Thompson Coburn's
Annual Labor, Employment and
Employee Benefits Law Seminar

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Keeping an Even Keel

Mental Health Parity and Non-Discrimination

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Mental Health Parity: Overview

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Definitions

- Quantitative Treatment Limitation (QTL)
  - Ex: deductibles, cost-sharing amounts
- Non-Quantitative Treatment Limitation (NQTL)
  - Ex: fail-first policies; network tier design; formulary design for prescription drugs; restrictions based on geographic location, facility type, provider specialty
- Mental Health or Substance Use Disorder (MH/SUD)

Background

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

- Promotes equal access to treatment for MH/SUDs by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than for medical/surgical benefits
- Annual reports over the next decade detailed applicable rules and guidance, and described DOL's strategy and enforcement efforts

Consolidated Appropriations Act

- Enacted December 27, 2020
- Section 203 of Title II, Division BB amended MHPAEA
- Provides DOL, HHS, and IRS an enforcement tool by amending MHPAEA to require plans and issuers to provide comparative analyses of NQTLs

Consolidated Appropriations Act

- Beginning February 10, 2021, plans and issuers must make their comparative analyses available to the Departments (IRS, DOL, HHS) or applicable State authorities upon request

2022 Report to Congress

- EBSA issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs
- CMS issued 12 letters
- None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt
- EBSA has received corrective action plans from 19 plans addressing 36 NQTLs
- CMS has received corrective action plans from 6 plans addressing 13 NQTLs
- 26 plans and issuers have agreed to make prospective changes to their plans

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Mental Health Parity: Completing Your Comparative Analyses

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EBSA Self-Compliance Tool

- Updated every two years
- Most recently updated in 2020

FAQ Part-45

- Published April 2, 2021
- Helpful guidance on NQTL comparative analyses since Compliance Tool has not yet been updated following the CAA

FAQ-Part 45

- Suggests using the EBSA Self-Compliance Tool to ensure plans and issuers are providing sufficient detail in the comparative analyses
- Although tool *recommends* that plans/issuers analyze NQTLs and document those analyses, this step is *required* following February 10, 2021

Comparative Analyses

- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies
- Factors, evidentiary standards or sources, strategies or processes considered

Comparative Analyses

- Precise definitions used and any supporting sources
- Explain any variation in the application of a guideline used for MH/SUD and medical/surgical benefits
- The nature of decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s)

Comparative Analyses

- Assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations
- A reasoned discussion of the plan's or issuer's findings and conclusions as to comparability
- The date of the analyses and the name, title, and position of the person(s) who performed or participated in the analyses

What to Avoid in Comparative Analyses

- A general statement of compliance or conclusory statements without evidence
- Large volume of documents without a clear explanation of each document's relevance
- Identification of processes, strategies, sources, and factors without the comparative analysis
- Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice
- Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application
- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason

Supporting Documents to Include

- Records documenting NQTL processes and detailing how the NQTLs are being applied to both
- Any documentation the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits
- Samples of covered and denied MH/SUD and medical/surgical benefit claims
- Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity)

Mental Health Parity: Enforcement

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Participants

- Entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits
- Entitled to information on the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan

EBSA, CMS Enforcement

- If insufficient information, Departments shall specify to the plan or issuer the information that must be submitted
- If noncompliance, the plan/issuer must specify to the Departments the actions it will take to come into compliance:
  - Additional comparative analyses to demonstrate compliance within 45 days after initial determination
  - If final determination of non-compliance, plan or issuer must notify all individuals enrolled in the plan that coverage is determined to be noncompliant
- Departments will share findings of compliance/non-compliance with State where plan is located and where issuer is licensed to do business

Basis for Requests

- May base requests of NQTL comparative analyses in response to complaints received
- May request NQTL comparative analyses in any other instance deemed appropriate

DOL, HHS, IRS Enforcement

Initial Areas of Focus:

- Prior authorization requirements for in-network and out-of-network inpatient services
- Concurrent review for in-network and out-of-network inpatient and outpatient services
- Standards for provider admission to participate in network, including reimbursement rates
- Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges)

2022 MHPAEA Report

How are we doing?

