AGENCIES ISSUE GUIDANCE ON COMPARATIVE ANALYSIS OF MENTAL HEALTH/SUBSTANCE USE DISORDER NON-QUANTITATIVE TREATMENT LIMITS

Hodgson Russ Employee Benefits Newsletter
May 26, 2021

The Consolidated Appropriations Act of 2021("CAA") amended the Mental Health Parity and Addiction Equity Act ("MHPAEA") to require group health plans and insurers that impose non-quantitative treatment limits on mental health or substance use disorder treatment benefits to prepare a detailed comparative analysis explaining the application of each such limit.

As background, the MHPAEA prohibits group health plans and insurers from imposing non-quantitative treatment limitations ("NQTL"), such as processes, strategies, evidentiary standards, or other factors with respect to mental health/substance use disorder ("MH/SUD") benefits that are more restrictive than those factors as applied to medical/surgical benefits under the plan.

Effective February 10, 2021, the CAA's required comparative analysis of NQTLs must be made available to the Departments of Labor, Health and Human Services and Treasury, or State agencies upon request. The Departments have jointly released FAQs describing this new compliance requirement.

The FAQs provide a detailed explanation of the comparative analysis content requirements. The analysis must be detailed, specific and reasoned in order to demonstrate that the processes, strategies, evidentiary standards, or other factors used in developing and applying the NQTL are comparable as between MH/SUD and medical/surgical benefits. Nine factors, derived from the DOL's MHPAEA Self-Compliance Tool, provide the minimum content requirements for the comparative analysis:

- A clear description of the specific NQTL, including the applicable plan terms;
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies, and a clear statement as to which benefits are considered MH/SUD versus medical/surgical;
- Identification of any factors, evidentiary standards, strategies or processes considered in the design or application of the NQTL and in determining which benefits are subject to the NQTL, and the weighting of such factors;

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- To the extent the plan or insurer 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;
- An explanation of any variation in the application of a guideline or standard used by the plan between MH/SUD and medical/surgical benefits and a description of 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 plan should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker (s);
- If the plan relies upon any experts, the analyses should include an assessment of each expert's qualifications and the extent to which the plan 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 findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above 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;
- The date of the analyses and the name, title, and position of the person(s) who performed or participated in the comparative analyses.

The comparative analysis must be carefully prepared to address these requirements. Conclusory or generalized statements without specific supporting evidence and detailed explanations are insufficient to satisfy these requirements. In addition, the comparative analysis requirements are not satisfied by transmitting a large volume of documents without a clear explanation as to how each document is relevant. Plans should be prepared to produce additional documentation in conjunction with an agency's request for the comparative analysis, including claims processing procedures; samples of covered and denied MH/SUD and medical/surgical benefit claims; and documents related to MHPAEA compliance by the plan's delegated service providers.

If, after reviewing the comparative analysis, an agency determines the plan is out of compliance with the MHPAEA, the plan will have 45 days to take corrective action and submit additional documentation. If compliance is not achieved after such corrective action, the plan must notify participants within seven days of the determination that the plan is not in compliance. Participants and claimants appealing an adverse benefits determination may request a copy of the plan's comparative analysis and supporting documentation.

The Departments' guidance ends with a discussion of MHPAEA enforcement priorities, including:

- 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 a network, including reimbursement rates; and
- out-of-network reimbursement rates, including plan methods for determining usual, customary, and reasonable charges.

Of course, the Departments may also focus on MHPAEA complaints, and may expand their compliance focuses in the future.

FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021, Part 45 (April 2, 2021), found at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/ouractivities/resource-center/faqs/aca-part-45.pdf