

How the Consolidated Appropriations Act of 2021 affects MHPAEA

New requirements for demonstrating parity compliance

Steve Melek, FSA, MAAA
Stoddard Davenport, MPH



The Consolidated Appropriations Act (CAA) of 2021, recently signed into law, does more than provide financial relief to Americans.

It impacts how health plans and insurers comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). At nearly 5,600 pages in length, the CAA is the longest bill Congress has ever passed.¹ Under it, group health plans and health insurance issuers that offer mental health (MH) or substance use disorder (SUD) benefits face additional reporting and compliance requirements for nonquantitative treatment limits.

Of particular urgency is a requirement that group health plans and health insurance issuers complete a formal compliance analysis and make the resulting documentation available, upon request, to applicable regulators within 45 days of enactment of the CAA (by February 10, 2021).

Increased attention on NQTLs

MHPAEA imposes different rules for quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs). QTLs include features such as copays, coinsurance, and deductible amounts, and day or visit limits. On the other hand, NQTLs include any processes, strategies, evidentiary standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Under MHPAEA, a plan cannot impose an NQTL (such as medical management standards, formulary or network tiers, or provider reimbursement criteria) for MH/SUD benefits in a classification (inpatient, outpatient, emergency room, prescription drugs), unless, under the plan's written terms and actual operations, any processes,

strategies, evidentiary standards, or other factors used to apply the NQTL are comparable to and applied no more stringently than the ones used for medical/surgical (M/S) benefits in the same classification.²

MHPAEA's implementing rules outline mathematical tests that can be used to determine a health plan's compliance with the requirements for QTLs, but no such objective processes exist for NQTLs. As a result, many plans have found demonstrating compliance to be much more challenging for NQTLs than for QTLs. In recent years, a stepwise comparative approach has increasingly come into favor. Similar approaches have been outlined in guidance issued by parity advocates as well as in self-compliance tools released by the U.S. Department of Labor (DOL).^{3,4} The CAA now requires group health plans and health insurance issuers to demonstrate NQTL compliance in a fashion similar to the process outlined by the DOL, which includes documentation of the following elements for each NQTL applied to MH/SUD benefits:⁵

- “(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
- “(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
- “(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

¹ Taylor, Andrew (December 22, 2020). \$900B COVID relief bill passed by Congress, sent to Trump. Associated Press. Retrieved February 11, 2021, from <https://apnews.com/article/congress-900-billion-coronavirus-bill-75389549d3eaf2f3828b16d45c9706e6>.

² MHPAEA, 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).

³ ParityTrack. Six Step Parity Compliance Guide. Retrieved February 11, 2021, from <http://www.paritytrack.org/six-step-parity-compliance-guide/>.

⁴ DOL. Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). Retrieved February 11, 2021, from <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>.

⁵ CAA, Pub. L. 116-260, sec. 203.

“(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder 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 or surgical benefits in the benefits classification.

“(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance.”

These requirements come on the heels of similar legislative changes happening at the state level in states such as California, Colorado, and Connecticut, each of which has enacted certain reporting and disclosure requirements related to mental health parity in the past two years.^{6,7,8}

Compliance guidance and illustrative examples

Despite guidance currently available, some plans have found it challenging to anticipate the level and types of documentation or analyses required by regulators to demonstrate compliance. While the DOL has issued a number of responses to frequently asked questions (FAQs) regarding parity compliance issues, the CAA instructs regulators to produce a compliance program guidance document, with examples illustrating compliance or noncompliance, including de-identified summaries of previous investigations.

The guidance document is also expected to include examples of disclosures that regulators have received, descriptions of any violations uncovered within those disclosures, explanations for how compliance decisions were reached, and more. The document is expected to have such examples for each step of the comparative analysis approach outlined in the CAA and is expected to be updated every two years.

Regulatory audits

While the CAA requires that documentation of NQTL compliance (including comparative analyses) be available by February 10, 2021, health plans are not required to submit this information to regulators on that date. Instead, the information must be available upon request, including for plans with suspected violations or complaints, or for other situations where regulators find it appropriate. The Secretary of the U.S. Department of Health and Human Services (HHS) is required by the CAA to make no fewer than 20 requests for such analyses per year.

If regulators determine that the documentation or comparative analyses produced by health insurance plans or issuers is insufficient, they can request additional information and analyses, which health plans or issuers are then required to produce. If regulators determine that a health insurance plan or issuer is out of compliance, corrective action plans to resolve any issues within 45 days may be required. If compliance isn't achieved after 45 days, regulators will notify individuals covered by the plan or issuer that the insurance plan has been found to be not in compliance with MHPAEA.

Reports to Congress

In addition to reporting requirements for health plans or issuers, the CAA also requires the Secretary of HHS to submit an annual report to Congress, beginning on October 1, 2021. This report will include a summary of the analyses that the Secretary requested, including the names of the relevant health plans or issuers that were found to be noncompliant. Besides final determinations, the Secretary's report will also include determinations with regard to the sufficiency of any submitted information, actions required of plans that did not submit sufficient information, and the specific reasons for any noncompliance determinations.

This process will provide additional public visibility to the results of the Secretary's review—and presents reputational risks for any health plans or issuers that are found to be noncompliant. Besides the reputational risks, plans that are found to be noncompliant with MHPAEA may also be subject to penalties or fines from departments of insurance or the DOL, and the IRS can assess fines from group health plans of up to \$100 per day for each individual affected by a parity violation.⁹

⁶ ParityTrack. Colorado Statutes: Parity Report. Retrieved February 11, 2021, from <http://www.paritytrack.org/reports/colorado/statutes/>.

⁷ The full text of the Connecticut law is available at <http://www.cga.ct.gov/2019/TOB/h/pdf/2019HB-07125-R00-HB.PDF>.

⁸ Manatt (September 29, 2020). CA approves new parity law expanding coverage obligations for mental health and SUD treatment. JD Supra. Retrieved February 11, 2021, from <https://www.jdsupra.com/legalnews/ca-approves-new-parity-law-expanding-98916/>.

⁹ New Tax Return Requirement for Certain Group Health Plan Mandates, Sullivan & Worcester Benefits Brief, December 21, 2009. Retrieved February 17, 2021 from <https://www.sullivanlaw.com/news-publications-269.html>.

Conclusions

While the early focus of MHPAEA compliance was on QTLs, the focus is increasingly shifting to NQTLs. The CAA continues that trend and puts NQTL compliance documentation in the spotlight. Health plans and insurers can no longer take NQTL compliance documentation lightly. The timeline for gathering proper documentation of NQTL processes, strategies, evidentiary standards, and other factors is tight and it would be prudent to get started on these analyses quickly (if they do not already exist). If the analyses already exist, many health plans or issuers would benefit from careful reviews to determine whether the documentation requirements described above have been met.

Plans should also complete the comparative analyses described above with appropriate attention to detail. Regulators will likely focus on these analyses when they review NQTL documentation, and while the process outlined by the CAA allows 45 days for correction of any identified deficiencies, plans will need to work quickly to resolve any issues before being publicly identified as noncompliant in the HHS Secretary's annual report to Congress.



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CONTACT

Steve Melek
steve.melek@milliman.com

Stoddard Davenport
stoddard.davenport@milliman.com

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