- EBSA has requested comparative analyses from 156 plans and issuers relating to 216 unique NQTLs
- CMS issued 15 requests for comparative analyses
- So far, none of the comparative analyses reviewed have contained sufficient information upon initial receipt

Note on Counting NQTLs

- An NQTL that applies to more than one benefit classification within a plan is counted as one NQTL
- An NQTL that applies to different plans or products by the same issuer/service provider is counted as one NQTL
- Counting each NQTL separately by benefit classification, plan, and product, the number of distinct NQTLs for which EBSA requested a comparative analysis would be 1,112

Common Deficiencies (EBSA)

- Failure to document comparative analyses before designing and applying the NQTL
- Conclusory assertions lacking specific supporting evidence or detailed explanation
- Lack of meaningful comparison or meaningful analysis
- Non-responsive comparative analysis
- Documents provided without adequate explanation

Common Deficiencies (EBSA)

- Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classifications affected by an NQTL at issue
- Failure to identify all factors
- Lack of sufficient detail about identified factors
- Failure to demonstrate the application of identified factors in the design of an NQTL
- Failure to demonstrate compliance of an NQTL as applied

Common Deficiencies (CMS)

- Did not include all supporting policies and procedures relevant to the design and application of the NQTL
- Did not include sufficient information regarding decisions, decision-makers, and the timing of decisions
- Insufficient information regarding factors, including definitions of factors, explanations for how factors were measured and applied, and any applicable quantitative thresholds used in the design and application of the NQTL

Common Deficiencies (CMS)

- Did not include a sufficiently reasoned discussion of the plan's or issuer's conclusions as to the comparability and stringency of the NQTL between MH/SUD and medical/surgical benefits
- Did not include sufficient information regarding any variations in the application of any guideline or standard between MH/SUD benefits and medical/surgical benefits
- Did not sufficiently describe any TPA involvement in the design and application of the NQTL
- Did not include specific identification or breakdown of MH/SUD benefits and medical/surgical benefits to which the NQTL applies within each benefit classification

Insufficiency Letters

- EBSA has issued 80 insufficiency letters, requesting additional information and identifying specific deficiencies
- CMS has issued 19 insufficiency letters identifying deficiencies and requesting additional information

Initial Determination Letters

- EBSA has issued 30 initial determination letters finding 48 NQTLS imposed on MH/SUD benefits lacked parity
  - EBSA received corrective action plans from 19 plans in response, addressing 36 NQTLs
- CMS has issued 15 initial determination letters finding 16 NQTLs imposed on MH/SUDs lacked parity
  - CMS received corrective action plans from 6 plans addressing 13 NQTLs

Outcomes

- As of the 2022 Report, 26 plans and issuers have agreed to make prospective changes to their plans

EBSA's Most Common Requests

- Preauthorization or precertification requirements
- Network provider admission standards
- Concurrent care review
- Limitations on applied behavior analysis or treatment for autism spectrum disorder
- Out-of-network reimbursement rates
- Treatment plan requirements
- Limitations on medication-assisted treatment for opioid use disorder

EBSA's Most Common Requests

- Provider qualification or billing restrictions
- Limitations on residential care or partial hospitalization programs
- Nutritional counseling limitations
- Speech therapy restrictions
- Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress
- Virtual or telephonic visit restrictions
- Fail-first or step therapy requirements

CMS' Most Common Requests

- Concurrent review
- Provider credentialing standards
- Prior authorization
- Provider network participation requirements
- Treatment certification requirements

EBSA's Initial Determination Letters

- Limitation or exclusion of applied behavior analysis therapy or other services to treat autism spectrum disorder (9)
- Billing requirements (7)
- Limitation or exclusion of medication-assisted treatment for opioid use disorder (4)
- Preauthorization or precertification (4)
- Limitation or exclusion of nutritional counseling for MH/SUD conditions (4)

EBSA's Initial Determination Letters

- Provider experience requirement (beyond licensure) (3)
- Care manager or specific supervision requirement for MH/SUD (2)
- "Effective treatment" requirement applicable only to SUD benefits (1)
- Treatment plan requirement (1)
- Employee assistance program referral requirement (1)

