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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

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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.

The new disclosure requirements requires plans and issuers to make available, upon request:

- the specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD or M/S benefits to which each such term applies in each respective benefit classification;
- the factors and evidentiary standards used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits;
- the comparative analyses demonstrating that the processes, strategies, evidentiary standards, *and* other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to M/S benefits in the benefits classification;
- the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses.

GROOM INSIGHT. The CCA's disclosure requirement builds on disclosure requirements that were included in the MHPAEA Final Regulations published November 13, 2013. In relevant part, the MHPAEA Final Regulations provide that certain documents related to parity under the NQTL rule are considered documents under which the plan is established or operating for purposes of section 104 of ERISA. As a result, group health plans and insurers for group health plans are required to provide documents with information on the application of any NQTL to plan participants within 30 days of a request under section 104 of ERISA. Plans and issuers should be able to use these existing MHPAEA compliance documents in response to a request from State authorities or the Secretary in response to the new CAA disclosure requirement after a review to ensure that the existing documentation fully encompasses the CAA's new requirements.

The CAA provides that the Secretaries shall request that a group health plan or health insurance issuer offering group or individual health insurance coverage submit the comparative analysis for plans that involve potential violations of MHPAEA or complaints regarding noncompliance with MHPAEA's NQTL rules and any other instances in which the Secretaries deem appropriate. The CAA requires the Secretaries to request at least 20 such analyses per year.

If a Secretary determines that the group health plan or health insurance issuer has not submitted sufficient information, the CAA authorizes the Secretary to request additional information to

demonstrate compliance. The statute specifies that mere production of the compliance document is not sufficient to demonstrate compliance.

If a Secretary determines that a group health plan or health insurance issuer is not in compliance with the CAA, the plan or issuer must specify to the Secretary the actions it will take to come into compliance and provide the Secretary additional comparative analyses that demonstrate compliance no later than 45 days after the Secretary's initial determination. If the Secretary concludes that the group health plan or health insurance issuer is still not in compliance with MHPAEA after this 45-day correction period, the plan or issuer must notify all individuals enrolled in the plan or health insurance coverage of such non-compliance.

GROOM INSIGHT. On October 23, 2020, the Department of Labor's Employee Benefits Security Administration ("EBSA") released an updated self-compliance tool to help employers comply with MHPAEA, which provides useful guidance for plans and issuers to prepare their NQTL disclosure documents. The self-compliance tool: provides an overview of MHPAEA's requirements, including the NQTLs; summarizes Tri-Agency guidance issued through Frequently Asked Questions; includes examples of how a group health plan can come into compliance if it identifies certain MHPAEA violations; includes compliance examples and warning signs; and provides best practices for establishing an internal MHPAEA compliance plan. We expect that the Department of Labor will update the self-compliance tool to incorporate the CAA's new requirements.

Publication of Analysis

The CAA specifies that the MHPAEA compliance documents outlined above are exempt from disclosure under the Freedom of Information Act. However, the CAA requires the Secretaries to submit to Congress, and make publicly available, a report that contains -

- the identity of each group health plan or health insurance issuer that is determined not to be in compliance;
- the Secretaries' conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretaries to review the comparative analysis;
- for each group health plan or health insurance issuer that the Secretaries conclude did submit sufficient information, the Secretaries' conclusions as to whether and why the plan or issuer is in compliance with the statute;
- the additional information the Secretaries requested from groups it determined did not submit sufficient information for the Secretaries to complete its NQTL compliance review; and
- the actions the group health plans and health insurance issuers that were determined to be out of compliance took to remediate such non-compliance during the 45-day correction period.

Compliance Program Document

The CAA also requires the Secretaries to issue a compliance program guidance document to help improve compliance with MHPAEA, which will include illustrative, de-identified examples of previous findings of compliance and noncompliance. In developing the compliance document, the Secretaries will enter into an interagency agreement with the Inspector Generals of the Departments of Health and Human Services, Labor and the Treasury to share findings of noncompliance and compliance. The compliance program guidance will also include recommendations to advance compliance and it will be updated every 2 years to include illustrative, de-identified examples of previous findings of compliance and noncompliance.

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Some Concluding Thoughts. Beginning February 10, 2021, the CAA requires plans and issuers to make available the comparative analyses upon request of a State or the Secretaries. Thus, plans and issuers should be prepared at any point after February 10 to submit this information. In addition, after February 10, 2021, plans and issuers that are under audit by the Department of Labor should be prepared to respond to any new request by the Department for the NQTL comparative analyses. Sponsors of self-insured plans should work closely with their third-party administrators to document compliance with MHPAEA's NQTL requirements to be sure they are prepared to respond to a request for the NQTL comparative analyses.