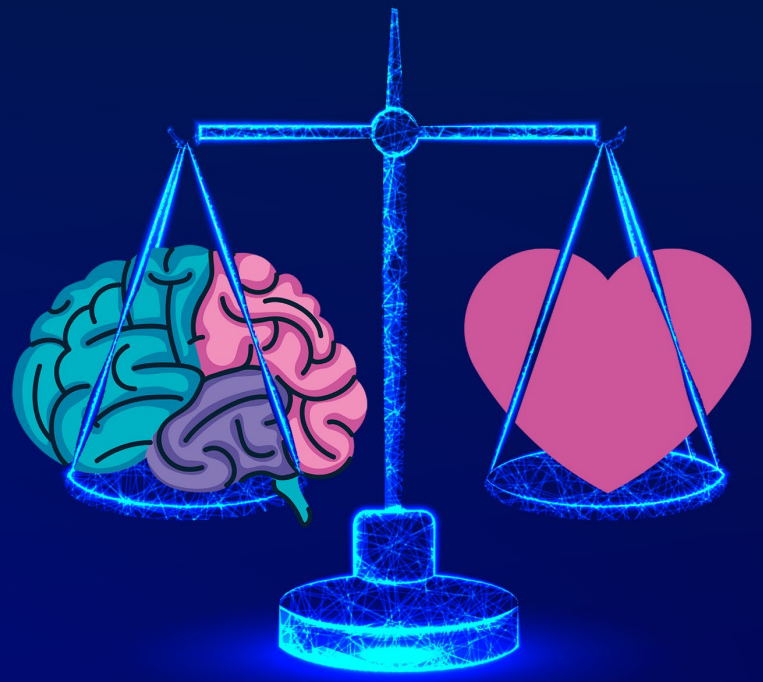


MENTAL HEALTH PARITY REFRESH

Wednesday, April 27, 2022
12:00 – 1:00 PM

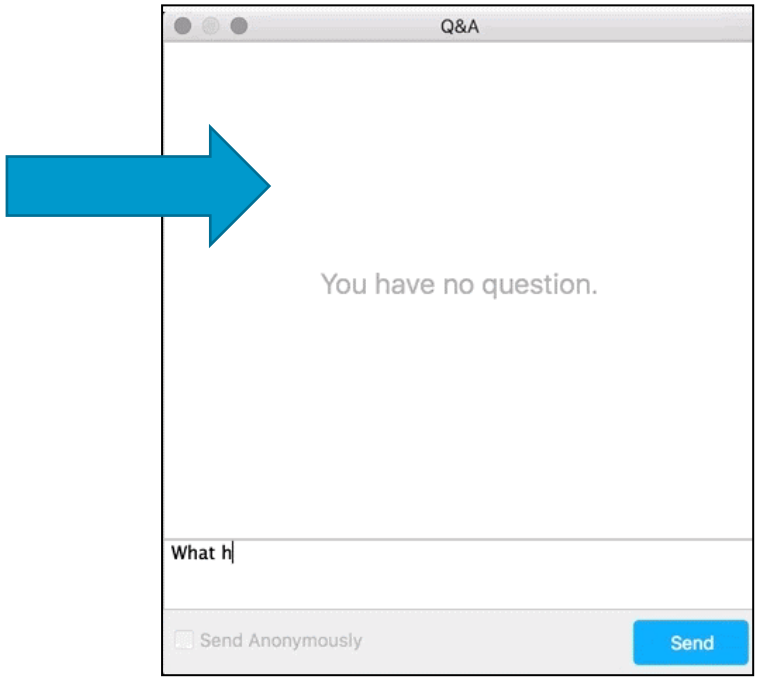
Webinar Procedures

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



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Speaker:

Kevin J. Malone
Member of the Firm
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Developments in MHPAEA Oversight and Enforcement

April 26, 2022

Presented by

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Agenda

1. Brief background on MHPAEA
2. Federal MHPAEA Audit Activity
3. Summary of the 2022 MHPAEA Report to Congress
4. Litigation Risks
5. Q&A

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Brief background on MHPAEA

Mental Health Parity and Addiction Equity Act (MHPAEA)

- Health plans and issuers must ensure that benefits design and delivery does not discriminate against individuals with mental health conditions or substance use disorders

