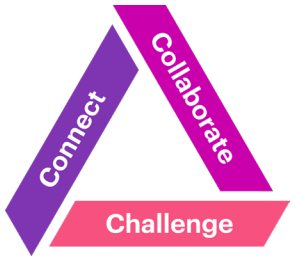
Health Policy Legislation, Regulation and Compliance: From Enactment to Enforcement

Friday, March 3, 9:00 – 10:30

Today's discussion



1. **Enactment**
   - Quick review of 2022
   - Overview and outlook for 2023
2. **Implementation**
   - End of the COVID-19 emergencies
   - Current regulatory and administrative issues
3. **Enforcement**
   - Mental health parity

Review 2022

Legislation

CAA 2022 (March 2022):

- Temporary extension of telehealth safe harbor

Inflation Reduction Act (August 2022):

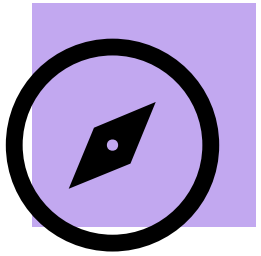
- Medicare prescription drug price negotiation
- Medicare prescription drug price rebates
- Medicare vaccine coverage and insulin cost-sharing restrictions
- Medicare Part D benefit restructure
- ACA expanded premium tax credit extension
- Insulin safe harbor for HDHPs

CAA 2023 (December 2022):

- Temporary (but longer!) extension of telehealth safe harbor
- Elimination of non-federal governmental plan parity opt-out
- Authorization for states to re-certify Medicaid eligibility
- SECURE 2.0 Act, Pregnant Workers Fairness Act, PUMP for Working Mothers Act

Review 2022

Regulations and rulings



Regulations and guidance

- Extension of COVID national emergency and PHE
- Family glitch regulation
- New ACA nondiscrimination (sec. 1557) regulation
- Guidance implementing prior laws (surprise billing, prescription drug reporting)
- Guidance addressing court decisions (Dobbs vs. Jackson Women's Health Organization)

Court rulings

- Roe vs. Wade
- ACA preventive services
- ACA section 1557

118th Congress

Implications for the benefits agenda

Divided 118th (2023 – 2024) Congress

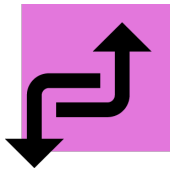
Senate: Democrats

- Democrats retain majority
- Democrats lack the 60 votes needed for effective control

House: Republicans

- Republicans hold a slim majority
- Republicans control House committees and floor agenda

What it means for benefits legislation



House priorities shift to reflect the new majority; will differ from the Senate's priorities.

Committee changes are important. New lawmakers chairing committees mean new priorities; new committee members will also play a role.

A divided and narrowly-controlled Congress limits the pathways available. Must-pass bills will likely remain key vehicles for legislative action.

Focus on must-pass legislation

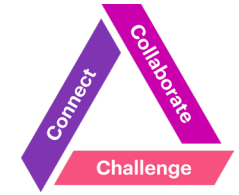
Debt ceiling

- “Extraordinary measures” in effect, Congress probably has until late spring/early summer to act
- Social Security and Medicare will be key topics in the discussion, regardless of actual discussions or outcome
- Likely to be one of very few moving bills this year — will it get loaded with other provisions?

More CAA?

