GROOM LAW GROUP

Publications

End-of-Year Omnibus Bill Adds Mental Health Parity and Addiction Equity Act Disclosure Requirements

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The Consolidated Appropriations Act, 2021 (the "CAA") that was signed into law on December 27, 2020, amends the Employee Retirement Income Security Act of 1974 ("ERISA"), the Public Health Service Act and the Internal Revenue Code to include new provisions that specifically require the Secretaries of the Departments of Health and Human Services, Labor, and the Treasury (the "Secretaries") to request documents that demonstrate compliance with the Mental Health Parity and Addiction Equity Act of 2008's ("MHPAEA") nonquantitative treatment limit ("NQTL") requirements from group health plans and health insurance issuers. The effective date of the disclosure requirement is 45 days after enactment of the CAA, which is February 10, 2021. This means that, beginning on February 10, 2021, plans and issuers must be prepared to submit the NQTL comparative analyses to the State authorities or Secretaries, upon request.

Background

MHPAEA prohibits group health plans that provide mental health/substance use disorder ("MH/SUD") benefits from applying "financial requirements" or "treatment limits" to those benefits that are more restrictive than the "predominant" financial requirement or treatment limit that applies to "substantially all" medical/surgical ("M/S benefits"). The statute defines "financial requirements" to include deductibles, copayments, coinsurance, and out-of-pocket expenses, "treatment limitations" to include limits on the frequency of visits, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, and the term "predominant" to mean the most common or frequent of such type of limit or requirement. MHPAEA does not specify when a financial requirement or treatment limit applies to "substantially all" M/S benefits.

On February 2, 2010, the agencies published Interim Final Regulations implementing MHPAEA, which were followed by several FAQs. The Interim Final Regulations

were later finalized on November 13, 2013 in the final regulations (the "Final Regulations"). One of the most far-reaching aspects of the Interim Final Regulations was a requirement that plans measure parity with respect to nonquantitative treatment limitations as well. A NQTL is a limitation that restricts coverage under the plan that is not expressed numerically. This requirement extends to a host of plan design components including medical management standards limiting benefits based on medical necessity or an exclusion for experimental/ investigational treatments; prescription drug formulary design; and standards for determining provider admission in a network, including reimbursement rates. The Interim Final Rule required group health plans to ensure that any processes, strategies, evidentiary standards or other factors used in applying NQTLs to MH/SUD benefits must be 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."

Requiring parity for NQTLs was a big surprise in the Interim Final Regulations as this requirement regulates medical management, provider reimbursement and other practices that were not regulated in the statute. The NQTL requirement has been a major source of uncertainty for group health plans and issuers, and a source of compliance and enforcement efforts of the Departments of Health and Human Service and Labor.

MHPAEA also requires that plan sponsors and insurance carriers disclose certain information on medical necessity criteria for both M/S and MH/SUD benefits, as well as the processes, strategies, evidentiary standards or other factors used to apply an NQTL. In fact, the final regulations consider these documents to be documents under which the plan is established or operated for purposes of responding to requests for documents by plan participants within 30 days of request under Section 104 of ERISA.

New Disclosure Requirements Under the CAA

The new provision of the CAA requires group health plans and health insurance issuers to make available to the applicable State authority or the Secretaries, upon request, the comparative analysis and information outlined below.

> ***GROOM INSIGHT:*** *This new requirement essentially codifies into statute the NQTL requirement that was added to MHPAEA through the Interim Final Regulations. We note that this new disclosure requirement is slightly different from the existing documentation requirement in that it requires disclosure of the factors used to determine that an NQTL will apply, and the evidentiary standards used for the factors, requiring that every factor is defined. This new statutory requirement to document the NQTL comparative analyses requires specific information as part of the documentation to demonstrate compliance.*