The Leapfrog CAA Compliance Webinar Series Session 2: New Mental Health Parity Requirements: Are you Ready?

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**ALERT: New U.S. Department of Labor Report published today (Jan 25, 2022) **

Link: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf

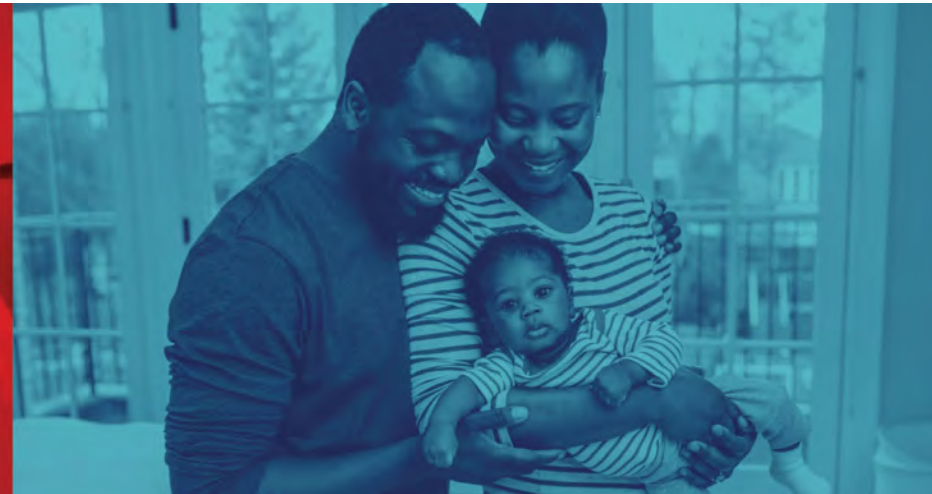
ERIC | *Shaping benefit policies before they shape you.*

January 25, 2022

Compliance Alert: 4 Things Employers Must Do Before January 1st

Leapfrog Consolidated Appropriations Act Webinar Series

James Gelfand, Executive Vice President, Public Affairs



Agenda

- MHP Basics
- Statutory Evolution
- Compliance Evolution
- Consequences for Noncompliance
- Closer Look at CAA (2020) Requirements

Mental Health Parity Basics

- Parity is **NOT** a mandate
- Designed to ensure medical/surgical benefits and mental/behavioral health benefits treated equally – benefits, treatments, and cost-sharing
- Original MHP legislation focused on simple quantitative limits. Copays, length of stay, etc.

Mental Health Parity's Abbreviated Statutory Evolution

- MHP has been expanded numerous times after passage of MHPAEA:
  - **Initial regulatory rollout (2009**): Created "NQTLs"
  - **ACA (2010):** Applied MHP to more plans, moved some mental/behavior health services to preventive (1st-dollar), made it an EHB (so no annual/lifetime limits)
  - **21st Century Cures (2016):** Expands mental and behavioral health to include eating disorders, steps up compliance
  - **CAA (2020):** Further steps up audits/compliance, requires plan sponsors to have all documentation available

Mental Health Parity's Compliance Evolution

- Initially focus was on *overt parity violations* in a plan – different deductibles, copays, and other limitations that were easy apples-to-apples comparisons. **LARGELY ADDRESSED**

- Next focus evolved to *"Non-quantitative treatment limitations,"* apples-to-oranges comparisons. Things like medical management, formulary structure, treatment exclusions. **EXPECTED TO BE ADDRESSED VIA CAA REGIME**

- DOL now signals they will advance to a *new phase*, looking for things like disparate impact on mental health patients, reimbursement gaps between mental/behavioral and medical/surgical, network strength. **FOCUS LESS ON PLAN DOCUMENTS AND MORE ON PATIENT EXPERIENCE**

Consequences for Noncompliance

- Under MHPAEA, a plan found to have parity violations must:
  - Update the terms of the plan to eliminate the violation(s)
  - Make right by plan participants who were affected by the violation, which could include paying any improperly denied benefits or claims
- Congress is currently considering legislation that would impose Civil Monetary Penalties for violations – whether intentional or inadvertent, and whether overt or via NQTL
  - Employers have opposed these provisions, and have asked that DOL differentiate between intentional and mistake violations

Closer Look at CAA (2020) Requirements

- Requires PLAN SPONSOR to have parity analyses on hand – not vendors
  - That means for every limitation on M/B in the plan, need a specific document with analysis that explains how it coincides with limitations on the M/S side
  - Cannot be a generalization, needs to specify the exact limitations
  - Cannot just be an equation, or statement of methodology
  - Also, cannot be a “document dump” with thousands of pages, to respond to a specific inquiry

Closer Look at CAA (2020) Requirements (Cont.)

