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EMPLOYEE BENEFITS AND EXECUTIVE COMPENSATION

AGENCY GUIDANCE ON MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT REQUIRES EMPLOYER ATTENTION

On April 2, 2021, the U.S. Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Agencies") issued guidance regarding the amendment made to the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") by the Consolidated Appropriations Act, 2021 ("Appropriations Act"). The guidance is in the form of detailed FAQs that are Part 45 in the Agencies' series of FAQ guidance publications that began in 2010 (accessible at the DOL website here).

The Appropriations Act requires employers to perform and document a comparative analysis of the design and application of non-quantitative treatment limitations ("NQTL") under their group health plan and to provide the analysis to the Agencies upon request. The Appropriations Act provision applies to self-insured and insured employer group health plans, as well as health insurance issuers, who must make their comparative analyses available to applicable state authorities.

The guidance emphasizes that the comparative analysis must be performed without regard to whether an Agency has requested it and describes in detail what is necessary for an analysis to satisfy the requirement. The comparative analysis described in the guidance will be a significant undertaking for most employers and will require the cooperation and assistance of their insurance carrier or claims administrator, including pharmacy benefits manager, as applicable. In accordance with the effective date specified in the Appropriations Act, the requirements described in the guidance are effective now.

MHPAEA Background

MHPAEA generally requires that group health plans and health insurance issuers that provide coverage for mental health and/or substance use disorder ("MH/SUD") benefits ensure that the financial requirements (such as coinsurance and copayments) and treatment limitations (such as visit limits) on MH/SUD benefits are no more restrictive than those that apply to medical/surgical benefits. These requirements are generally referred to as the financial requirements and quantitative treatment limitation requirements ("QTL"). Application of the financial and QTL requirements involves complicated testing of a group health plan's claim payments.

In addition to the financial and QTL requirements, longstanding MHPAEA regulations require that a group health plan or health insurance issuer not impose an NQTL on MH/SUD benefits under the plan or insurance coverage unless, under the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to medical/surgical benefits. NQTLs include the following (this is not an exhaustive list):

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- 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;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- 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; and
- 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.

Group health plans that satisfy the requirements to be "retiree-only" plans and certain non-federal governmental plans are not subject to MHPAEA requirements. In addition, MHPAEA does not apply to employers who employed an average of at least two, but not more than fifty employees on business days during the preceding calendar year and who employed at least one employee on the first day of the plan year. However, if a small employer purchases insured group health coverage (as most employers of that size would do), the coverage itself would be subject to MHPAEA requirements. Also, group health plans that constituted "excepted benefits," such as a standalone dental plan, a standalone vision plan, a health care flexible spending account, and an employee assistance program meeting certain criteria, are exempt from the MHPAEA requirements.

Appropriations Act Amendment and Agency Guidance

The Appropriations Act amended MHPAEA to expressly require employer group health plans and health insurance issuers to perform and document a comparative analysis of the design and application of NQTLs under the plan and insurance coverage. In addition, the Appropriations Act requires group health plans and health insurance issuers to make their comparative analyses available to the Agencies or applicable state authorities upon request. The comparative analyses must also be made available to participants and beneficiaries (and to their authorized representatives) upon request.

The Appropriations Act specifies a detailed list of information that must be included in the comparative analysis prepared by a group health plan or health insurance issuer:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical/ surgical benefits to which each such term applies in each respective benefits classification;
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/ surgical benefits;
- The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical/ surgical 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 medical/surgical benefits in the benefits classification; and
- The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

The guidance emphasizes that the obligation to perform this detailed NQTL comparative analysis is now mandatory, without regard to whether an Agency has requested a copy of the analysis. This will present a challenge to employers, particularly those who self-insure their group health plan benefits, as they typically rely on their claims administrators to develop medical necessity standards and other criteria used to make claim determinations.

Historically, employers have not proactively engaged in extensive analysis of their group health plan's compliance with MHPAEA, and have instead responded to DOL requests for information regarding compliance with MHPAEA in the course of DOL investigations of health plan compliance with ERISA or specific complaints regarding compliance with MHPAEA. In the case of insured group health plans, an employer whose plan was being investigated typically relied on the insurance carrier to provide responsive information to the DOL, since the employer normally would not have access to the claim information necessary to perform the financial and QTL testing, or information regarding the carrier's operation of the NQTL provisions. Self-insured employers have generally been more aware of MHPAEA compliance, at least from a plan design perspective, but are reliant on their claims administrators in connection with financial and QTL testing and operation of the NQTL provisions (over which the employer would have little control).

The guidance notes that the DOL's online MHPAEA self-compliance tool (available on the DOL website here) outlines four steps that plans and health insurance issuers should take to assess their compliance with the MHPAEA NQTL requirements and that the information identified in each step "closely aligns with" the information that plans and issuers must include as part of their comparative analyses. The guidance also says that for an analysis to be treated as sufficient under the Appropriations Act, it must contain a "detailed, written, and reasoned explanation of the specific plan terms and practices at issue, and include the bases for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA." The guidance sets out a detailed

list of nine elements and says that "at a minimum" sufficient analysis must include a "robust discussion" of all the elements. The list of elements clearly illustrates that the involvement of the insurance carrier or self-insured plan claims administrator is necessary to conduct a proper comparative NQTL analysis.

Recommendations

Employers should take the time to review the guidance to understand the scope of this new requirement. Employers with self-insured plans should contact their claims administrators to inquire about the claims administrators' readiness to assist in the performance of the analysis. Our ongoing conversations with several national insurance carriers who serve as claims administrators for self-insured plans lead us to believe that it may be some time before claims administrators are in a position to offer the necessary assistance. Employers with insured plans should contact their carrier to determine whether the carrier is in a position to provide an analysis to the employer. Ideally, carriers, which have to perform the analysis on their insured product, may be in a better position to offer a prepared analysis to employers. Self-insured employers who want to start to prepare the portion of the analysis that an employer can feasibly prepare (a review of plan coverage terms regarding NQTLs and description of the benefits to which the NQTLs apply) should review the DOL MHPAEA self-compliance tool.

If you have any questions about MHPAEA or compliance with the comparative analysis requirement, please contact any member of the Employee Benefits and Executive Compensation group at 585.232.6500, 716.853.1616, or visit www.hselaw.com.