- Fundamentally a consumer-protection anti-discrimination statute, similar to the Civil Rights Act and Americans with Disabilities Act

- Oversight and enforcement have steadily increased since 2008 and are now requiring comprehensive, organizational culture changes, similar to the roll-out of HIPAA

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Federal MHPAEA Audit Activity

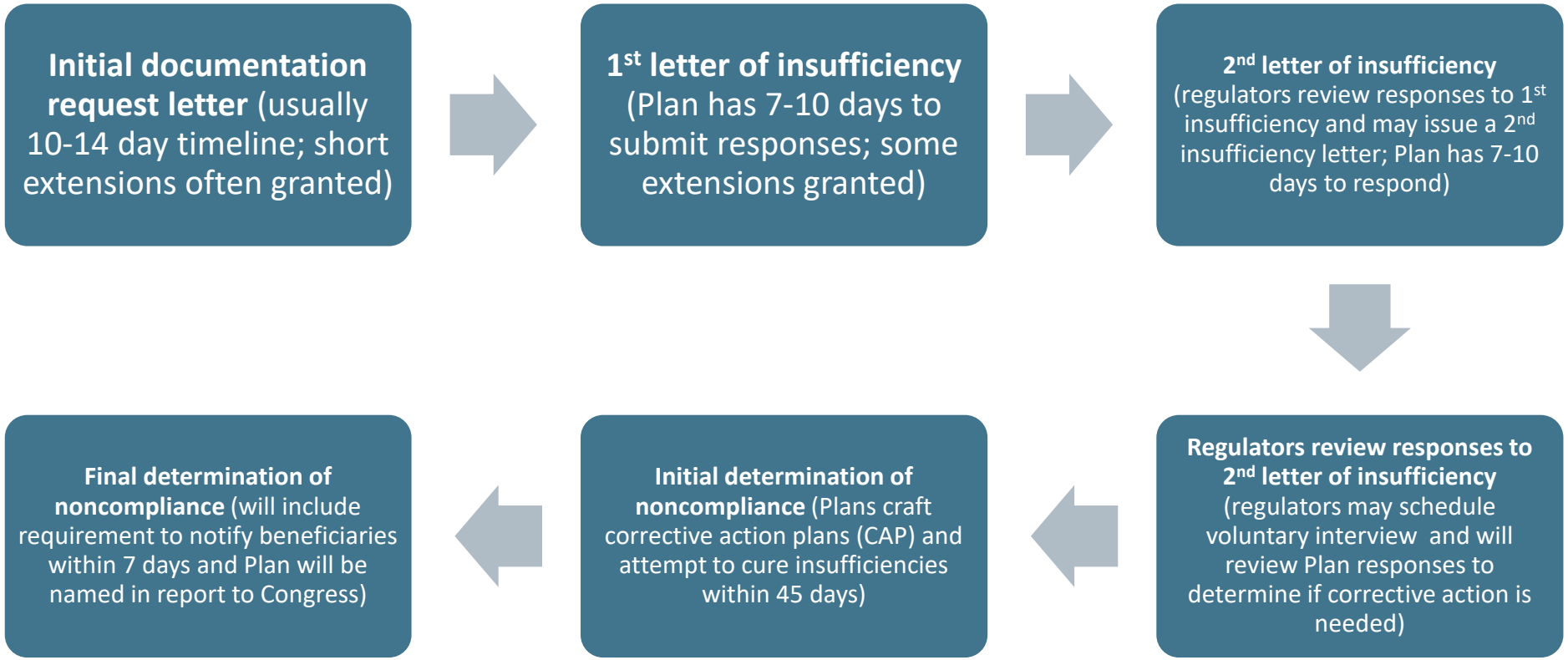
DOL Significantly Increased Enforcement Structure

- EBSA made significant investments in its infrastructure and resources for parity investigations during 2021
  - Significantly expanded its staffing, increased staff specialization, developed tools for use in investigations, and retained contractor support
  - EBSA formed a MHPAEA NQTL Task Force composed of experienced investigators, health policy experts, technical experts from EBSA's regional and national offices, and attorneys from the Office of the Solicitor of Labor
- This investment in infrastructure for enforcement likely indicates that EBSA is planning to continue to expand the scope and intensity of its investigations in 2022 and beyond