- DOL has begun affirmatively auditing plans, rather than just waiting for complaints
- DOL has NOT been satisfied with disclosures from plan sponsors
  - They have rejected analyses as incomplete
  - They have rejected document dumps as not specific enough
  - They have rejected "excuses" that documents not provided by vendors

Closer Look at CAA (2020) Requirements (Cont.)

- Remember, parity analyses should in theory have already existed
- Vendors assure plan sponsors that limitations in their plan are in compliance with MHP rules. But how can that be, if parity analyses have not been conducted?
- So, while employers traditionally have not necessarily possessed or reviewed this information, DOL's position is, it should be possible to instantly come into compliance

Conclusion

- Remember – THE BUCK STOPS WITH THE EMPLOYER

- DOL often cannot regulate vendors. They're focused on the employer.
  - "I relied on the insurance company" will NOT work

Questions?

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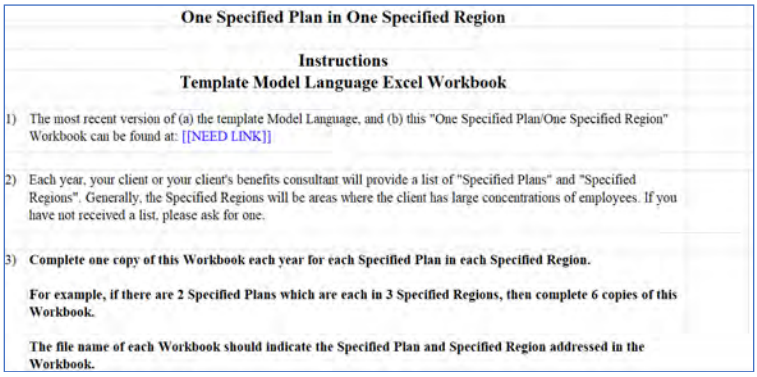
CAA COMPLIANCE: Mental Health Parity Requirements
5 Tips & Tools for Employers To Do Now

- **Action Item #1**:

Request from your carrier the data necessary to validate the mental health parity on the quantified, non-qualitative, and experiential dimensions.

Tool: MDRF Materials that any employer can email to their carrier as a questionnaire to request the data necessary to validate the mental health parity on the quantified, non-qualitative, and experiential dimensions.



One Specified Plan in One Specified Region

Instructions
Template Model Language Excel Workbook

1) The most recent version of (a) the template Model Language, and (b) this "One Specified Plan/One Specified Region" Workbook can be found at: [[NEED LINK]]

2) Each year, your client or your client's benefits consultant will provide a list of "Specified Plans" and "Specified Regions". Generally, the Specified Regions will be areas where the client has large concentrations of employees. If you have not received a list, please ask for one.

3) **Complete one copy of this Workbook each year for each Specified Plan in each Specified Region.**

For example, if there are 2 Specified Plans which are each in 3 Specified Regions, then complete 6 copies of this Workbook.

The file name of each Workbook should indicate the Specified Plan and Specified Region addressed in the Workbook.

Link here: MDRF_Model_Data_Request_Form_Employers.pdf

- **Action Item #2**: **Action Item #2**: ***Reduce the amount of fraud conducted through out-of-network facilities by sending the following request (or similar) to your carrier or simply having a conversation with them about curbing Out-Of-Network (OON) abuse.***

Note: Much of OON abuse has been targeting the mental health benefit, which puts this benefit at risk for members and drives up the cost for everyone on the plan:

> *[Account Manager],*
> *It has come to our attention that many out-of-network providers will call into the carrier to inquire about plan benefits to determine limits and how much they can charge the health plan, rather than billing a fair price for a service and letting the appropriate benefit apply. To prevent this kind of abuse, we ask that benefit levels not be quoted over the phone to out-of-network*

inpatient, skilled nursing, and rehabilitation providers who call in to inquire, but instead having benefits be quoted directly to plan members, reducing the opportunity for provider-driven abuse. ***Link here****: HTA Acct Manager Data Request*

TIP: If you simply want this type of abuse to be screened each month within your claims and eliminated, there are a couple of firms that specialize in this and can be added easily, so you don't have to wonder.

