

The Path Forward

for mental health and substance use

Health Equity for all Americans

DOL Mental Health Parity Enforcement: Implications for Plan Sponsors and The Path Forward

June 17, 2021



Speakers



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The Path Forward for
Mental Health &
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America Today

1 in 4 of us has a mental health condition and
1 in 12 has a substance use disorder.
COVID-19 is increasing these rates.

When we are hurting, we cannot find the help we need.

Our system for treating mental health and substance abuse disorders (MH/SUD) is broken: 60% of cases go undetected, undiagnosed, and untreated.

- Minimal screening for early detection (10-year lag between disease onset and diagnosis).
- Most mental health and substance abuse care and prescriptions are given by primary care docs who are capable, but unsupported.
- Access barriers to counselors and psychiatrists:
 - Inadequate insurance networks
 - Poor participation in the networks
 - Shortages
- No one is being held accountable.

Mental Illness

Leads other common chronic medical conditions in all the wrong ways

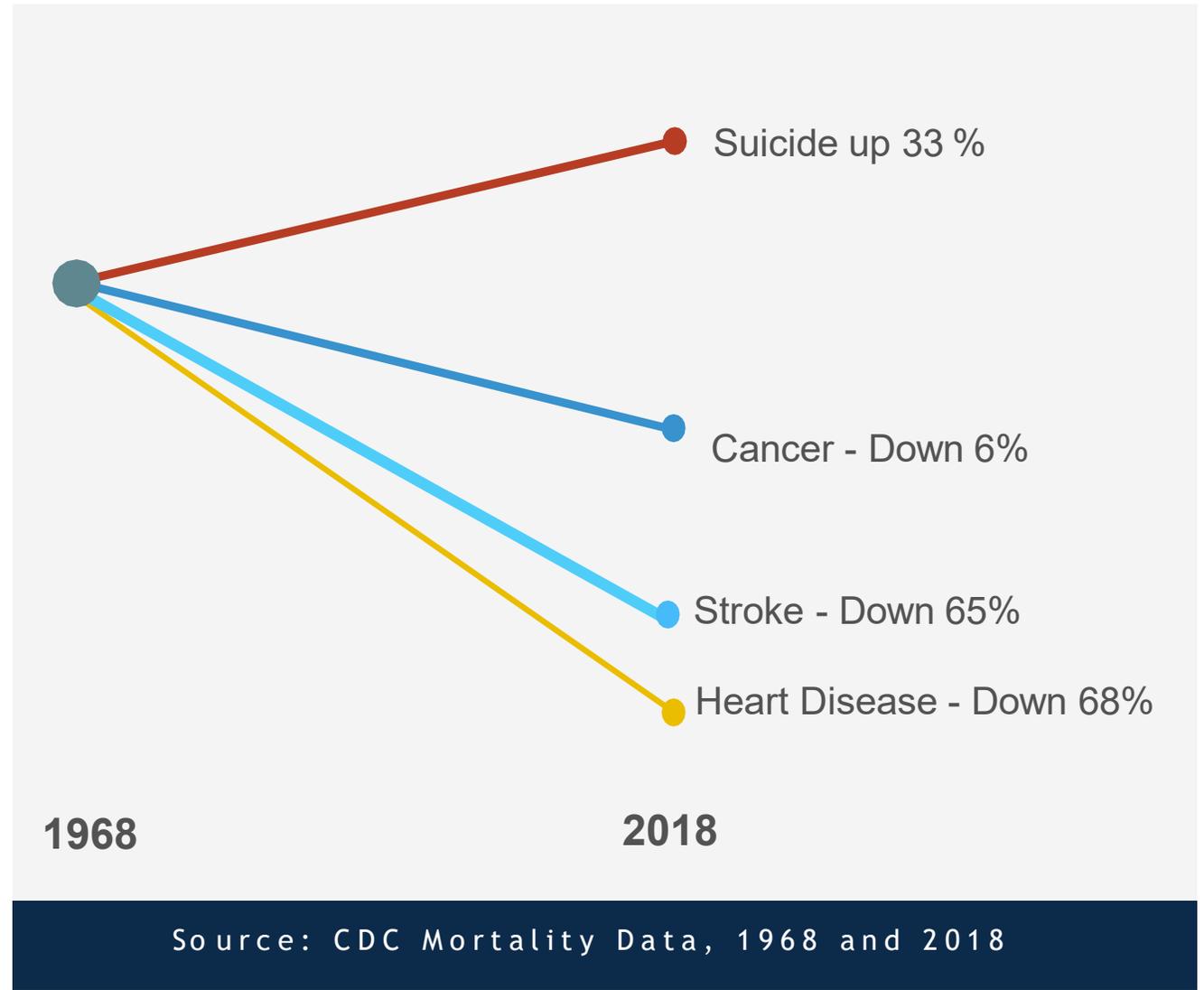
Surpasses cancer, heart disease and stroke as the:

Ø Only common chronic condition with climbing deaths over the past 50 years

Ø #1 cause of disability ¹

Sources: 1 Lancet Commission, 2020, 2014

Hoy,



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Health Equity for all Americans



