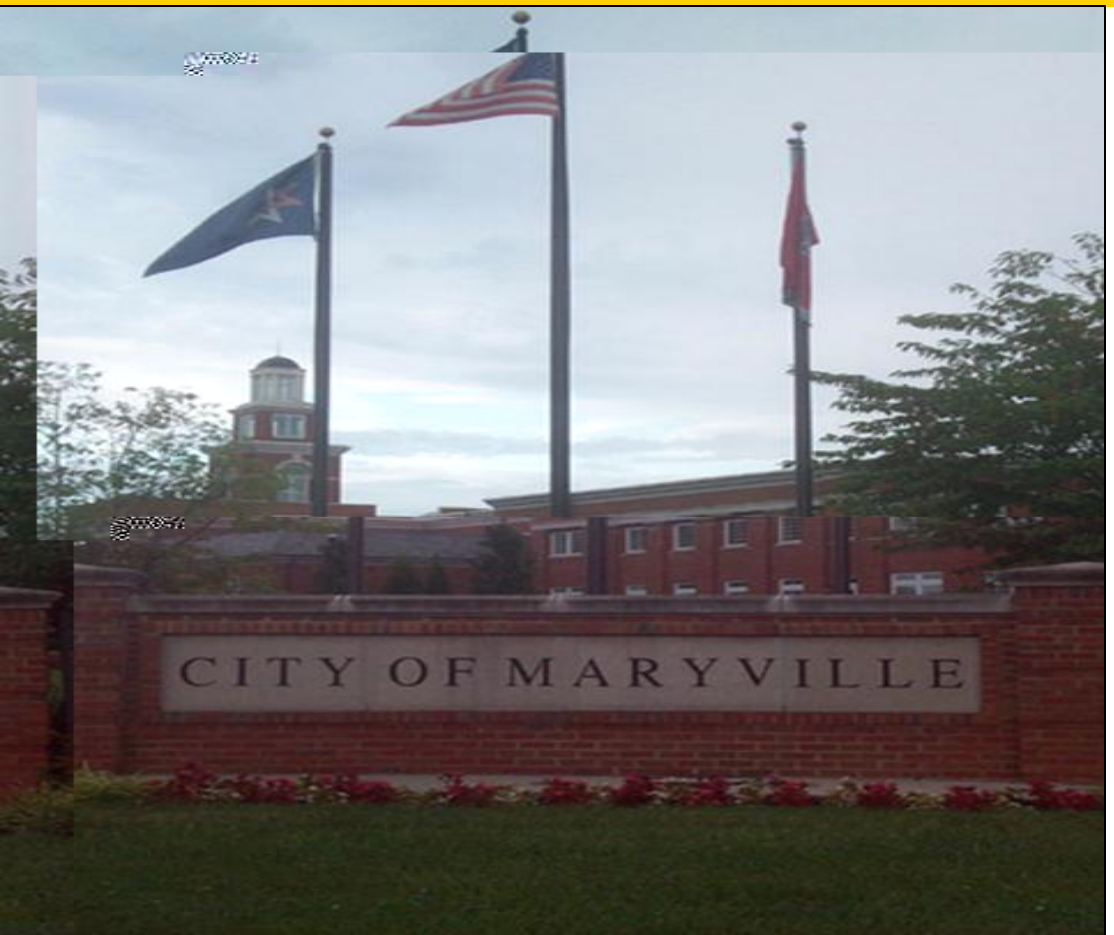
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES



- This is a 60-minute session.
- This webinar is being recorded. CMS requires all webinar materials to undergo a clearance process prior to being distributed to issuers, states, and the public. This may affect the posting and availability of materials.
- This webinar will provide an opportunity for Subject Matter Experts (SMEs) to respond to questions.
- For questions regarding content, contact CMS Help Desk by email at: NonFed@cms.hhs.gov.
- For questions regarding webinar access or logistics, contact Registration Support at: (800) 257-9520.

At the end of today's presentation, we will have a question-and-answer session. Please submit your questions in the Q&A tab.

Type your question in the text box under the " " tab and click " ."

Due to time constraints, we may not be able to answer all questions posed during today's session either in writing, or during the live Q&A portion. However, CMS will review all questions and provide responses accordingly.

- The information provided in this presentation is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This presentation summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.
- This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

CMS is committed to providing Non-Federal Governmental Plan (Non-Fed Plan) sponsors the resources, support, technical assistance, and information they need to ensure their Plans are fully compliant with applicable federal requirements.

The purpose of this presentation is to:

- provide an overview of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- discuss how MHPAEA applies to Non-Fed Plans;
- provide information related to MHPAEA enforcement; and
- introduce MHPAEA resources and compliance tools.