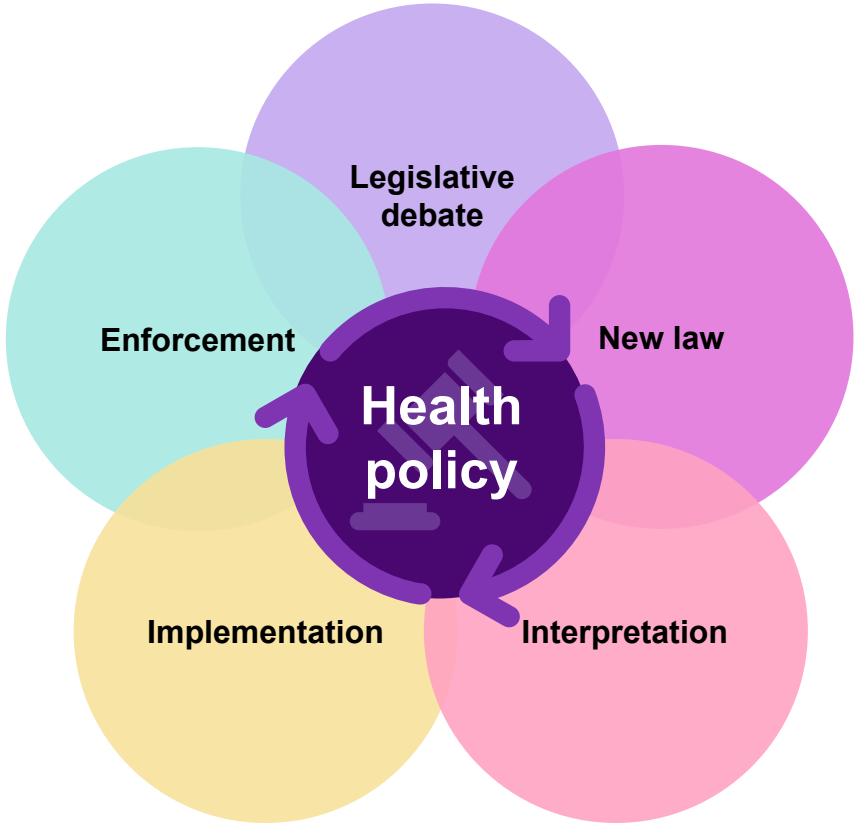
- Year-end consolidated appropriations bills have carried significant policy provisions in recent years
- 2023 legislative environment has potential for another CAA or similar year-end package

Focus may shift to regulatory agenda



Increased pressure on the administration:

- Challenging legislative environment
- 2024 elections
- Court decisions



Expect both proactive and reactive action from the administration.

End of COVID emergencies

- Current plan is to end both the National Health Emergency (President) and Public Health Emergency (HHS) on **May 11**
- Public Health Emergency
  - Required coverage of COVID-19 testing
  - HDHP/HSA and telehealth
  - COVID-19 testing and preventive care under EAP
- National Health Emergency
  - End of deadline extensions
  - Outbreak period continues for 60 days — to **July 10**

End of COVID emergencies

Administration

Three stages

Now to May 11
National Emergency still in effect

May 11 to July 10
Outbreak period — transition

July 11 onward
Normal deadlines resume

Beginning July 11th :

Enforce normal deadlines

- Reporting HIPAA special enrollment events
- Reporting COBRA qualifying events
- Deadline to elect COBRA
- Paying for COBRA
- Requesting a COBRA disability extension

COBRA-specific

- Remove extension language from notices
- Qualifying events after end of outbreak period: enforce normal election and payment deadlines
- Qualifying events during outbreak period? Guidance needed
- Discontinue coverage suspension process and restart insignificant shortfall process

Section 1557 nondiscrimination rules

- New proposed rules issued in August
- "Covered entity" – federal funding
  - When does plan, vs. plan sponsor (employer), receive federal funding?
  - HHS has requested comments on "the circumstances under which a group health plan might receive funds that could be considered federal financial assistance from the [HHS]."

Section 1557 covered entities

- What if the TPA, not the plan, receives federal funding?
- *C.P. v. Blue Cross Blue Shield of Illinois* (W.D. Wash. Dec. 19, 2022): court held that TPA violated Section 1557 by denying coverage for gender-affirming care for a transgender youth.
  - Plan was self-insured
  - TPA was applying plan rules
  - TPA received federal funding

Section 1557 taglines

- Taglines:
  - Short statements about availability of language assistance services
  - Top 15 languages spoken by LEP individuals in the relevant state(s)
  - Expanded to include availability of auxiliary aids and services

Transparency

No Surprises Act notice

Must be posted on a public website.

Machine-readable files

Must be posted on a public website, not intended for participants. Generally, carrier-hosted.

Rx data collection report

Claims information provided by carriers. Narrative information, population counts and premium information supported by WTW health and benefits consulting.

Provider directories

Maintained by carriers and specific to the coverage the individual is enrolled in and their geographic area.

Price comparison tool

Supported by carriers and specific to the individual's coverage, geographic area and progress toward accumulators (such as deductibles).

Privacy

- California Privacy Rights Act
  - Service provider protocols
  - Participant rights requests
- Other state initiatives
- Federal law?
  - Federal preemption — scope?
  - Separate standards for employee data?