EBSA's Initial Determination Letters

- Exclusion of care for chronic MH/SUD conditions (1)
- Exclusion of speech therapy to treat MH/SUD conditions (1)
- Concurrent care and discharge planning requirements (1)
- Retrospective review (1)
- Maximum allowable charge and reference-based pricing (1)

EBSA's Initial Determination Letters

- Age, scope, or durational limits (1)
- Formulary design (1)
- Limit on telehealth for MH/SUD (1)
- Restriction on lab testing for MH/SUD (1)
- Other exclusion specifically targeting MH/SUD benefits (1)

CMS' Initial Determination Letters

- 41 instances of noncompliance across 14 of the comparative analyses reviewed due to insufficient information provided
- Two of the comparative analyses submitted resulted in four instances of noncompliance due to findings of impermissible separate treatment limitations:
  - MH/SUD continued-stay criteria, requirement of evident progress for continued care coverage
  - MH/SUD discharge criteria, no coverage if no significant improvement in condition
  - MH/SUD discharge criteria, no coverage if enrollee leaves against medical advice
  - MH/SUD covered charges, no coverage if no certification that participant completed full continuum of care necessary available at the facility

EBSA Example 1

- Large service provider was administering claims for hundreds of self-funded plans across the country that excluded applied behavior analysis therapy to treat autism spectrum disorder
- EBSA's LA office issued requests for comparative analyses to some plans using exclusion, issued initial findings of non-compliance
- Three plans have confirmed the removal of the exclusion going forward
- Service provider issued a notice to nearly one thousand plan clients notifying the plans of EBSA's parity concerns about the exclusion
- Service provider advised plans that it would not apply the ABA exclusion going forward unless a plan affirmatively states that it wishes to retain the exclusion, has consulted with legal counsel concerning the exclusion, and wishes to contend that the exclusion is compliant with MHPAEA

EBSA Example 2

- A large, self-funded Taft-Hartley plan covering 7,600 participants specifically excluded methadone and naltrexone as treatment for SUD conditions
- The plan did not place a similar restriction on medications to treat medical/surgical conditions and did not have comparative analyses describing the processes, strategies, evidentiary standards, or other factors used to develop the exclusion
- After receiving initial determination letter, the plan removed the exclusion from its plan documents and notified its participants and beneficiaries of the change in terms
- EBSA's Boston regional office is working with the plan to identify affected participants and beneficiaries to take retrospective corrective action

EBSA Example 3

- Two large plans using similarly fully insured products offered by the same health insurance issuer covered nutritional counseling for medical/surgical conditions like diabetes, but not for mental health conditions like anorexia nervosa, bulimia nervosa, and binge-eating disorder
- EBSA's New York office requested comparative analyses for the nutritional counseling limitation from both plans and directly from the issuer
- The responses received did not explain or demonstrate that the discriminatory exclusion was compliant with parity requirements
- Both plans have amended their coverage documents to remove the exclusion
- Issuer is in process of submitting forms to state regulators to remove the NQTL from the fully insured products
- EBSA's regional office is working with plans and issuer to implement retrospective corrective action

CMS Example 1

- Issuer was found to have impermissible separate treatment limitations in the form of MH/SUD continued-stay criteria requiring demonstrable progress for continued care coverage.
- Issuer was also found to have impermissible separate treatment limitations in the form of MH/SUD discharge criteria resulting in loss of coverage if there was no significant improvement in an enrollee's condition or if enrollee left against medical advice
- No similar criterial for medical/surgical benefits
- After initial determination letter, issuer included revised continued-stay and discharge criteria along with supporting documentation showing that the more stringent limitations on MH/SUD benefits were removed.
- Insurer initiated self-audit to identify claims impacted by the criteria described in initial determination letter and has committed to re-adjudicating those claims.