- A group health plan or health insurance issuer offering health insurance coverage in the group or individual market (that is not otherwise exempt) must ensure that parity requirements are met in the coverage of MH/SUD and Med/Surg benefits with respect to the following areas:
  - Annual and Lifetime Dollar Limits (PHS Act section 2711);
  - Financial Requirements; and
  - Treatment limitations, including:
    - Quant633cludpDdsL (t63Le V* n h g C2_He6/MCwWTf 435.167.998 (t) (Qu)su8ct

- MHPAEA mandate that Non-Fed Plans provide MH/SUD benefits.
- However, under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the regulations, MH/SUD benefits must be provided in every classification in which Med/Surg benefits are provided.

section 2707(a) of the PHS Act and its implementing

- Non-Fed Plan is not required to and does NOT offer MH/SUD benefits →
  - Plan is self-funded and is defined as a small employer plan (employer has 50 or fewer employees)→ ;
  - Plan incurs at least one (1) percent increase in cost in years since complying with MHPAEA (two [2] percent in the case of the first plan year in which this section is applied to the plan or coverage) and meets requirements for the increased cost exemption→ for the applicable plan year.

- Non-Fed Plan DOES


ey Term

- How does the Non-Fed Plan categorize its Med/Surg and MH/SUD benefits using the following classifications?
- Does the Non-Fed Plan comply with parity requirements in lifetime & annual dollar limits?
- Does the Non-Fed Plan comply with parity requirements in financial requirements and QTLs?
- Does the Non-Fed Plan comply with parity requirements for cumulative financial requirements or cumulative QTLs?
- Does the Non-Fed Plan comply with parity requirements for NQTLs?
- Does the Non-Fed Plan comply with MHPAEA disclosure requirements?

How does the Non-Fed Plan categorize its Med/Surg and MH/SUD benefits using the following classifications (in 45 C.F.R. § 146.136(c)(2)(ii)(A)(1)(6))?

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

In determining the classification to which a benefit belongs, the Plan must apply the same standards for classifying MH/SUD benefits as for Med/Surg benefits. If a Non-Fed Plan offers MH/SUD benefits in any classification of benefits, it must offer MH/SUD benefits in every classification in which Med/Surg benefits are provided.

Multi-tiered drug formularies typically involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the different levels of financial requirements must be based on reasonable factors determined in accordance with rules for NQTLs and without regard to whether a drug is generally prescribed for Med/Surg or MH/SUD benefits.

- <u>Reasonable factors include:</u>

- cost
- efficacy
- generic vs. brand name
- mail order vs. pharmacy pick up

applies to less than

Breaking it down:

“ ”: A type of or is considered to apply to substantially all Med/Surg benefits in a classification of benefits if it applies to at least 2/3 of all Med/Surg benefits in that classification.

- If a type of financial requirement or QTL to substantially all (at least 2/3 of) Med/Surg benefits in a classification, then the financial requirement or QTL of that type to MH/SUD benefits in that classification.
  - Types of Financial Requirements include: copayments, coinsurance, deductibles, and out of pocket maximums.
  - Types of QTLs include: annual and lifetime day limits and visit limits, cumulative limits other than annual or lifetime dollar limits including limits on the number of treatments, visits, or days of coverage.

- The portion of Med/Surg benefits in a classification of benefits subject to a financial requirement or QTL is determined
  for Med/Surg benefits in the classification expected to be paid under the Non-Fed Plan for the plan year.

- may be used to determine the dollar amount expected to be paid under a plan for Med/Surg benefits subject to a financial requirement or QTL.

Breaking it down, continued:

: If a type of financial requirement or QTL does apply to at least 2/3 of ("substantially all") Med/Surg benefits in a classification, the predominant level of that financial requirement or QTL is the level that applies to
subject to the financial requirement or QTL.

If a Non-Fed Plan applies different levels of a financial requirement or QTL to different coverage units in a classification of Med/Surg benefits, the predominant level that applies to substantially all Med/Surg benefits is determined separately for each coverage unit.

– Next, determine what level of financial requirement or QTL is predominant; in other words: the level that applies to more than half the Med/Surg benefits in the relevant classification subject to the financial requirement or QTL.

: The Gladville Fire Department plan includes a $35 copay for visits to a specialist, like a cardiologist, under the Med/Surg outpatient, in-network classification. The copay for primary care physician office visits within the same classification is $20. Which level of copayment may be applied to the MH/SUD benefits in the same classification?

- Applying the "Predominant" Test: using the same reasonable method as in the "Substantially All" Test, the plan projects plan costs of $25 million for the specialist visit benefits, to which the $35 copay applies and $15 million for the primary care physician benefit, to which the $20 copay applies.
  - The $35 copay is the predominant copay because it applies to more than half of the Med/Surg benefits subject to a copay.
  - The plan may impose any level of copay for outpatient, in-network MH/SUD benefits that is .

