COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

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DOL FAQs Address Mental Health Parity Requirements under the Appropriations Act

Introduction

On April 2, The Department of Labor (DOL), in conjunction with Health and Human Services (HHS), and the Treasury (the Departments), released FAQs Part 45 on new requirements for employer plan sponsors under the Mental Health Parity and Addiction Equity Act (MHPAEA) added by the Consolidated Appropriations Act of 2021 (the Appropriations Act). (See Alert 2020-23, Year-End Appropriations Act Details New Requirements Under Mental Health Parity.) Under longstanding Mental Health Parity rules, group health plans that cover mental health (MH) or substance use disorder (SUD) benefits must ensure that any financial requirements (copays, deductibles, etc.), quantitative treatment limits (visit limits), and non-quantitative treatment limits (NQTL) (medical management standards, network access, and formulary design) applicable to MH/SUD benefits are not more restrictive than the requirements or limitations for medical/surgical benefits (MS). The Appropriations Act mandated NQTL testing, and requires plans to provide the results of testing on request, in addition to other requirements generally designed to strengthen parity, to the DOL (or appropriate Department) as well as relevant State authorities. The Appropriations Act sets an aggressive compliance timeline in allowing requests to be issued within 45 days of enactment, or as soon as February 10, 2021. This most recent set of FAQs provides additional details on the type of documentation that will be required, outlines a corrections process, and confirms that plan participants can also make these requests. Importantly, the FAQs identify four specific areas on which the DOL initially intends to focus. The FAQs also strongly encourage use of the DOL's MHPAEA Self-Compliance Tool.

NQTL Requirements under the Appropriations Act

Under the Appropriations Act group health plans must make NQTL comparative analyses available to the relevant Department or applicable State authorities, upon request. The analysis must specifically include:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
3. 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 or surgical benefits;

4. 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
5. 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.

As noted above, the Departments can request that a group health plan or health insurance issuer submit their testing and comparative analyses for review beginning in February 2021. Additionally, by December 27, 2021, and annually by October 1 thereafter, the Departments must submit to Congress and make publicly available a report on their NQTL audits.

Clarifying Guidance in the FAQs

Required Information

The FAQs emphasize that a plan's comparative analyses must be sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying an NQTL are comparable and applied no more stringently to MH/SUD benefits than to medical/surgical benefits. The DOL expressly warns that a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet the statutory requirement. At a minimum, sufficient analyses must include a robust discussion of all of the elements listed below.

1. A clear description of the specific NQTL, plan terms, and policies at issue.
2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or

issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

8. A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

The FAQs strongly encourage use of the DOL's MHPAEA Self-Compliance Tool. The MHPAEA Self-Compliance Tool was last updated in 2020, before the enactment of the Appropriations Act, and it recommended that plans and issuers analyze and document as a best practice, but with the passage of the Appropriations Act, this process is no longer a "best practice;" it is required.

In addition to the items listed above, the FAQs identify additional documents that plans should be prepared to make available on request, including:

1. Records documenting NQTL processes and detailing how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under State law.
2. Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support its rationale.
3. Samples of covered and denied MH/SUD and medical/surgical benefit claims.
4. Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

Notably, the precise information needed to support an NQTL analysis will vary depending on the type of NQTL and the processes, strategies, evidentiary standards, and other factors used by the plan or issuer.

Practices to Avoid

The FAQs specifically identify practices that plans should avoid when responding to requests based on past NQTL investigations. The FAQs identify the following problematic practices:

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis;

4. Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice;
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

Corrective Procedures

If the Departments conclude a plan or issuer has not provided sufficient information to review the comparative analyses, the Departments shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request. Where the Departments have reviewed the comparative analyses and any other materials submitted by a plan and determined that the plan is not in compliance with MHPAEA, the plan must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance. Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer is still not in compliance, within 7 days of that determination the plan must notify all individuals enrolled in the plan that the coverage is not compliant with MHPAEA. The Departments will also share findings of compliance and noncompliance with the State where the group health plan is located or where the issuer is licensed to do business. Although not directly addressed in the FAQs Mental Health Parity violations are also subject to Internal Revenue Code Chapter 100 penalties, which are generally $100 per day per participant.

State and Participant Requests

The FAQs confirm that plans must make their comparative analyses of NQTLs and other information available to the applicable State authority upon request. The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or an official or officials designated by the State for enforcement.

The FAQs also confirm that under prior guidance, participants and beneficiaries (or their authorized representatives) in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits. The FAQs emphasize that if a provider or other individual is acting as a patient's authorized representative, the provider may request these documents. This can be problematic where out-of-network providers have every patient sign an authorized representative designation and then attempt to use ERISA and other document requests as a way to leverage higher plan payments for services. Employer plan sponsors may want to tighten their procedures on authorized representative designations as well as anti-assignment language to limit these types of requests.

Areas for Initial Focus

The FAQs confirm that the Departments may request comparative analyses on NQTLs that have been the subject of complaints or potential violations. For example, in the event that the Departments receive a complaint regarding prior authorization requirements for coverage of buprenorphine for the

treatment of opioid use disorder, the Departments may request an NQTL comparative analysis for prior authorization requirements placed on prescription drugs. In addition, the FAQs also identify four specific areas that the DOL expects to focus on in its initial enforcement efforts:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

Plans should also be prepared to make available a list of all other NQTLs for which they have prepared a comparative analysis and a general description of any documentation that exists regarding each analysis.

Conclusion

This set of FAQs includes important information for employers that sponsor group health plans that provide both MS benefits and MH/SUD benefits. If employers have not already done so, it is important to reach out to carriers, Third Party Administrators (TPAs) and any vendor partners supporting carved out benefits (e.g., Pharmacy Benefit Managers) to identify NQTLs and begin an analysis of their parity with respect to MH/SUD benefits. In addition, employers should closely review the MHPAEA Self Compliance tool and go through the compliance review steps outlined for NQTLs. Although the Departments have not made significant NQTL disclosure requests yet, this guidance could indicate that requests are forthcoming. Please contact your Alliant representative with additional questions.

Compliance Alert is presented by the Compliance Practice Group of Alliant Employee Benefits

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