This Fundamental Health Inequity

Is even worse for some of us

- Before COVID-19, 50.1% of Whites versus 33% of Blacks and 34% of Latinos with any mental illness received MH/SUD services.¹
- COVID-19 increased demand: Latino and Black people, women, and people with low-incomes report greater levels of stress, anxiety and great sadness due to the pandemic:
 - 39% of women vs. 26% of men
 - 40% of Latinos and 39% of Blacks vs. 29% of Whites ²

Sources: 1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2018 and 2019 2. Commonwealth Fund, 2020

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

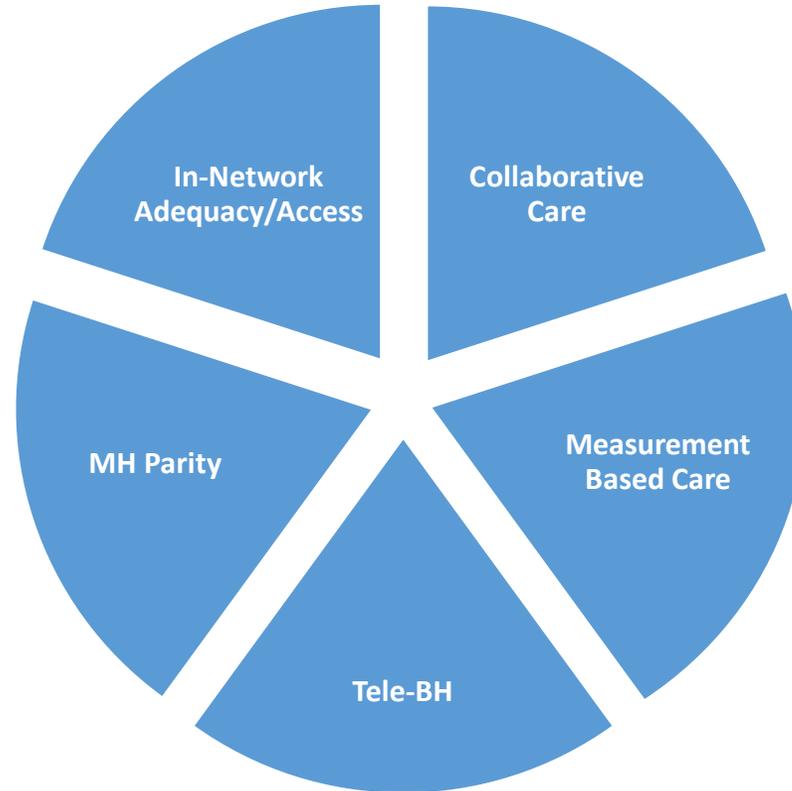
Lack of parity compliance governance and oversight

- Process = Compliance

Path Forward for MH & SU - Five Evidence-based Reforms

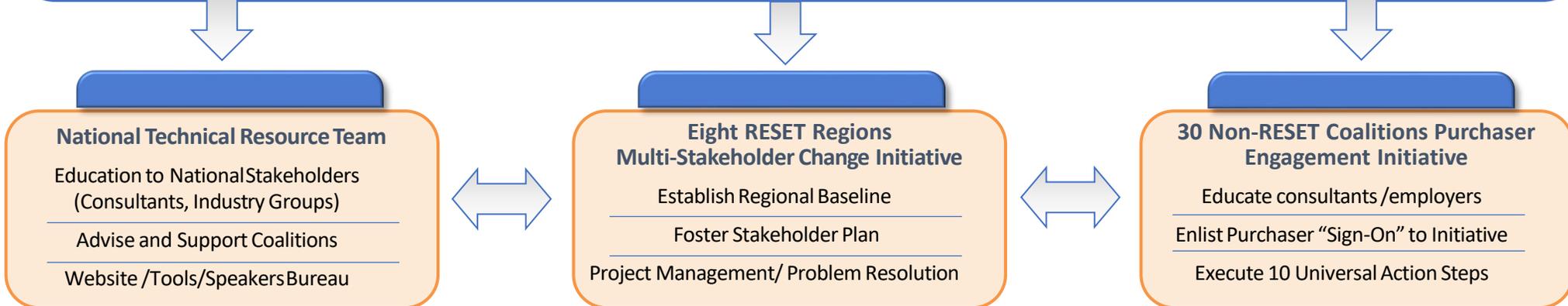
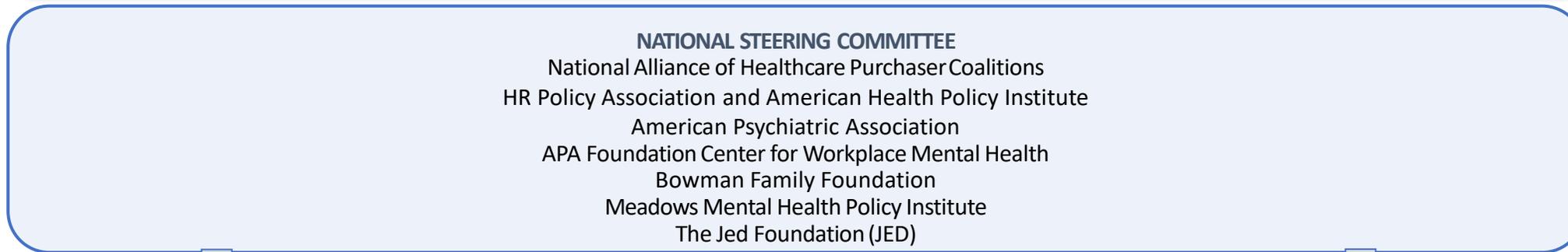
Dramatically Improve Early Detection and Access to Effective Behavioral Healthcare