Broader theme

- For a decade, Congress' health care agenda driven by ACA
- COVID took over and dominated agenda
- No single issue clearly emerging as the dominant health policy issue
- 2022 was a peek into varied attention to prescription drug costs, mental and behavioral health, telemedicine and many other issues
- The 2023 agenda is still evolving…and could have space for a range of topics
  - Transparency/no surprises
  - Mental health parity
  - Rx drug costs

MHPAEA enforcement statistics

2022 Congressional report findings

Under the Consolidated Appropriations Act, 2021 (CAA), the DOL was required to review **20** comparative analyses.

Between April 16, 2021, and October 31, 2021, Employee Benefits Security Administration (EBSA) received and began reviewing responses from **156** plans.

This substantially exceeds the amount required, showing the emphasis and prioritization of MHPAEA compliance under the Biden administration.

Top five NQTLs requested in a comparative analysis

- Pre-authorization requirements
- Concurrent care review frequency
- Limits on applied behavior analysis or treatment for autism spectrum disorder
- Network provider admissions standards
- Out-of-network reimbursement rates

Top NQTLs with non-compliance findings

- Pre-authorization processes
- Limitation or exclusions of ABA therapy or other services to treat autism
- Limit or exclusion of medication-assisted treatment for opioid use disorder
- Limitation or exclusion of nutritional counseling for MH/SUD conditions
- Billing requirements: licensed MH/SUD providers can bill the plan only through specific types of other providers
- Provider experience requirement beyond licensure

MHPAEA enforcement

- ERISA contains no specific penalty or enforcement rule for violations of MHPAEA
- IRS may impose excise taxes of $100/day for each individual to whom a failure relates for a group health plan's failure to comply with the MHPA's and the MHPAEA's requirements
- Participants, beneficiaries, and the DOL may use ERISA's civil enforcement provisions to file lawsuits to enforce MHPAEA's requirements
- Affected parties can seek damages for unpaid benefits, interest, and attorney's fees under ERISA § 502
- The plan may be subject to corrective actions including reprocessing denied claims, plan design modifications and amending and redistributing plan documents
- Legislative proposals for implementing specific MHPAEA penalties

Understanding MHPAEA coverage rules

Overview	Requires health plans providing Mental Health/Substance Use Disorder (MH/SUD) benefits to provide those benefits in parity with Medical/Surgical (M/S) benefits.
Financial requirements/ Quantitative treatment limitations	Group health plans offering M/S benefits and MH/SUD benefits that impose **"financial requirements"** (e.g., deductibles, copayments, coinsurances, out-of-pocket maximums) or **"quantitative treatment limitations" (QTLs)** (e.g., number of visits, days of coverage, days in a waiting period) must apply these requirements/limitations to MH/SUD benefits no more restrictively than the **"predominant"** financial requirements or quantitative treatment limitations applied to **"substantially all"** M/S benefits in the same classification.
Non-quantitative treatment limitations	Group health plans may not impose **"non-quantitative treatment limitations" (NQTLs)** (e.g., prior authorization, utilization review) on MH/SUD benefits unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA) which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

Evaluating compliance with NQTLs

Comprehensive evaluation is required to ensure NQTL compliance

Identify the individuals who are making claim denial determinations with respect to MH/SUD claims

- Consider whether decision makers have comparable expertise respecting MH/SUD and M/S benefits and claim reviews

Performance of a claim review/audit is a threshold and required activity

- Assess average claim denial rates
- Assess claim appeal overturn rates
- Assess parity respecting claim denials and overturned appeals for MH/SUD benefits as compared to M/S benefits

There is no requirement to utilize the same NQTL for MH/SUD benefits and M/S benefits to establish parity

- Focus on the underlying processes, strategies, evidentiary standards, and other factors used in applying the NQTLs (not necessarily the results)

Document and archive any plan analysis or audit that is performed

- Participant disclosure of certain analytic points may be required
- Federal agencies (DOL and HHS) may request an inspection of audit findings
- Report should contain evidence to demonstrate the plan is compliant with respect to MHPAEA's requirements, which may include charts, graphs, and other documents comparing the processes, strategies, evidentiary standards and other factors used in applying NQTLs to MH/SUD benefits versus M/S benefits *(along with supporting documentation demonstrating compliance)*

What areas of NQTLs will the DOL focus on in 2023?

- Potential NQTL focus in 2023
  - Eating disorders
  - Network adequacy
  - Impermissible exclusions
  - Continued focus on 2022 areas of compliance
    - ABA therapy
    - Nutritional counseling
    - Opioid use disorder medication limits or exclusions
- What to watch for in 2023?
  - Consolidated Appropriations Act (CAA) elimination of MHPAEA opt-out for nonfederal governmental plans