



Health Insurance Issuers & MHPAEA Comparative Analysis Reviews



*Center for Consumer
Information and
Insurance Oversight*

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Introduction

The Centers for Medicare & Medicaid Services (CMS) is committed to providing health insurance issuers (Issuers) the resources, support, technical assistance, and information they need to help ensure their plans are compliant with applicable Federal requirements.

The purpose of this presentation is to:

- Provide an overview of the provisions related to the Mental Health Parity and Addiction Equity Act (MHPAEA) added by the Consolidated Appropriations Act, 2021 (CAA);
- Discuss how the new provisions apply to Issuers; and
- Introduce MHPAEA resources and compliance tools.

Roadmap

- Overview of MHPAEA Requirements;
- Overview of Non-Quantitative Treatment Limitations (NQTLs);
- Discussion of the MHPAEA-related provisions in the CAA;
- Overview of NQTL Comparative Analysis Review Process;
- Resources and Compliance Tools; and
- Questions and Answers.

MHPAEA: Overview

- MHPAEA generally provides that financial requirements and treatment limitations imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical (M/S) benefits in the same classification.
- Under MHPAEA regulations, any Issuer that provides MH/SUD benefits in any classification described in the regulations must provide MH/SUD benefits in every classification in which M/S benefits are provided.
- Separate treatment limitations and cost sharing requirements that apply only to MH/SUD benefits are prohibited.

42 U.S.C. §300gg-26.

45 C.F.R. §146.136(c)(2)(i).

45 C.F.R. §146.136(c)(2)(ii)(A).

MHPAEA: Overview

The MHPAEA regulations define six classifications of benefits:

- **Inpatient, out-of-network;**
- **Inpatient, in-network;**
- **Outpatient, out-of-network;**
- **Outpatient, in-network;**
- **Emergency care; and**
- **Prescription drugs.**

45 C.F.R. 146.136(c)(2)(ii).

Which Plans Are NOT Subject To MHPAEA?

MHPAEA generally applies to group health plans and group and individual health insurance issuers that offer both MH/SUD and M/S benefits with the following exemptions:

- **HIPAA Opt-Out Exemption:** Self-funded, non-Federal governmental plans that submit or renew a timely, complete Health Insurance Portability and Accountability Act (HIPAA) opt-out exemption electing to opt out of MHPAEA;
- **Small Employer Exemption:** Some plans sponsored by employers with 50 or fewer employees;
- **Excepted Benefit Exemption:** Group health plans and group or individual health insurance coverage offering only excepted benefits are generally exempt from MHPAEA;
- **Retiree-Only Group Health Plans;** and
- **Increased Cost Exemption:** Plans that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or at least one percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost.

45 C.F.R. 146.136(g).

DOL MHPAEA Self-Compliance Tool, pg. 6.

NQTL Overview

The MHPAEA regulations require that Issuers may not impose an NQTL on MH/SUD benefits in any classification unless, under the terms of the plan or health insurance coverage, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the same classification.

45 C.F.R. §146.136(c)(4)(i).

NQTL Examples

Some examples of NQTLs are:

- **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 a network, including reimbursement rates;
- **Formulary design** for prescription drugs; and
- **Fail-first policies or step therapy protocols** (refusal to pay for higher-cost therapies until it can be shown a lower-cost therapy is not effective).

MHPAEA NQTL FAQ, pg. 7-8.

See also 45 C.F.R. §146.136(c)(4)(ii)(A)-(H); DOL MHPAEA Self-Compliance Tool, pg. 19.