1. Improve **in-network access** to BH providers
2. Expand MHSU screening and monitoring through **Measurement Based Care**
3. Expand integration of BH care into primary care settings through implementation of the **Collaborative Care** model (CoCM)
4. Improve and expand use of **tele-behavioral health** (TBH)
5. Achieve true **mental health parity**



Together, the five strategies can overcome the multidimensional, interdependent issues to accessing affordable outcomes-focused care

The PATH FORWARD Five-Year Plan

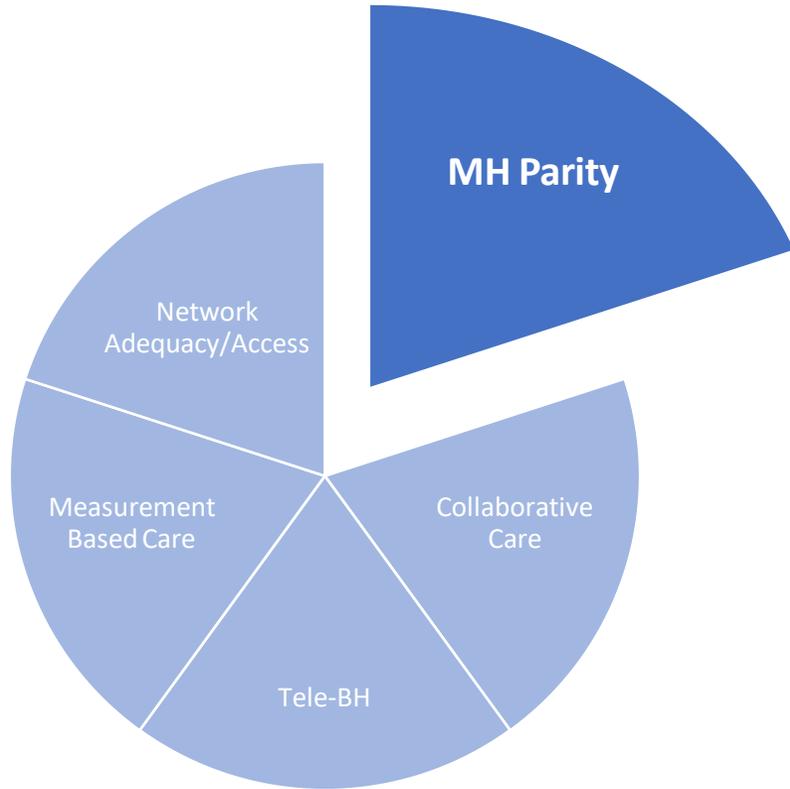


RESET

Regional
Employer
Stakeholder
Engagement
Team



Achieving MH Parity: Partnering to Close Gaps



- Employers - just as payers - are subject to MH parity compliance.
- The Path Forward embraces a private sector approach - collaborative, multi-stakeholder - where payers are viewed as partners in accelerating needed changes.
- Through advances in all 5 Priority Strategies we believe we can fully achieve true parity. These strategies align with health plans across the country to improve access to and quality of BH care.

Key Takeaways for Employers and other Plan Sponsors

Plan sponsors should require their TPAs to provide them with detailed comparative analyses including quantitative comparisons based on DOL requirements.

- As Network Adequacy is an NQTL, plan sponsors should expect their TPA to highlight any plans for improvement to address network access problems
 - Expand their behavioral networks
 - Remove barriers such as low reimbursement rates or slow admission to networks
- Use the increased focus on parity to truly accelerate improvements in access to behavioral care not limited to meeting the minimum requirements of parity

The Path Forward [Model Data Request Form](http://www.mhtari.org/Model%20Data%20Request%20Form.pdf) can serve as a vehicle to demonstrate efforts to improve MHSA access and parity

[http://www.mhtari.org/Model Data Request Form.pdf](http://www.mhtari.org/Model%20Data%20Request%20Form.pdf)

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Upcoming Webinars & Events

Mental Health Index – U.S. Worker Edition April Results

June 18 | noon-12:30 p.m. (EDT)



National Alliance
of Healthcare Purchaser Coalitions
Driving Health, Equity and Value

ANNUAL FORUM

NOVEMBER 8–10, 2021

Crystal Gateway Marriott
1700 Richmond Highway
Arlington, VA 22202