Initiating a MHPAEA Investigation

- Most plans and issuers that received NQTL documentation requests from DOL or CMS were already under investigation by the Departments
- Investigative leads were developed in many ways including:
  - Investigators reviewed plan documents (e.g. SPD), noted potential parity violations in plan documents and requested comparative analyses related to those potential violations
  - EBSA established working groups to consider legal theories for enforcement, targeting methods and leads with regard to network accuracy, network adequacy, and coverage of autism.
    - The working groups examined potential investigative leads by using claims data to identify networks with parity "red flags," and then identified specific plans with certain characteristics that use those networks.
- Ultimately the Report is unclear regarding exactly what prompts an investigation
  - Investigations could be prompted based on the size of an organization, investigator review of plan documents, leads developed by targeting service providers (such as third-party administrators and managed behavioral health organizations), or member complaints
  - The Departments likely reserve the right to pursue investigations at their own discretion

DOL/CCIIO Process for Parity Investigations



What to expect from investigations

Large number of investigations remain open

- Enforcement tends to focus on:
  - Utilization management
  - Provider reimbursement
  - Prescription drug limits
- Investigators aggressively pursue any language in the benefit booklet that suggests exclusions or other limits

Investigations are best understood to be premised on a presumption of noncompliance

Often can be challenging to prove that a policy or practice is "*not* more stringent"

Solution is to ensure that any decision regarding a "limit" can be demonstrated to be the result of a general principle that is defined clearly and applied consistently across all benefits

What's Coming for Enforcement?

DOL has made significant investments in enforcement infrastructure

- Significantly expanded staffing,
- Increased staff specialization,
- Developing investigator "playbook" and tools
- Retained contractor support
- Formed MHPAEA Task Force

Current legislative push to amend ERISA to create:

- Direct liability for TPAs and ASOs
- Private right of action
- New civil monetary penalties

Volume of new investigations may temporarily abate in lead-up to new rulemaking

- But investment in infrastructure shows we should expect sustained commitment to extensive enforcement over medium term

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Summary of 2022 MHPAEA Report to Congress

Key Facts Concerning the Tri-Departments' Findings

- ***None*** of the NQTL comparative analyses reviewed by either DOL or HHS were determined to contain sufficient information to meet the compliance documentation requirement.
- EBSA issued 30 initial determinations of non-compliance, and CMS issued 15 initial determinations of non-compliance. Several health plans and issuers have entered into corrective action plans.
  - To date, the Departments have not issued any ***final*** determinations of non-compliance with parity requirements.
  - CMS determined there were four instances in which plans provided sufficient documentation to warrant a "no finding of non-compliance"
- The Departments state that they will be initiating a notice of proposed rulemaking to clarify and amend MHPAEA regulations

Focus on Specific Non-Quantitative Treatment Limitations (NQTLs)

- Four of the top five most-frequently investigated NQTL types were signaled in Frequently Asked Questions, Part 45 as enforcement priorities for FY2021:
  - (1) preauthorization for inpatient services;
  - (2) concurrent care review for inpatient and outpatient services;
  - (3) out-of-network provider reimbursement rates; and
  - (4) provider network admission and participation criteria, including reimbursement rates
  - ***These NQTL types appear to have driven most of the findings regarding insufficiency of documentation***
- Many of the other frequently-investigated NQTL types were likely identified for scrutiny due to limiting language in the coverage description, summary plan description or other plan documents
  - E.g. limitations on ABA therapy, limitations on residential care, limitations on MAT, speech therapy restrictions, and other exclusions or limits explicitly targeted to MH/SUD conditions or services
  - ***These NQTL types appear to have driven most of the initial determinations of non-compliance***

NQTL Analyses - Common Insufficiencies Cited by EBSA

- EBSA found comparative analyses to be deficient where they contained:
  - Conclusory assertions lacking specific supporting evidence or detailed explanation
  - Lack of meaningful comparison or meaningful analysis
    - E.g. reliance on statements that processes, strategies, evidentiary standards, or other factors are “the same”
  - Non-responsive comparative analysis
    - E.g. reporting based on outdated plan terms or not tailored to the plan or product under investigation
  - Documents provided without adequate explanation
    - E.g. attachment of medical policies without discussion or analysis of the contents
  - Failure to identify the benefits, classifications, or plan terms to which the NQTL applies
    - E.g. failure to identify whether certain therapies are MH/SUD benefits, or whether intermediate services are classified as inpatient or outpatient benefits

