Agencies Issue Guidance on Updated Mental Health Parity Rules

On April 2, 2021 the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (IRS), published FAQs about the Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (FAQs). The Agencies' guidance clarifies the new self-assessment requirement added by the Consolidated Appropriations Act, 2021 (the "Act") to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

This Alert summarizes the guidance provided by the FAQs. We will refer to the DOL, HHS, and IRS collectively as the "Agencies" in this Alert.

Updated Mental Health Parity Rules

Federal Mental Health Parity Rules

The MHPAEA generally provides that certain financial requirements and treatment limitations imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the financial requirements and treatment limitations imposed on similar medical/surgical benefits. This includes non-quantitative treatment limitations (NQTLs), which involve behind-the-scenes plan administration, consisting of the processes, strategies, evidentiary standards and other factors used in determining whether a benefit should be covered or denied. NQTLs also include plan design gatekeeping requirements, such as preauthorization, precertification, fail first, and other protocols that affect MH/SUD benefits.

Any group health plan or insurance carrier that applies NQTLs to MH/SUD benefits must ensure they are consistent with the NQTLs that apply to the plan's medical/surgical benefits. A comparative analysis of these NQTLs is a best practice to ensure compliance with these rules.

Amendment to the Rules: New Self-Assessment Requirement

The Act amends MHPAEA and the new rules affect both fully insured and self-insured group health plans, including church plans, and non-federal governmental plans.[1]

Under the Act, group health plans and insurance carriers that offer both medical/surgical and MH/SUD benefits and impose NQTLs on these benefits must perform a self-assessment and document their

[1] Certain exceptions apply, including exceptions for plans that provide only excepted benefits (such as most dental, vision, and health flexible spending accounts), plans that cover fewer than two current employees, and retiree-only plans. Self-insured, non-federal governmental plans also have the option to opt out of the MHPAEA. Further discussion of available exceptions is outside the scope of this Alert.

analysis and findings. This self-assessment must be made available to Federal and State enforcement authorities upon request and include the following information:

- The specific MH/SUD benefits subject to NQTLs and relevant terms regarding the NQTL;
- How the NQTLs apply to and affect those benefits; and
- An analysis of how each NQTL satisfies (or fails to satisfy) the MHPAEA parity rules.

Effectively, this amendment changes the self-assessment from a best practice to a requirement that must be available upon request.

Note: The compliance obligations belong to insurance carriers for fully insured group health plans. Plan sponsors are responsible for the compliance of self-insured plans, and may receive support from third parties.

How to Comply

The FAQs provide some clarity about the scope of the requirement and guidance on documentation requirements. Because determining compliance and analyzing NQTLs can be complex, we recommend self-insured plan sponsors coordinate with their medical/Rx third party administrators and other vendors to ensure the plan is compliant and to be able to demonstrate that compliance to the Agencies.

When Does this Apply?

The effective date of this new requirement was February 10, 2021. The Agencies declined to delay this enforcement date, and it appears enforcement began mid-April. We expect limited enforcement action will continue throughout 2021.

Based on the FAQs, near-term enforcement priorities will focus on prior authorization and concurrent-review NQTLs, provider network standards, and out-of-network reimbursement rates, although the Agencies may request information on other NQTLs. Participant complaints of potential violations may also impact NQTL investigations.

Note: In addition to the Agencies, state agencies and participants also have a right to request this information under various laws. Plans should be prepared to respond to all such requests for information.

How Do You Perform the Self-Assessment?

The self-assessment should be detailed enough to demonstrate whether the NQTL is applied to MH/SUD benefits in compliance with MHPAEA. Confirming our prior recommendation to use the DOL's Self-Compliance Tool to perform the self-assessment,[2] the Agencies provide that plans and carriers that have carefully applied the guidance in the Self-Compliance Tool will be in a "strong position" to comply with the self-assessment requirement. We recommend employers continue to use the DOL's Self-Compliance Tool unless and until the Agencies release a new tool specific for NQTLs.

What Documentation Should be Included with the Self-Assessment?

Additional documentation may be necessary to support asserted findings and conclusions in the self-assessment. This includes documentation of claims guidelines, policies and procedures, as well as samples of approved and denied claims.[3] Employers should keep these documents readily accessible to respond to any requests for additional information.

When Will a Self-Assessment be Considered Insufficient?

A self-assessment will be deemed insufficient if it does not include enough detail about the NQTL and how it is applied to MH/SUD benefits or medical/surgical benefits.

The Agencies provide common examples of insufficient responses, including:

- Production of large volumes of documents without explaining their relevance;
- Providing conclusory or generalized statements without supporting evidence or explanation;
- Identifying NQTLs under the plan without explaining how they are applied or performing a self-assessment for that NQTL. Any NQTL identified must be analyzed; or
- Relying on outdated self-assessments. New self-assessments should be performed when plan modifications are made or there are changes to regulatory guidance.

Based on this guidance, it is important that the reasoning behind a determination of compliance is documented in the self-assessment.

What Enforcement Action Will Be Taken if Insufficient/Noncompliant?

When information is insufficient, the federal/state agency that requested the assessment will request additional information. If the agency determines the plan or insurance carrier does not comply with the MHPAEA, a 45-day corrective action period will apply. During this time the plan must:

- Specify what actions it will take to come into compliance; and
- Submit another self-assessment demonstrating compliance.

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[2] Section F of the DOL Self-Compliance Tool includes the four step process that should be used to meet the self-assessment requirement
[3] The full list of supporting documentation is described in the DOL's FAQ #4

Upon receipt of the new self-assessment, the agency will make a final determination. Failure to comply within the corrective action period will result in the plan being required to notify enrolled individuals of its non-compliance with MHPAEA. This disclosure must be made within 7 days of the final determination of non-compliance. Participants could then start an enforcement action or sue the plan for denied claims and/or other benefits due to them. Excise taxes under the Internal Revenue Code of $100 per day for each individual for whom a failure relates may also apply.

The Great Unknown

The Agencies acknowledge these FAQs may not answer all questions surrounding this new requirement. The Agencies may release additional guidance in the future, which we expect to come in the form of draft regulations or additional FAQs. Until then, some remaining "unknowns" under the new rules include:

- The time an insurance carrier or plan sponsor has to respond to the initial request to provide the self-assessment, and subsequent request for additional information, if insufficient;
- Whether there will be an appeals process if the plan or carrier disagrees with the findings of the Agencies or state insurance agency; and
- The effect corrective action may have on potential MHPAEA penalties or other potential liability. For example, are potential civil penalties (e.g. the $100/day excise tax) stayed during the review process or waived if a group health plan timely implements corrective action following the review process?

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