Summary of Benefits Provisions in the 2021 Consolidated Appropriations Act – Part 2

An Update to the Parity Rules for Mental Health and Substance Use Disorder Benefits

The Consolidated Appropriations Act, 2021 (the "Act") was signed into law on December 27, 2020. The Act combines the $1.4 trillion omnibus federal spending package for the 2021 fiscal year and a $900 billion COVID-19 stimulus package. We addressed the Act's limited relief for flexible spending account plans, the optional limited extension to emergency paid sick leave and public health emergency leave, student loan repayment assistance, and a high level overview of surprise billing legislation in our earlier Alert.

This Alert summarizes the Act's additions to the Mental Health Parity and Addiction Equity Act (MHPAEA), which require group health plans to self-assess compliance with the MHPAEA's parity rules for *nonquantitative treatment limitations*. Group health plans must provide this self-assessment to an appropriate federal and/or state agency upon request.

Quick Recap: The MHPAEA generally requires group health plans that cover medical/surgical benefits *and* mental health or substance use disorder benefits to meet certain parity requirements with respect to cost sharing, visit limits, and plan administration requirements.

When, Exactly?

The Act indicates that an appropriate federal and/or state agency may begin requesting self-assessments for review on **February 10, 2021**. However, the Act gives the *enforcing federal agencies* until **June 27, 2022** to issue guidance in support of the new requirements. This guidance will include tools to aid self-assessment and compliance efforts, and the Act specifically refers to a "Compliance Program Guidance Document." We suspect this document will include a standardized self-assessment format or template for use by group health plans.

Although possible, it seems unlikely that federal or state agencies will request self-assessments before this regulatory guidance appears. We believe the federal agencies will specify a later enforcement date in draft regulations or other guidance. In the meantime, we recommend using the existing MHPAEA self-assessment tool from the U.S. Department of Labor (DOL) to analyze plan compliance. Section F of this tool addresses nonquantitative treatment limitations and may form the basis for any later standard self-assessment format or template.

Which Plans are Affected?

The MHPAEA exists in three separate federal laws:

1. The Employee Retirement Income Security Act (ERISA) enforced by the DOL;
2. The Internal Revenue Code (IRC) enforced by the U.S. Department of Treasury (Treasury); and
3. The Public Health Services Act (PHSA) enforced by the U.S. Department of Health and Human Services (HHS).

The Act amends all three laws, meaning the new requirements apply to fully insured and self-insured group health plans, including church plans, and non-federal governmental plans.[1] The MHPAEA applies to grandfathered plans under the Affordable Care Act. We will collectively refer to the DOL, Treasury, and HHS as the "Federal Agencies" in this Alert.

State Enforcement: State insurance agencies have primary MHPAEA enforcement authority for fully insured coverage issued to private sector employers, although HHS has the authority to intervene. States may also implement their own parity rules, but the state law requirements cannot be less restrictive than the MHPAEA.

Who is Responsible for Compliance?

Fully insured group health plans – The insurance carrier is responsible for MHPAEA compliance. This includes performing the self-assessment, responding to agency requests to provide the assessment for review, and any corrective action.

Self-insured group health plans – The plan sponsor is responsible for MHPAEA compliance, although the plan sponsor may have contractual indemnification rights against a third party administrator (TPA) or other third party for non-compliance. The plan sponsor is responsible for performing the self-assessment, responding to agency requests to provide the assessment for review, and any corrective action.[2] Most plan sponsors will perform self-assessments with significant support from the TPA and/or other third parties.

[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.
[2] For multiemployer self-insured plans funded through a trust, this responsibility should belong to the trustees.

Nonquantitative Treatment Limitations (NQTLs)

NQTLs are limits on the scope or duration of mental health and/or substance use disorder benefits for treatment under a group health plan that are not financial, cost sharing, or visit limits. It is probably easiest to think of these as plan administrative or "gatekeeping" limitations for receiving benefits.

Frequent NQTL Parity Violations

Example 1: A group health plan requires preauthorization (a type of medical management standard) for inpatient medical or surgical treatment, but requires preauthorization for all inpatient *and* outpatient mental health or substance use disorder treatment.

Example 2: A group health plan requires medical necessity review for ongoing treatment. The plan's standards for medical necessity review consistently require reviews for mental health and/or substance use disorder treatment with more stringent evidentiary standards than those applied to medical or surgical care.

Please see the DOL's NQTL warning signs guidance for additional examples.

Self-Assessment Requirement

The Act requires group health plans to analyze and document the following information:

- The specific mental health and/or substance use disorder benefits subject to NQTLs;
- 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.

The Act does not contain an annual assessment requirement. We believe an existing assessment will remain valid unless and until there are substantive changes to the group health plan's design that may affect MHPAEA compliance.

Subject to Review

The Federal Agencies are each required to review at least 20 self-assessments per year.[3] The reviewing agency may request additional information to complete the review process. Once complete, the reviewing agency will indicate whether the group health plan complies with the MHPAEA or if corrective action is

[33] This is a very low number relative to the number of group health plans subject to the MHPAEA. This is merely a minimum limit, but the number of reviews the Federal Agencies can realistically perform in a given year is small. As written, it is not clear if reviews by state insurance agencies will count toward HHS satisfying its 20 review minimum requirement.

required. If required, a group health plan will generally have 45 days to implement corrective action. If the plan fails to take corrective action or is still not in compliance, the plan may be subject to civil penalties. The reviewing agency will notify all covered participants that the plan does not comply with the MHPAEA, which may make the plan vulnerable to litigation.

The Federal Agencies will report summary findings of the reviews annually to the United States Congress. The Federal Agencies will also update their guidance, including the Compliance Program Guidance Document, at least every two years.

Note: The DOL and HHS already conduct MHPAEA compliance reviews and annually publish a high-level summary of findings. The Federal Agencies may use or modify this existing report format to satisfy the new NQTL requirements.

Enforcement Questions

The Federal Agencies and state insurance agencies may begin requesting self-assessments on February 10, 2021. As discussed earlier, we believe actual enforcement will occur sometime after the Federal Agencies issue regulatory and other guidance. The following is a non-exhaustive list of current "unknowns" under the new rules:

- The acceptable form and format for self-assessments;
- The time an insurance carrier or plan sponsor has to respond to a request to provide the self-assessment;
- Whether there will be an appeals process if the group health plan disagrees with the findings of the Federal Agency 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 stayed during the review process or waived if a group health plan timely implements corrective action following the review process?

About the Author

Christopher Beinecke, J.D., LL.M. *is the Employee Health & Benefits National Compliance Leader for Marsh & McLennan Agency.*