NQTL Analyses - Common Insufficiencies Cited by EBSA *(cont.)*

- EBSA found comparative analyses to be deficient where they contained *(cont.)*:
  - Incomplete scope
    - E.g. failure to address pricing methodologies of third-party pricing entities
  - Failure to identify all factors
    - E.g. noting that other factors may apply, or failing to confirm that no other factors were applied
  - Lack of sufficient detail about identified factors
    - E.g. failure to adequately define evidentiary standards, or to explain how factors are weighted and balanced
  - Failure to demonstrate the application of identified factors in the design of the NQTL
    - E.g. documentation of decisions based on the identified factors
  - Failure to demonstrate compliance of an NQTL as applied
    - E.g. outcomes measures such as comparisons of denial rates or reimbursement rates

NQTL Analyses - Common Insufficiencies Cited by CMS

- Insufficiencies cited by CMS closely paralleled those identified by EBSA, and included determinations that the comparative analysis did not include sufficient information regarding:
  - Any TPA involvement in the design and application of the NQTL
  - Decisions, decision-makers, and the timing of decisions
  - All supporting policies and procedures relevant to the NQTL
  - Any variations in the application of any guideline or standard between MH/SUD benefits and medical/surgical benefits
  - Which MH/SUD benefits and M/S benefits are subject to the NQTL
  - Factors, including definitions of factors, explanations for how factors were measured and applied, and any applicable quantitative thresholds used
  - The comparability and stringency analysis, as written and/or in operation

Key Themes in Insufficiencies Cited by the Departments *(cont.)*

- **Lack of sufficient demonstration of factor application**: Regulators are interpreting parity to create a duty to ensure that factors, sources, and evidentiary standards are formulated with sufficient specificity that the plan can affirmatively prove that each factor has, in fact, been applied consistently to determinations of whether or not the factor was met.
- **Lack of robust operations metrics**: Departments note that operations metrics showing claims metrics or relative percentages may not be sufficient to demonstrate compliance.
  - Operations metrics, they state, should be accompanied by a description of the methodology, source data, and calculations used to generate the numbers being compared, so that regulators can accurately assess parity compliance.
  - The Report provides some suggested operations metrics for PA/CR (denial rates, reasons for denial, utilization rates, frequency of reviews, lengths of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, or review turnaround times)

Key Themes in Insufficiencies Cited by the Departments

- **Lack of Quantitative Factor Definitions**: Report noted that plans did not define every factor and did not specify the evidentiary standard used in each factor's application, especially when the factor was applied or evaluated in a quantitative way.
  - The Departments indicated that factors such as "cost containment" or "high-cost services" require a precise quantitative definition, an explanation of whether and how the plan derived a numerical standard for applying such terms to benefits, and supporting documents showing the term's application.
- **Descriptions of Committee Processes**: The Departments stated that if plans describe committee processes in their NQTLs, those descriptions must provide details about what specifically was done or decided, and by whom, when, or how it related to specific NQTLs.
  - This includes an explanation of precisely how each factor was applied by the committee members, to which benefits, the outcome of the factor's application, and documentation showing this process

Substantive Parity Violations Cited by EBSA

- A large majority of EBSA's initial determinations of non-compliance were based on coverage exclusions and limits that specifically target MH/SUD conditions, including:
  - Limitation or exclusion of applied behavior analysis therapy or other services to treat autism spectrum disorder
  - Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers
  - Limitation or exclusion of medication-assisted treatment for opioid use disorder
  - Limitation or exclusion of nutritional counseling for MH/SUD conditions
  - Provider experience requirement beyond licensure
  - Care manager or specific supervision requirement for MH/SUD
  - Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions
  - "Effective treatment" requirement applicable only to SUD benefits
  - Employee assistance program referral requirement Limit on telehealth for MH/SUD
  - Restriction on lab testing for MH/SUD
  - Exclusion of care for chronic MH/SUD conditions
  - Exclusion of speech therapy to treat MH/SUD conditions
  - "Other exclusion specifically targeting MH/SUD benefits"