NQTLs and Factors Considered In Design

An Issuer may consider a wide array of factors in designing an NQTL. Factors considered may include (but are not limited to):

- **Excessive utilization;**
- **Recent medical cost escalation;**
- **Provider discretion in determining diagnosis;**
- **High variability in cost per episode of care;**
- **High levels of variation in length of stay;**
- **Lack of adherence to quality standards;**
- **Claim types with a high percentage of fraud; and**
- **Current and projected demand for services.**

NQTLs and Sources Considered In Design

Issuers have flexibility in determining the sources of factors to apply to NQTLs as long as they are applied comparably and no more stringently to MH/SUD benefits as to M/S benefits. Sources include:

- **Internal claims analysis;**
- **Medical expert reviews;**
- **State and federal requirements;**
- **National accreditation standards;**
- **Internal market and competitive analysis;**
- **Medicare physician fee schedules; and**
- **Evidentiary standards (including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits).**

Consolidated Appropriations Act, 2021

- The Consolidated Appropriations Act, 2021 (CAA) was enacted on December 27, 2020.
- Division BB, Title II, Section 203 of the CAA expressly requires that group health plans or health insurance issuers offering group or individual health insurance coverage that provide both M/S and MH/SUD benefits and that impose NQTLs on MH/SUD benefits perform and document comparative analyses of the design and application of their NQTLs.
- The law requires Issuers to make their NQTL comparative analyses available to the Secretary of Health and Human Services (HHS) or applicable state authorities upon request.
 - This requirement went into effect on **February 10, 2021**.
- The CAA also requires HHS to submit to Congress and make publicly available an annual report summarizing the comparative analyses requested and providing HHS' conclusions as to the analyses that it has requested.

*Pub. L. 116-260 (Dec. 27, 2020).
See also PHS Act § 2726(a)(8)(A),(B)(iv).*

NQTL Comparative Analysis Review Process

- CMS will request at least 20 NQTL comparative analyses each year from Issuers in states in which CMS is directly enforcing MHPAEA, and non-Federal governmental plans in those or other states.
- CMS will request an NQTL comparative analysis in the following circumstances:
 - **CMS determines that a plan involves a potential MHPAEA violation;**
 - **CMS receives a complaint regarding potential noncompliance with MHPAEA that concerns NQTLs; and**
 - **Any other instance that CMS deems appropriate.**
- Note: When reviewing an NQTL comparative analysis, CMS may observe compliance concerns with MHPAEA's other rules, including those relating to financial requirements and quantitative treatment limitations. In such cases, CMS will bring those concerns to the Issuer's attention.

NQTL Comparative Analysis Review Process - Continued

When an Issuer is selected for an NQTL comparative analysis review, CMS will send an initial call letter that will:

- Identify the NQTL(s) for which CMS is requesting the comparative analyses and supporting documents;
- Describe the documents that the Issuer must provide to be responsive to the review;
- Describe the process by which documents should be submitted to CMS; and
- Provide contact names and email addresses for CMS staff, and any applicable contractors, to assist you with your questions while you gather information for response.

NQTL Comparative Analysis Review Process - Continued

What actions will CMS take if it determines that an Issuer has not submitted sufficient information to review an NQTL comparative analysis?

- If CMS concludes that an Issuer has not provided sufficient information for CMS to review the comparative analysis, it will send a notice of insufficient documentation.
- The notice will specify the information that the Issuer must submit to be responsive to CMS's request.

PHS Act § 2726(a)(8)(B)(ii).

NQTL Comparative Analysis Review Process - Continued

What actions will CMS take if it determines that an Issuer is not in compliance with MHPAEA after its initial review?

- If CMS determines that an Issuer is not in compliance with MHPAEA after its initial review, it will send an initial notice of noncompliance to the Issuer detailing the compliance issues uncovered in its review.
- The Issuer will have 45 calendar days from the date of the initial notice of noncompliance to specify the actions it will take to come into compliance **AND** submit an additional NQTL comparative analysis that demonstrates compliance, even if the actions have not yet been implemented.

PHS Act § 2726(a)(8)(B)(ii).

NQTL Comparative Analysis Review Process - Continued

What actions will CMS take if it determines that an Issuer is not in compliance with MHPAEA after its review of the updated NQTL comparative analysis submitted within the 45-day correction period?

- If CMS determines that the Issuer is still not compliant with MHPAEA after a resubmission, it will send a final notice of noncompliance to the Issuer describing the remaining compliance issues and required corrective actions the Issuer must take.
- The Issuer will then have seven calendar days to send notification to enrollees that it is not compliant with MHPAEA.
- CMS will, in its annual report to Congress, identify the Issuer and the corrective actions it must take to come into compliance with MHPAEA.
- CMS will follow up with the Issuer to ensure the corrective actions required in the final determination notice are implemented by the Issuer.

