COMPLIANCE ALERT

EMPLOYEE BENEFITS | AUGUST 19, 2021

Summary of Mental Health Parity and Transparency Provisions Under the Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 (the "CAA"), which was signed into law on December 27, 2020, included several provisions impacting group health plans and health insurance issuers. Below is a summary of the provisions focused on mental health parity and health plan transparency (specifically, broker/consultant commissions and pharmacy benefits and drug costs).

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), prohibits a group health plan from applying financial requirements (e.g., deductibles, co-payments, coinsurance, and out-of-pocket maximums), quantitative treatment limitations (e.g., number of treatments, visits, or days of coverage), or non-quantitative treatment limitations (such as restrictions based on facility type) to its mental health and substance use disorder benefits that are more restrictive than those applied to the plan's medical and surgical benefits.

MHPAEA compliance has been a focus in DOL audits in recent years. As part of the action plan for enhanced enforcement in 2018, the DOL, HHS and IRS released a self-compliance tool plans and issuers can use to evaluate their plan. However, Section 203 of the CAA took this a step further, requiring more active engagement by group health plans.

Beginning on February 10, 2021, group health plans were required to perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs). Specifically, the NQTL analyses must include certain information specified in the CAA, such as, among other things, specific plan terms or other relevant terms regarding NQTLs and the specific substance abuse, mental health, medical and surgical benefits to which they apply, and the factors used to determine that NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

Per the CAA, the DOL, IRS (Treasury) and HHS are required to request no fewer than 20 group health plan analyses per year, and group health plans must provide them to the agencies upon such request. In the last several months, the DOL began requesting the NQTL comparative analyses from plans that are currently undergoing DOL audits for other reasons, as well as from plans not currently under investigation. In addition, plan participants and authorized representatives such as out-of-network providers may request these analyses. Therefore, all plans should be prepared to provide their NQTL comparative analyses at any time.

If the agencies determine the group health plan is not in compliance, then the plan must respond to the agencies within 45 days by specifying any actions it will take to come into compliance and providing further comparative analyses demonstrating the plan's compliance. If still not in compliance, the agencies will notify all individuals enrolled in the plan of the plan's noncompliance. This could lead to significant exposure for non-compliant plans, as it basically opens a clear pathway to litigation.

On April 2 2021, the DOL released FAQs regarding these CAA provisions. The FAQs clarify the following:

- Because the requirement to make the comparative analyses available to federal or applicable state authorities was effective February 10, 2021, all plans and issuers should be ready to make their analyses available upon request.
- General, broad, and conclusory statements will not suffice for the analyses. Any analyses should be sufficiently specific, detailed, and reasoned to demonstrate the processes, strategies, evidentiary standards, or other factors used to develop and apply a NQTL for mental health/substance use disorder benefits are comparable to, and apply no more stringently than, those for medical/surgical benefits. The DOL's MHPAEA Self-Compliance Tool includes a 4-step roadmap for generating a comparative analysis. Therefore, plans and issuers that carefully follow the most recent (2020) MHPAEA Self-Compliance Tool when developing their analyses may be able to identify and mitigate potential issues.
- Specifically, at a minimum, the analyses must contain:
    - A clear description of the specific NQTL, plan terms, and policies at issue;
    - Identification of the specific mental health/substance use disorder ("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;
    - 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, including whether any factors were given more weight than others and why (including an evaluation of any specific data used in the determination);
    - 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;
    - 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;
    - If the application of the NQTL turns on specific decisions in administration of the benefits, the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) should be identified;
    - An assessment of the qualifications of each expert used, if any, 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;
    - 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 (including citations) identified above within each affected classification, and their relative stringency, both as applied and as written, including the results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA; and
    - The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.
- Any of the below practices (which the DOL has observed in the past), may result in an unsuccessful comparative analysis:
    - Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
    - Conclusory or generalized statements, including mere

recitations of the legal standard, without specific supporting evidence and detailed explanations;

- Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis;
- Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice;
- 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
- Analyses that are outdated due to the passage of time, a change in plan structure, or for any other reason.

This means plans should take the necessary time to ensure thoughtful, thorough analyses are conducted now and at any time applicable provisions of the plan change.

- The DOL's MHPAEA Self-Compliance Tool provides an example of the types of documents and information that would need to be available to support the comparative analyses, such as samples of claims, any process documents, guidelines or other claims processing policies and procedures, or documentation of standards, instructions to providers where management is delegated to an outside service provider, etc. Furthermore, if the comparative analyses reference any type of study, tests, data, reports, meeting minutes/decisions, or other considerations, documentation should be available to support those references.
- State regulators, participants, beneficiaries, or enrollees (or their authorized representatives) may all request, and the plan or issuer is required to provide, the comparative analyses.
- Where applicable, non-grandfathered plans would be required to provide any participants who are appealing an adverse benefit determination with copies of the comparative analyses (and supporting documentation) when providing all other documents the plan relied upon to support the denial of a claim.
- The DOL clarified that it may request discrete comparative analyses specific to a particular area of concern (such as where a complaint was received) but may request them in other instances where it is deemed appropriate by the agency. Currently, it intends to focus on the following NQTLs in its enforcement efforts:
  - Prior authorization requirements for in-network and out-of-network inpatient services;
  - Concurrent review for in-network and out-of-network inpatient and outpatient services;
  - Standards for provider admission to participate in a network, including reimbursement rates; and
  - Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

