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EMPLOYEE BENEFITS ADVISORY

New Mental Health Parity Disclosure Requirements Require Swift Action

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The Consolidated Appropriations Act, 2021 (the CAA), which was enacted on December 27, 2020, contained a number of significant transparency and disclosure requirements for group health plans. In particular, the CAA requires group health plans to meet new federal requirements to show compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) ***as early as February 10, 2021***. The requirements generally apply to self-insured group health plans covered by ERISA, as well as self-insured state and local governmental plans and church plans.

Under MHPAEA, group health plans and insurers that provide coverage for mental health and substance use disorder benefits are required to ensure that any financial requirements or treatment limitations for those benefits are no more restrictive than those for medical or surgical benefits. Under the CAA, plans and insurers must be prepared to disclose comparative analyses to document compliance with the existing rules under the MHPAEA governing non-qualitative treatment limitations (NQTLs). NQTLs generally include all plan design features other than financial requirements or numerical benefit limits. The DOL has provided a list of examples of NQTLs, which includes:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative
- Prior authorization or ongoing authorization requirements
- Concurrent review standards
- Formulary design for prescription drugs
- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers)

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- Standards for provider admission to participate in a network, including reimbursement rates
- Plan or issuer methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols)
- Exclusions of specific treatments for certain conditions
- Restrictions on applicable provider billing codes
- Standards for providing access to out-of-network providers
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

In its guidance, the DOL highlighted examples of provisions that could indicate a violation of MHPAEA if the same type of limits is not imposed on medical/surgical benefits. Examples include:

- The plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.
- For residential treatment of mental health/substance use disorders, the plan requires a demonstration that the inpatient treatment is likely to result in improvement.
- For mental health/substance use disorder benefits, the plan requires a written treatment plan prescribed and supervised by a behavioral health provider.

While some states already require that insurance companies perform comparative analyses of NQTLs, the CAA now requires this analysis nationwide. The analyses, plan documentation, factors, evidentiary standards, and findings and conclusions must be made available to state regulators, the DOL, or HHS upon request, beginning 45 days after the CAA's enactment (in other words, as early as February 10, 2021). Federal regulators are also required to ask at least 20 plans or insurers to submit their analyses for further review each year.

The American Psychiatric Association, the Kennedy Forum, and the Parity Implementation Coalition have prepared blank templates that can be used for these analyses (the Six-Step Parity Compliance Guide), but those templates are 134 pages long. Parity rights groups have recommended that agencies choose some of the worksheets and not attempt to require a plan or issuer to complete all worksheets at once. The DOL also has issued a self-compliance tool for the MHPAEA, which provides a list of examples of NQTLs and a list of "warning signs" to review.

If, after review, the applicable agency has determined that the plan is not in compliance, the plan is required to specify steps it will take to comply and to provide additional analyses demonstrating compliance within 45 days of the agency's determination. If the agency still finds noncompliance, it will notify all plan participants within seven days of its determination. In enforcing the new requirements, the DOL can require plans to correct violations, impose penalties for failure to disclose information, or allege

a breach of fiduciary duty. The IRS also can assess excise taxes of up to $100 per day under Internal Revenue Code Section 4980D.

Given the upcoming deadline, self-insured plan sponsors should have taken or should take immediately the following steps:

1. Contact third-party administrators and pharmacy benefit managers for the comparative analyses they have completed, or ask them to conduct the analyses as soon as possible, if they have not already done so.
2. Consider taking steps to reflect good-faith efforts to meet the requirements now if comparative analyses are not available. A good place to start might be a combination of the steps found in the DOL self-compliance tool and the Six-Step Parity Compliance Guide:
    - Select the NQTLs in the DOL self-compliance tool that apply to your plan.
    - Identify the specific plan language regarding the NQTL and describe all services to which it applies in each benefits classification.
    - Identify the factors that were considered in the design of the NQTL (for example, excessive utilization, recent medical cost escalation, lack of adherence to quality standards, etc.).
    - Identify the sources of the evidentiary standards that the plan used to define the factors above. (For example, internal claims data that showed that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may show a high level of variation in the length of stay; the same claims data showing that medical costs for certain services increased 10% or more per year for two years may show recent medical cost escalation.)
    - Determine whether the processes, strategies, and evidentiary standards used are comparable and applied no more stringently to mental health/substance use disorder benefits than to medical/surgical benefits:
        - Look at the written terms of the NQTL.
        - Look at the operation of the NQTL.
    - Prepare a summary of how these analyses show compliance with the MHPAEA.
3. Keep an eye out for requests from applicable regulators and respond promptly with available information.

Questions

This is a rapidly changing area that could have severe consequences for failure to follow the guidance. If you have questions about your plan's compliance with these requirements, please contact a member the Sherman & Howard Employee Benefits Group.