PHS Act § 2726(a)(8)(B)(iii),(iv)(I),(V).

NQTL Comparative Analysis Review Process - Continued

What actions will CMS take if it does not find any MHPAEA compliance issues after its initial review?

- If CMS finds no compliance issues with MHPAEA requirements after its initial review, it will send a notice stating that no MHPAEA compliance issues were found.
- If the initial review was conducted based on a complaint or other indication of a potential violation of this section of MHPAEA, CMS will conduct an investigation into compliance with other MHPAEA provisions, including:
 - Financial requirements; and
 - Quantitative treatment limitations.

What Information Must An Issuer Provide In Response To CMS's Request For Documentation Of Its NQTL Comparative Analyses?

- For an NQTL comparative analysis to be sufficient, it must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue, and include the bases for the Issuer's conclusions that the NQTL complies with MHPAEA.
- Please see the FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 and the Department of Labor's (DOL) MHPAEA Self-Compliance Tool (linked on the Resources slide of this presentation) for a detailed description of the minimum elements a sufficient NQTL comparative analysis must contain.

Why Might CMS Conclude That An Issuer's Documentation Of An NQTL Is Insufficient?

When responding to requests for comparative analyses, a general statement of compliance or conclusory references to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient.

Issuers should also avoid the following practices:

- Production of a large volume of documents without a clear explanation of how and why each document is relevant to the NQTL comparative analysis;
- Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
- Identification of processes, strategies, sources, and factors without the required or clear and detailed NQTL 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; or
- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

What Types Of Additional Documents Should An Issuer Be Prepared To Provide CMS To Support Its Analyses?

Issuers should be prepared to provide any other documents and information that support the conclusions of their NQTL comparative analyses.

The exact information needed to support an NQTL comparative analysis will depend on the type of NQTL and the processes, strategies, evidentiary standards and other factors used by the Issuer.

As an example, the DOL MHPAEA Self-Compliance Tool highlights the following information:

- Records documenting NQTL processes and detailing how NQTLs are being applied to both M/S and MH/SUD benefits to ensure that the issuer can demonstrate compliance;
- Any documentation, including guidelines, claims processing policies and procedures, or other standards that the Issuer relied upon to determine that any NQTL applied to MH/SUD benefits is comparable to and applied no more stringently than the NQTL as applied to M/S benefits (Issuers should include details about how the standards were applied and any internal testing, review, or analysis done by the Issuer to support its rationale);
- Samples of covered and denied MH/SUD and M/S benefit claims;
- Documents related to MHPAEA compliance with respect to service providers if a plan delegates management of MH/SUD benefits to another entity.

DOL MHPAEA Self-Compliance Tool, pg. 34.

MHPAEA NQTL FAQ, pg. 5-6.

Disclosure Requirements

- In general, Issuers must make available the criteria for medical necessity determinations with respect to MH/SUD benefits to any current or potential participant, beneficiary, or contracting provider upon request.
- Issuers must also make available the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits to any participant or beneficiary.
- Non-grandfathered plans must provide claimants reasonable access to all documents relevant to a claim upon appeal, including access to an NQTL analysis if applicable.
- In addition, Issuers must make their NQTL comparative analyses and other information available to the applicable state authority upon request.

PHS Act § 2726(a)(8)(A).

45 C.F.R. §146.136(d)(1)-(2).

See Also 45 C.F.R. § 147.136(b).

Disclosure Requirements

- The Departments of Health and Human Services, Labor, and the Treasury have created a template form for disclosure requests that enrollees may use to request information about the processes, strategies, evidentiary standards, and other factors used in applying an NQTL.
- The template can be found here:
<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-Disclosure-Template-1.pdf>

How to Contact CMS Directly

MHPAEA Enforcement Team Email Resource:

MHPAEA_Enforcement@cms.hhs.gov

Resources

- FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.
- DOL MHPAEA Self-Compliance Tool: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>
- CMS MHPAEA Fact Sheet: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

Questions & Answers

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