: Does the Non-Fed Plan comply with parity requirements for cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for MH/SUD benefits in a classification that accumulates separately from any established for Med/Surg benefits in the same classification.

A plan may not establish a $250 deductible for MH/SUD benefits in a classification, and a separate $250 deductible for Med/Surg benefits in the same classification. A $500 combined deductible for all Med/Surg and MH/SUD benefits would comply with the rule above.

- Note: As noted on slide 21, different rules apply to aggregate lifetime and annual dollar limits. MHPAEA excludes lifetime and annual dollar limits from the definition of “financial requirement.”

: Does the Non-Fed Plan comply with parity requirements for NQTLs?

"A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder 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 non-quantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."

: Identify the NQTL(s) and all MH/SUD and Med/Surg benefits to which it (or they) applies. A non-exhaustive list of NQTLs includes:

- Medical management standards that limit/exclude benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Refusal to pay for higher-cost therapies until it can be shown a lower-cost therapy is not effective, also known as fail-first policies or step therapy protocols;
- Exclusions based on failure to complete a course of treatment
- Coverage restrictions based on geographical location facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services.

: "Warning Signs: Plan or Policy Non-Quantitative Treatment Limitations that Require Additional Analysis to Determine MHPAEA Compliance." (see Resource slide 44 for URL)

: are the processes, strategies, evidentiary standards, and other factors used by the Non-Fed Plan in applying the NQTL comparable and no more stringently applied to the MH/SUD benefits than to the Med/Surg benefits both as written and in operation?

Plans and issuers should be ready to demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL for MH/SUD services and Med/Surg services are comparable.

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and Med/Surg benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and Med/Surg conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and Med/Surg benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and Med/Surg benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and Med/Surg benefits were the same, both as developed and applied.

Compliance with disclosure requirements in 45 C.F.R. § 146.136(d) is not determinative of compliance with other provisions of state or federal law, including the internal claims and appeals and external review processes regulations (45 C.F.R. § 147.136).

- The internal claims and appeals rules include the right of claimants (or their authorized representative) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
  - This includes documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to Med/Surg benefits and MH/SUD benefits under the plan.
- If a Non-Fed plan sponsor fails to provide these documents, it may be liable for up to $177* a day from the date of failure to provide these documents.

CMS has direct enforcement authority with respect to Non-Fed Plans and the provisions of Title XXVII of the PHS Act that apply to them, including MHPAEA (see: 45 C.F.R. § 150.101(b)(1)):

- CMS investigates Non-Fed Plans that are not otherwise exempt when it receives information indicating potential non-compliance. (see: 45 C.F.R. § 150.303)
- CMS also has the authority to initiate a market conduct examination to determine whether a Non-Fed Plan is out of compliance with MHPAEA. (see: 45 C.F.R. § 150.313)
- CMS partners with State Department of Insurance (DOI's) with respect to fully-insured Non-

- Clause (ii) states “Exception for certain collectively bargained plans. – Notwithstanding clause (i)(II), a plan described in subparagraph (B)(ii) that is subject to multiple agreements described in such subparagraph of varying lengths and that has an election described in subparagraph (A) with respect to section 2726 in effect as of the date of the enactment of this subparagraph that expires on or after the date that is 180 days after the date of such enactment may extend such election until the date on which the term of the last agreement expires.”

What this means for Plans:

- No new HIPAA opt-out elections for MHPAEA on or after December 29, 2022.
- No renewal of HIPAA opt-out elections for MHPAEA expiring on or after June 27, 2023.
- Special rule for certain Collective Bargaining Agreement (CBA) plans: Plans subject to CBA of varying lengths with a HIPAA opt-out election for MHPAEA that expires on or after June 27, 2023 may extend such election until the date on which the term of the last such agreement expires.

- 2018 MHPAEA Self-Compliance Tool: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf

- Warning Signs: Plan or Policy NQTLs that Require Additional Analysis to Determine MHPAEA Compliance: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

- MHPAEA Draft Disclosure Form Template: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf

- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html
- https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act
- https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/understanding-implementation-of-mhpaea.pdf#page=3
- https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf
- https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf
- https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf

- https://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Self-Funded%20Non-Federal%20Governmental%20Plans
- https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HHS-2008-MHPAEA-Enforcement-Period.pdf
- https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/FY2018-MHPAEA-Enforcement-Report.pdf
- https://www.hhs.gov/about/news/2022/01/25/us-dol-hhs-treasury-issue-2022-mental-health-parity-addiction-equity-act-report-to-congress.html
- NonFed@cms.hhs.gov
- MHPAEA_Enforcement@cms.hhs.gov
- HIPAAOptOut@cms.hhs.gov

ow to Contact us Direct!

Closing Remarks