HTA example:
Two Employer members are saving over $100,000 per month on fraudulent claims blocked, and one is saving about $40,000 per month, much of which is targeting the mental health benefit.

- ***Action Item #3: Get access to and control over your data so that you can confirm these analyses yourselves.*** Many employers have gotten data feeds for over a decade (not to a data warehouse, but their own servers). Warning, some benefits teams do not have the IT support to conduct this safely.

  HTA example:
  HTA Employers have been using AWS servers with max encryption and data software to receive data feeds to themselves without having to worry about a breach, and we recommend every employer look at this strategy. The software programs are **Abett, Switchbridge**, or **Tableau**.

- **Action Item #4**: ***Change the plan benefit to add in-network benefits for out-of-network behavioral health providers to amplify In-network access and reduce reimbursement discrimination quickly.***

  HTA example: We have almost a dozen employers who have used this strategy. It is becoming quite common, enabling people to find providers wherever possible and use them with a more affordable benefit. Remember that we already do something similar in emergency rooms, anesthesiology, radiology, and pathology—most of these providers are out of network, so we pay all of them with in-network benefits because otherwise there's not enough access, which is terrible for members. The same can be said of mental health, where a large portion is OON, and in order for us to secure affordable access for members, we are seeing many employers simply pay them with in-network benefits.

- **Action Item #5**: ***Consider a behavioral health network overlay.*** This solution is the most comprehensive and is the newest, which is to say that the group finds behavioral health providers and simply adds them to their medical network. This can be done in a grassroots manner or through a vendor.

  HTA examples:
  Grassroots: One employer reached out to NYU, who has a medical school, and asked to have a direct contract to use all their therapists as in-network for their population. The school went for it, and it added dozens of new providers in NYC just for them. It didn't take anything away from Cigna/Aetna/UHC but just added more in-network contracted providers.

Vendor: If building your own seems like a lot of work, you're not alone, so we recommend considering an innovative mental health vendor. Several vendors are out there, such as **AbleTo, Ginger, Headway, Lyra Health, Quarter, Spring Health**, and more.

HTA utilizes Lyra Health which has over 5,000 therapists, psychiatrists, and other mental health providers who can overlay your medical network. The result is rapid access, online booking, in-person and virtual therapy, and psychiatry solution to make a terrific in-network mental health benefit on top of what the carrier already offers. HTA members can add this network reinforcement for no PEPM cost and simply pay for the services through the claims if people want to use them. For more information, see contact info provided in toolkit.

BONUS:

Best practice tools for NQTL analyses can be found at The Bowman Family Foundation:

1. ***Model Data Request Form (MDRF) for employers:***
   An employer tool for improving access to behavioral health care.
   The MDRF focuses on four (4) key quantitative measures:

   (1) Out-of-Network Use of MH/SUD providers versus medical/surgical (M/S) providers
   (2) In-Network Reimbursement Rates for MH/SUD versus M/S providers
   (3) Denial Rates for MH/SUD versus M/S services
   (4) Network Adequacy and Participation for Psychiatrists

2. ***Model Hold Harmless Language*** *- sample indemnification/hold harmless clause for use by employers in their vendor contracts with third party administrators as related to parity law compliance.*

3. ***Updated Issue Brief: State Regulators' Use of Required Quantitative Data Templates to Assess NQTL Parity Compliance*** *– an issue brief identifying a number of quantitative templates that several state regulators are requiring for use in assessing NQTL compliance.*

4. ***Six-Steps Parity Guide for NQTL Compliance*** *– a detailed issue brief covering specific types of non-quantitative treatment limitations governed by the federal parity law and regulations, with detailed illustrations to assist issuers, regulators, or others.*

5. ***Best Practice Examples for NQTL Compliance with Regulatory Guidance Embedded*** *– a set of examples for regulators and others, illustrating compliant design, application and comparability testing of non-quantitative treatment limitation.*

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VIIII. Additional Resources:

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