Substantive Parity Violations Cited by EBSA *(cont.)*

- For NQTL types for which EBSA made initial determinations of non-compliance that were not based on a coverage exclusion or limit that explicitly targeted MH/SUD coverage, further details are needed to understand the basis for the finding of non-compliance. These include:
  - Preauthorization or precertification
  - Treatment plan requirement
  - Concurrent care and discharge planning requirements
  - Retrospective review
  - Maximum allowable charge and reference-based pricing
  - Age, scope, or durational limits
  - Formulary design

Corrective Actions Cited by the Departments

- Most corrective actions that are identified in the Report simply involve the removal of an exclusion or limit that was targeted to MH/SUD conditions or services, including:
  - Exclusions for ABA therapy
  - Exclusions for Medication-Assisted Treatment for Opioid Use Disorder
  - Exclusions for nutritional counseling for MH conditions
  - Exclusions for Urine Drug Testing for SUD conditions
  - Blanket pre-certification requirement for MH/SUD benefits but not for all M/S benefits in the classification
  - Exclusions for out-of-network residential treatment for MH/SUD conditions but not for M/S conditions
- The Departments also report that corrective actions were taken for two other violations for which the compliance analysis and specifics of the remedy may be more complex:
  - Remove of continued stay criteria requiring demonstrable progress and exclusions of coverage where a patient left a treatment facility against medical advice
  - Reprocessing of claims for drug testing for SUD that were denied for failure to establish medical necessity

Types of Corrective Actions

- The Departments identified a range of types of corrective actions that may be necessary, including:
  - Making retroactive changes to plan terms to remove a limit, reduce the scope of a limit, or add a benefit previously excluded
  - Providing notice to participants and enrollees of an opportunity to submit or resubmit claims as a result of a retrospective change in plan terms
  - Re-adjudicating or paying claims denied due to application of noncompliant NQTLs
  - Amending medical policies, claims processing policies and procedures, or other practices
  - Training for claims processing staff

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Litigation Risks

Walsh v. United Behavioral Health

- Groundbreaking lawsuit filed by DOL alleging MHPAEA violations
- The settlements in the case include:
  - **$2.5 million** to resolve claims brought by the U.S. Department of Labor
  - **$1.1 million** for claims brought by the New York Attorney General
  - **$2 million** for New York state penalties
  - **$10 million** for restitution to members with denied claims
- Substantive complaints addressed:
  - Different levels for OON reimbursement for mid-level providers
  - Different approaches to outlier management
  - Failure to disclose and analyze the identified differences in parity reporting and disclosures

"The Secretary of Labor views [mental health parity] as probably our top health enforcement priority for EBSA"

– Ali Khawar, Acting Assistant Secretary, Employee Benefits Security Administration (EBSA)

Key Themes in Litigation Risks

Lawsuits involving MHPAEA filed on a nearly daily basis, including an increasing number of class actions, with sometimes unpredictable results

Medical necessity criteria and UM

- *Wit v. United Behavioral Health* requiring United to reprocess 67,000+ claims
- *Meridian Treatment Centers v. UBH* presents same facts on behalf of a nationwide class of providers, asserting $9 billion in affected claims

Provider reimbursement strategies

- *O'Dowd v. Anthem* – alleged disparities in reimbursement strategies, settled
- *Smith v. United Healthcare* – plaintiffs survived a motion to dismiss

Residential treatment and wilderness therapy

Highest volume of litigation to date—plaintiffs challenge coverage exclusions, provider network exclusions, and medical necessity criteria

Availability and adequacy of documentation

M. S. v. Premera Blue Cross – failure to disclose InterQual criteria and related plan documents was key factor in awarding penalties under ERISA

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Q&A

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- **May 2** – Monday COVID-19 Update
- **May 9** – Special Edition COVID-19 Update – Long COVID w/ Dr. Chen
- **May 10** – Racial Health Equity: Make Sure ALL Employees Have Access to Best Practice Obesity and Diabetes Treatment
- **May 18** - CAA Transparency in Coverage Rules: What We Know
- **June 16** - Benefits Leadership for a Changing World: Accept the Challenge!