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ALERT

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Group Health Plans and Compliance With the Nonquantitative Treatment Limitations of the Mental Health Parity and Addiction Equity Act

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While sponsors and/or administrators of Group Health Plans select the design of the their group health plans, they do not, generally, act as claims administrators. Insurance carriers (for fully-insured programs) and third-party administrators (for self-insured plans) decide whether claims incurred for health care services are covered by a group health plan and what the plan will pay. Generally, plan administrators have little or no experience applying the parity requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act ("MHPAEA") that was enacted in 2008, or understand what constitutes a "nonquantitative treatment limitation" (NQTL") under MHPAEA. The Consolidated Appropriations Act of 2021 ("Appropriations Act") adds new enforcement provisions and requires documentation of group health plan compliance with NQTLs, effective February 10, 2021.

MHPAEA generally requires employment-based group health plans and health insurance issuers that provide mental health/substance use disorders ("MH/SUD") benefits to maintain parity between such benefits and their medical/surgical ("M/S") benefits. This means that the financial requirements (such as copays and deductibles), quantitative treatment limitations (such as visit limits), and nonquantitative treatment limitations ("NQTLs") (such as medical management standards) applicable to MH/SUD benefits under plans can be no more restrictive than the requirements or limitations applied to M/S benefits.

MHPAEA interim and final rules issued jointly by the Department of Labor ("DOL"), Treasury and Health and Human Services ("HHS") ("collectively, the "Departments") in 2010 and 2013 listed six classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. If a plan covers MH/SUD benefits in a classification, the plan must provide MH/SUD benefits in all of the classifications in which M/S benefits are available. While MHPAEA financial limitations (i.e., co-insurance and co-payments) and treatment limitations (i.e., number of covered visits to a provider, day limits) are numerical and objective, this is not the case for NQTLs. The parity requirements for NQTLs are not satisfied unless, under the terms of the plan (as written and in operation), the processes, strategies, evidentiary standards or other factors (collectively, "Factors") used in applying a NQTL to any MH/SUD in each of the six categories are not more stringent than the Factors used in applying NQTLs to M/S benefits in that same category.[1]

The Appropriations Act amended the Employee Retirement Income Security Act of 1974 ("ERISA"), the Public Health Service Act and the Internal Revenue Code[2] to require plan administrators of group health plans (grandfathered and non-grandfathered) and health insurance issuers to *"[p]erform and document a comparative analysis of the design and application of "nonquantitative treatment limitations for any mental health and substance abuse disorder coverage if the plan or issuer imposes nonquantitative treatment limitations. Upon request, this information must be submitted to state and federal regulators, who can request the information as early as 45 days after the Act became law (emphasis added)."*

The requirement to perform and document a comparative analysis of the design and application of NQTLs[3] applies to self-insured plans and insurance carriers, including qualified health plans offered by the Health Insurance Marketplace.

The analysis for each plan (and each benefit option under the plan) must be detailed and specific. A general statement of compliance will be unacceptable. On April 2, 2021, the Departments issued Frequently Asked Questions ("FAQs") related to the Appropriations Act NQTLs comparative analysis obligation. These FAQs direct plan administrators to an MHPAEA Self-Compliance Tool, updated in 2020, and FAQs issued on September 5, 2019 (Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act, Part 39) for guidance on preparing the comparative analysis.

The Appropriations Act also requires group health plans and health insurance issuers to make available to the Secretaries of the Departments (individually, a "Secretary"), upon request, documentation (including the comparative analysis) that demonstrates the plan's NQTL compliance. In April, 2021, the DOL began making these requests. If a Secretary determines that a group health plan is not in compliance with the Appropriations Act, the plan will be given 45 days after the initial non-compliance determination to provide documentation that satisfies the NQTL comparative analysis requirement. If, after the 45-day period, the group health plan is still not in compliance, it will be required to notify plan enrollees that the group health plan does not comply with the NQTLs of MHPAEA.[4]

Carriers that process benefit claims for insured group health plans and TPAs as claims administrators for self-insured group health plans are in the best position to perform and document the required NQTL comparative analysis. However, obtaining assistance from carriers and TPAs may be difficult and expensive. If a provider claims the NQTL analysis is outside the scope of the administrative service agreement or contract, the preparation of this complex documentation will fall on the plan administrator or plan sponsor. Outsourcing the preparation of the analysis to benefit consultants (for a fee) is a possibility. TPAs may also agree (now or in the future) to perform the comparative analysis only if existing agreements are modified to add this to the scope of work and additional administrative fees are paid.

There is another very important reason to complete this analysis. Final Regulations issued on November 13, 2013, as well as the FAQs issued by the Departments on April 2, 2021, provide that, for purposes of section 104 of ERISA, certain documents related to parity under the NQTL rule are considered documents under which the plan is established or operated and, if requested by plan participants, must be provided within 30 days of the request. Documents under which a group health plan is established or operated include comparative information on medical necessity criteria for both M/S benefits and MH/SUD benefits, as well documentation of the processes strategies, evidentiary standards and other factors used to apply a NQTL to any M/S and MH/SUD benefit. *See:* Q&A 6 in the April 2, 2021 FAQs issued by the Departments.

Plan sponsors and administrators should contact their vendors (carriers and TPAs) to determine how best to satisfy this complicated compliance requirement.

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1. See: Final MHPAEA regulations issued by the Departments on November 13, 2013. Interim Final Rules issued under MHPAEA in 2010 also required the measurement of NQTL requirements.
2. The Departments share responsibility for enforcement of MHPAEA, together with the States. The States have primary enforcement responsibility with respect to health insurance issuers, while HHS has direct enforcement responsibility for non-Federal governmental plans (plans sponsored by State and local governments).
3. The Department of Labor ("DOL") expects to focus on the following NQTLs in its enforcement efforts: prior authorization requirements, concurrent review requirements, 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). See: Q&A 8, FAQs issued by the Departments on April 2, 2021.
4. Since the parity requirement for NQTLs is not new, it is reported that the DOL has rejected excuses for non-compliance based upon lack of access to information held only by a group health plan vendor.

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