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Self-Insured Group Health Plan Sponsors: Action Steps to Mitigate Risk Under the Mental Health Parity and Addiction Equity Act

by Karen K. Hartford on September 22, 2021

The Mental Health Parity and Addiction Equity Act ("MHPAEA") provisions of the Consolidated Appropriations Act, 2021 ("CAA") introduced a requirement that group health plans and insurance providers offering both medical and surgical benefits ("M/S benefits") and mental health and substance use disorder benefits ("MH/SUD benefits") that impose non-quantitative treatment limitations ("NQTLs") must conduct and document a detailed comparative analysis of the design and application of the NQTLs. An NQTL is any restriction on the scope or duration of a treatment or service that is not expressed numerically. [1] The analysis is required to be available beginning February 10, 2021.

For context: the MHPAEA applies to insured, self-insured, private sector and most governmental plans. The focus of this post is compliance with the NQTL comparative analysis requirement for private sector, self-insured plans.[2 On April 2, 2021, the Departments of Labor, Treasury, and Health and Human Services (the "Departments") published FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 ("FAQs Part 45"), which provide guidance regarding the NQTL comparative analysis.

The CAA amended the MHPAEA to specifically require the Departments to request and review at least twenty NQTL comparative analyses per year, beginning in 2021. The Departments are also required to request and review the analyses if they receive complaints relating to noncompliance with the MHPAEA and may request the comparative analysis for any other reason they deem appropriate. The Department of Labor ("DOL") has already made MHPAEA and, in particular, issues involving NQTLs, an enforcement priority. Litigation relating to mental health parity has been steadily increasing over the thirteen years since the statute's initial passage, often with a focus on the application of NQTLs. In August, the DOL and the New York Attorney General reached a $15.6 million settlement in a first-of-its-kind case initiated directly against an administrative service provider for violations of MHPAEA (*Walsh v. United Behavioral Health*, E.D.N.Y. (8/11/21)). In light of the heightened enforcement activity, the growth of litigation in this area, and the complexity and length of the NQTL comparative analysis, we encourage plan sponsors to consider the following actions to mitigate risk:

- Review and familiarize yourself with the DOL's Self Compliance Tool for the Mental Health Parity and Addiction Act ("Self Compliance Tool"). The Self Compliance Tool was most recently updated in October 2020 and is designed to give "the user a basic understanding of MHPAEA to assist in evaluating

compliance with its requirements" and includes a lengthy section about NQTLs, including a process for performing a comparative analysis of NQTLs. FAQs Part 45, FAQ 2 explicitly states that "plans and issuers that have carefully applied the guidance in the Self-Compliance Tool should be in a strong position to comply with the [CAA's] requirement to submit comparative analyses upon request."

- Contact your third party administrator ("TPA") and pharmacy benefit manager ("PBM") to determine the steps they have taken to develop and document the NQTL analysis. The task of identifying and analyzing every NQTL under a plan is detailed and will require access to internal clinical guidelines, policy statements, provider reimbursement standards, and claims information, among many other things. It is difficult to conceive how a plan sponsor could produce an adequate analysis alone; rather, we expect the majority of plan sponsors to depend upon their TPA and PBM to prepare, maintain, and update the necessary documentation.
- Request a copy of the comparative analysis and supporting documentation from the TPA and PBM and review it (either internally, or together with the plan's benefit consultant or attorney) to confirm that it includes a "robust discussion" of each "specific NQTL, plan terms, and policies at issue" as well as, at a minimum, the other eight elements listed in FAQs Part 45, FAQ 2.
- Ensure that the supporting documentation includes at least the following, referenced in FAQs Part 45, FAQ 4 and further detailed in the Self Compliance Tool:
    - Claims processing policies and procedures
    - Samples of covered and denied MH/SUD and M/S claims
    - Guidelines, internal protocols, and any other records describing the development and application of NQTLs and demonstrating that such guidelines and protocols apply no more stringently to MH/SUD benefits than to M/S benefits
    - Documents relating to MHPAEA compliance with respect to service providers
- If you do not have a TPA or PBM, work on developing the analysis, utilizing the Self Compliance Tool and the FAQs. Prepare a strategy and timeline for identifying and reviewing all NQTLs. Consider starting by reviewing the plan document and summary plan description and focusing on the four areas of current priority identified in FAQs Part 45, FAQ 8:
    - Prior authorization requirements for in-network and out-of-network inpatient services
    - Concurrent review of in-network and out-of-network inpatient and outpatient services
    - Standards for provider admission to participate in a network, including reimbursement rates

    - Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges)
- Consider developing internal controls to monitor compliance with the MHPAEA ("MHPAEA Compliance Program"). A MHPAEA Compliance Program should include at least the following elements:
    - Training of individuals involved in plan administration to ensure that such individuals understand the basics of MHPAEA compliance and the plan's policies and procedures for handling complaints and requests for documentation
    - Recordkeeping requirements
    - Methods for detecting noncompliance, such as periodic audits of claims
    - A process for participants to request plan documentation, including the comparative analysis[3]
    - A process for participants to file complaints about potential MHPAEA violations
    - A process to ensure that plan service providers provide the documentation that the plan sponsor needs to assess MHPAEA compliance
    - A policy for regular review and revision of the NQTL comparative analysis
- When negotiating service agreements with the plan's TPA and PBM, carefully review and consider terms relating to responsibility for preparing and updating the NQTL comparative analysis and supporting documentation as vendors' coverage and claims review practices change and include a process for timely provision of the analysis upon request from the plan sponsor, participants, or regulators; to the extent service agreements do not include such terms, consider adding them.
- When conducting a Request for Proposal for the plan's TPA and PBM, request and review the comparative analysis before entering into a new engagement.

MHPAEA compliance is no small task, and the consequences for noncompliance are high, including penalties of $110 per day for failure to furnish documentation on request, IRS excise taxes of $100 per day, potential litigation, and annual public disclosure by the Departments of the names of noncompliant plans and issuers. Accordingly, we urge plan sponsors to take action to review their current and future MHPAEA compliance.

Please contact any member of Verrill's Employee Benefits & Executive Compensation Group if you need assistance with MHPAEA compliance.

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[1] Some examples of NQTLs include: medical management techniques such as pre-authorization requirements, fail first and step therapy practices, and requirements that limit or exclude benefits based on medical necessity or whether a treatment is experimental/investigative; prescription drug formulary design; methods for determining

usual, customary, and reasonable charges; restrictions based on facility type or geographic location; and standards for admitting providers to a network.

[2] Retiree-only plans, plans offering only excepted benefits, and plans of small employers (*i.e.*, employers who employ an average of at least 2 but no more than 50 employees on all business days during the preceding calendar year) are generally exempt from the MHPAEA requirements. There is also a limited exemption for plans that experience increased cost after a plan amendment to comply with the MHPAEA.

[3] Note that the Departments published a model form for participant requests as part of their September 2019 FAQ guidance, FAQs Part 39.

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