CMS Example 2

- Corrective action plan submissions for six reviews described plans for new annual compliance review of processes to assess and ensure compliance with MHPAEA

Additional Enforcement Efforts

United Behavioral Health Settlement

- August 2021: EBSA and NY Attorney General's office entered into settlement agreements with United Behavioral Health, United Healthcare Insurance Co., and Oxford Health Insurance Inc.
- $13.6 million in restitution to participants/beneficiaries; $2.08 million in penalties, $3.35 million in attorney's fees, and $750,000 already paid to affected participants and beneficiaries
- Issues investigated: a provider reimbursement NQTL that discounted MH/SUD lower-level licensures disproportionately; the Algorithms for Effective Reporting and Treatment, an outlier management NQTL that disproportionately applied to MH/SUD services; and disclosures to participants and beneficiaries that failed to provide detailed information about the NQTLs
- United agreed to cease the investigated practices, improve its disclosures to plan participants and beneficiaries, and committed to future compliance

Additional Enforcement Efforts

Investigation of Large Claims Administrator

- Two EBSA regional offices investigated a large claims administrator for self-insured health plans, focusing on the exclusion of coverage for ABA therapy for autism spectrum disorder
- Claims administrator offered self-insured plans the option to exclude coverage for ABA therapy
- Following investigation, claims administrator made ABA therapy coverage the default for all its self-insured plans

Recommendations to Congress

- EBSA believes that authority for DOL to assess **civil monetary penalties** for parity violations has the potential to greatly strengthen the protections of MHPAEA

Recommendations to Congress

- DOL recommends that Congress amend ERISA to expressly provide the agency with the authority to directly pursue parity violations by **entities that provide administrative services to ERISA group health plans** (including health insurance issuers that provide administrative services to ERISA plans and TPAs)

Recommendations to Congress

- Congress amend ERISA to expressly provide that participants and beneficiaries, as well as DOL on their behalf, may **recover amounts lost by participants and beneficiaries** who wrongly had their claims denied in violation of MHPAEA, ensuring that participants and beneficiaries are made whole

Recommendations to Congress

- Departments recommend that Congress consider ways to permanently expand access to **telehealth and remote care** services

Recommendations to Congress

- Departments recommend that Congress consider amending MHPAEA to ensure that MH/SUD benefits are defined in an objective and uniform manner pursuant to external benchmarks that are based in nationally recognized standards

Mental Health Parity: Key Takeaways

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What to Do Today

- Review your comparative analyses for potential insufficiencies
  - Organize supporting documents
  - Ensure analysis is complete, not based on conclusory statements
- Ensure all parties are on the same page as to who has completed the analyses
- Implement annual review process
  - Look for already established impermissible NQTLs highlighted in report

If You Receive a Request

- Be careful in requesting additional time
  - Per 2022 report, 40% of plans and issuers requested an extension
  - EBSA concluded that many were unprepared
- Remember that plans and issuers have compliance responsibility
  - A number of plans stated that they were unable to comply because they assumed that service providers would prepare a comparative analysis for the plan, realizing only after receiving EBSA's request that the service provider had not prepared a comparative analysis that the plan could use

Nondiscrimination for Group Health Plans

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Background

- Section 1557 of ACA:
  - An individual shall not, on the grounds of race, color, national origin, sex, age or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance or under any program or activity that is administered by an Executive agency or any entity established under Title 1 of the ACA.

Application

- ACA Section 1557 applies to the following group health plans:
  - Any “health program or activity,” any part of which is receiving federal financial assistance (including credits, subsidies, or contracts of insurance) provided by HHS
  - Any program or activity administered by HHS under Title I of the ACA
  - Any program or activity administered by any entity established under Title I of the ACA.

2016 Final Rule

- Defined discrimination “on the basis of sex” to include discrimination on the basis of gender identity.

2020 Final Rule

- Removed the specific definition of discrimination "on the basis of sex," incorporating a reference to the definition in civil rights statute
- In preamble, HHS indicated that discrimination "on the basis of sex" did *not* include discrimination based on sexual orientation or gender identity.

Bostock v. Clayton County, Georgia

- Issued shortly after 2022 final rules were published
- Held that employment discrimination on the basis of an employee's sexual orientation is prohibited as discrimination "on the basis of sex"
- Following *Bostock*, several lawsuits were filed in response to the 2020 final rules
  - Two cases resulting in injunctions, staying the repeal of the definition of discrimination "on the basis of sex"

2021 HHS Announcement

- Announced May 10, 2021
- HHS to interpret and enforce ACA nondiscrimination provisions to include a prohibition on the basis of sexual orientation and gender identity
- Aligns with *Bostock* decision

Questions?

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