APRIL 18, 2021

New MHPAEA Compliance Requirements -- FAQs Released

The Consolidated Appropriations Act, 2021 amended the Mental Health Parity and Addiction Equity Act ("MHPAEA") to add several provisions designed to facilitate and strengthen compliance with that law. Among other things, group health plans and insurers are required to ***perform, document, and disclose comparative analyses*** of the design and application of non-quantitative treatment limitations (NQTLs) for mental health and substance use disorder benefits ("MH/SUD Benefits") in the plan.

On April 2, 2021, the Departments of Treasury, Labor and Health and Human Services (the "Departments") jointly released a set of FAQs (Part 45) elaborating on this requirement ("New FAQs"). The New FAQs confirm that group health plans and insurers must make this analysis available to the Departments (or applicable state authorities) upon request beginning February 10, 2021.

Non-Quantitative Treatment Limitations

These new requirements focus on ensuring that a health plan's non-quantitative treatment limitations ("NQTLs") satisfy MHPAEA, as compliance with these limitations has been much more challenging than complying with MHPAEA's financial and quantitative treatment limitations (such as limitations on applicable copays, coinsurance and visit limits). Examples of NQTLs include limitations on the scope or duration of benefits, such as due to medical management techniques, network admission standards, provider reimbursement methodologies, requirements to complete a course of treatment, and "fail-first" or step-therapy requirements for prescription drugs.

In general, any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD Benefits (both as described in the plan document and in actual operation) must be comparable to, and applied no more stringently than, those that apply to medical or surgical benefits ("Medical Benefits") with respect to any of six classifications: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

Comparative Analysis Must Be Documented and Available on Request

Although group health plans and insurers have been required to comply with the MHPAEA rules regarding NQTLs for many years, effective as of February 10, 2021, health plans and insurers that provide MH/SUD Benefits and impose NQTLs on these benefits must be prepared to make available a comparative analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD Benefits (both as written and in operation) are comparable to, and are applied no more stringently than with respect to Medical Benefits in each of the six classifications ("Comparative Analysis").

The Comparative Analysis and supporting information must be made available on request to the Departments, to the applicable state authorities and to plan participants and enrollees (and their authorized representatives).

At a minimum, the Comparative Analysis must include the following:

1. A clear description of the specific NQTL, plan terms, and policies at issue.
2. Identification of the specific benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD Benefits and which are treated as Medical Benefits.
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. To the extent the plan defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan between MH/SUD Benefits and Medical Benefits and, if so, describe the process and factors used for establishing that variation.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
7. If the plan's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD Benefits and Medical Benefits.
8. A reasoned discussion of the plan's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

In general, if the Comparative Analysis references a specific document or information, the plan should be prepared to provide that document or information on request. For example, the following information should be readily available:

1. Records documenting NQTL processes and detailing how the NQTLs are being applied, including any materials that may have been prepared for compliance with any applicable reporting requirements under State law.
2. Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or insurer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD Benefits than to Medical Benefits. Plans should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or insurer to support its rationale.
3. Samples of covered and denied MH/SUD Benefit and Medical Benefit claims.
4. Documents related to MHPAEA compliance with respect to service providers to which it delegates management of such benefits.

The Comparative Analysis must contain a specific, detailed, and reasoned written explanation of the

specific plan terms and practices at issue, including a robust discussion of all listed elements demonstrating the basis for a conclusion that the plan is in compliance with MHPAEA.
The Departments will not consider a "general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors" to be compliant with this requirement. Using conclusory or generalized statements, disclosing a large volume of documents without clearly explaining how each document is relevant, or providing outdated documentation, will not be sufficient.
The New FAQs refer to the MHPAEA "self-compliance tool" which includes a roadmap of the process that can be used to conduct the Comparative Analysis and states that the information suggested by the self-compliance tool (which has been available for many years) "closely aligns" with the information that is now required to support the Comparative Analysis.

Consequences of Noncompliance & Enforcement Focus

If the Departments determine that a group health plan or insurer is not in compliance with MHPAEA, then the plan or insurer will be given 45 days to provide a Comparative Analysis demonstrating compliance with MHPAEA. If the plan or insurer is still not in compliance, the plan or insurer must notify all participants within 7 days that the coverage is noncompliant with MHPAEA, and the Departments will notify the State in which the group health plan is located or the insurer is licensed.
The New FAQs indicate that the Department of Labor expects to focus its enforcement efforts on the following NQTLs initially:

- Issues that are the subject of a complaint;
- 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; and
- Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

Action Items

Employers must add compliance with the MHPAEA comparative analysis requirement to the growing list of issues that must be addressed this year (and quickly). Employers with self-insured health plans bear the risk of liability relating to non-compliance. Yet, they do not have the expertise or the information which is needed to perform and document the required analysis. They should consult with their claims administrators or other service providers to ensure that this analysis is being performed and will be available for disclosure in response to participant or regulator requests.