However, the DOL expects that even when comparative analysis is requested in a discrete area or areas, the plan or issuer must provide a list of all other NQTLs for which they have completed a comparative analysis and a general description of any supporting documentation. The DOL's initial request can broaden at any time, so having all comparative analyses completed, rather than only completing those listed above is essential for plans and issuers. Additionally, while insurance companies have fiduciary responsibility and must prepare the analysis for fully insured plans, third party administrators (TPAs) for self-insured plans typically do not have the same fiduciary responsibility that would require them to prepare the analysis. Sponsors of self-insured plans (including level-funded plans) should inquire with their TPA whether they have completed an analysis specific to their plan or the TPA's products in general, and whether they are prepared to assist in the event of a request. They may want to introduce language into the administrative services agreement upon renewal to clarify the extent to which the TPA will assist. In most cases, the TPA will be in the best position to perform the analysis – i.e., they will have established the NQTLs and will be able to identify them; they will have all the data and other information necessary for the analysis.

Transparency Requirements

Broker and Consultant Transparency

Section 202 of the CAA amends §408(b)(2) of ERISA and creates new transparency requirements that impact group health plans and their brokers or consultants. Specifically, group health plans must receive the following disclosures from brokers or consultants (or their affiliates or subcontractors) who reasonably expect to receive $1,000 or more (indexed for inflation) in direct or indirect compensation in connection with providing certain designated insurance-related services for the group health plan:

- A description of the services provided under the contract with the plan;
- Whether the broker, consultant, or their affiliate or subcontractor's services provided are, or reasonably expected to be in the capacity of a fiduciary;
- A description of all direct compensation, either in the aggregate or by service that the broker or consultant reasonably expects to receive in connection with the services;
- A description of all indirect compensation the service provider, or their affiliate or subcontractor, reasonably expects to receive in connection with the services;
- A description of any compensation that will be paid among the broker, consultant, their affiliate or subcontractor for commissions, finder's fees, or other similar incentive compensation based on business placed or retained. This must include identification of payers and recipients, regardless of whether it is disclosed as direct or indirect compensation; and
- A description of any compensation the broker or consultant reasonably expects to receive in connection with termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded.

Failure to comply puts the arrangement with the broker or consultant at risk of being considered not "reasonable." Timeframes for providing the information to the group health plan and updating the plan of any changes to information previously provided pursuant to these requirements, as well as good faith compliance and other considerations for non-compliance are discussed in more detail in the CAA. These requirements are effective for contracts for covered services executed or renewed on or after December 27, 2021 (one year from enactment of the CAA). We expect more guidance from the DOL prior to the deadline.

Pharmacy Benefits and Drug Costs

Section 204 of the CAA requires group health plans or issuers to begin reporting the following information regarding health plan coverage to the IRS, HHS, and DOL:

- The plan year start and end dates;
- The number of enrollees;
- Each state in which the plan is offered;
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of claims for each such drug;
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year before the plan year in which the report pertains, including the amounts expended by the plan for each drug during such plan year;
- Total spending on health care serviced by the plan, broken down by hospital costs, health care provider and clinical service costs for both primary care and specialty care prescription drug costs, other medical costs (including wellness services), and spending on prescription drugs by the health plan and enrollees;
- The average monthly premium broken down by employer share and employee share;
- Any impact on premiums by rebates, fees, and drug manufacturer remunerations for prescription drugs, including the amount paid for each therapeutic class and the amount paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration from drug manufacturers; and
- Any reduction in premiums and out-of-pocket (OOP) costs associated with rebates, fees, or other drug manufacturer remuneration.

The information reported pertains to the health plan or coverage offered during the previous plan year. The first report is due on December 27, 2021 (one year after enactment of the CAA), while each subsequent annual report is due by June 1st. In June 2021, the agencies released a request for information regarding the impact of the legislation on impacted health plans. Thus, they are in the early stages of implementing regulations, and have not yet indicated how the information will be reported to/received by the agencies.

What's Next for Employers?

While we expect more guidance on the transparency requirements for brokers and consultants, in the meantime, they should review their existing contracts and disclosures in light of these requirements and begin implementing any necessary changes. Further, group health plans are encouraged to review their coverage of mental health and substance use disorder benefits and carefully follow the DOL's most recently updated (2020) MHPAEA Self-Compliance Tool when developing their MHPAEA comparative analyses. Finally, later in the year, group health plan sponsors should prepare to comply with pharmacy benefit and drug cost disclosure requirements.

About the Authors: This alert was prepared for Woodruff Sawer by Marathas Barrow Weatherhead Lent LLP, a national law firm with recognized experts on the Affordable Care Act. Contact Stacy Barrow or Nicole Quinn-Gato at ***sbarrow@marbarlaw.com*** *or* ***nquinngato@marbarlaw.com****.*