ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Earl Porter provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken and Amy are senior members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

GROUP HEALTH PLAN PROVISIONS OF THE CONSOLIDATED APPROPRIATIONS ACT: A DEEPER DIVE

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. In addition to funding the government and further COVID-19 relief, the CAA included significant provisions impacting health benefit coverage.

Over the next several articles we will discuss four of the provisions relevant for group health plans: (1) expanded relief for health and dependent care flexible spending arrangements; (2) new expanded compliance requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA); (3) new reporting requirements for commission and similar compensation; and (4) new requirements to limit surprise billing.

In prior articles we discussed the impact of CAA on FSA administration and the forthcoming broker/consultant fee disclosure rules.

This article provides background on new comparative analysis disclosure requirement under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The CAA specifically mandates that group health plans and insurers perform and document a MHPAEA comparative analysis of a plan's or policy's nonquantitative treatment limitations (NQTLs) and provide such documentation to the auditing agencies (and participants) upon request.

A. BACKGROUND

MHPAEA is designed to require benefit parity between medical and surgical (Med/Surg) benefits and mental health and substance use disorder (MH/SUD) benefits.

If a plan provides Med/Surg benefits and MH/SUD benefits the plan must provide parity with respect to (1) financial requirements (e.g., deductibles, copayments, coinsurance and out-of-pocket maximums); (2) quantitative treatment limitations (e.g., number of visits or treatments or days of coverage); and (3) NQTLs, discussed below.

The CAA's amendment to MHPAEA's provisions in ERISA, the Internal Revenue Code (Code) and the Public Health Services Act (PHSA) focus on NQTLs.

Since MHPAEA's provisions fall under three distinct statutes, enforcement falls under three federal agencies: the IRS, the Department of Health and Human Services (HHS) and the Department of Labor (DOL) (collectively the Tri-Agencies).

Also, state departments of insurance have jurisdiction over insured plans. MHPAEA applies not only to ERISA-covered plans but also, with limited exceptions, to local state and governmental plans and church plans.

MHPAEA compliance has been a primary focus in DOL audits of group health plans over the last several years. In a 2018 Report to Congress DOL acknowledged that "a MHPAEA investigation can take a year or more, depending on a variety of factors". In our experience MHPAEA audits can stretch over several years.

B. NQTLS

The following is a non-exclusive list of NQTLs

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);

- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

DOL has put out several useful tools with regard to NQTLs including a Self-Compliance Tool and a listing of MHPAEA NQTL Warning Signs.

Under MHPAEA, benefits are broken down into six different classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.

MHPAEA regulations prohibit a group health plan from imposing NQTLs on MH/SUD in a classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to Med/Surg benefits in the same classification.

The parity analysis requires not only identifying the NQTLs as written and in operation but also examining the factors considered in the design of the NQTLs.

Examples of factors include:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for service

Then the sources for the factors must be examined. Examples of sources include:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits

Group health plans must then demonstrate that any factor used, evidentiary standard or source relied upon, and process employed, in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services as compared to Med/Surg services.

Needless to so say this is a huge and difficult undertaking. In our experience many self-insured group health plans have not undertaken the exercise of documenting a NQTL analysis and compliance.

This is not a service normally performed by a third party administrator (TPA) or pursuant to an administrative services only (ASO) agreement with an insurer.

Most often a firm with specialized MHPAEA expertise and/or actuarial capabilities must be engaged for the analysis. As frequently noted by the

agencies, the Self-Service Tool linked above is a useful start and framework for such an analysis.

C. CAA'S AMENDMENT TO MHPAEA

Although MHPAEA compliance has been required for well over a decade, there has never been a specific statutory requirement to have a documented NQTL analysis; although DOL frequently requests such an analysis when it performs a group health plan audit.

The CAA now mandates that group health plans and insurers *shall perform and document comparative analyses of the design and application of NQTLs.*

The CAA requirements are specific as to the analysis as described above and must: identify the NQTLs; identify the factors used to determine the NQTLs; identify the evidentiary standards and sources used to develop the factors; perform a comparative analysis; and contain specific findings and conclusions.

Beginning 45 days after the enactment of the CAA (February 10, 2021), that comparative analysis of the NQTLs must be provided, upon request, to state regulators (e.g. a state department of insurance for an insured plan) or to any one of the Tri-Agencies. Each of the Tri-Agencies is required to request at least 20 NQTL analyses per year.

The request from each Tri-Agency will be triggered by complaints, identification of potential violations of MHPAEA, or any "in any other instances that the [Tri-Agency] determines appropriate".

The Tri-Agency will then review the NQTL analysis and if it finds it noncompliant the Agency will provide the plan/insurer 45 days to provide an analysis showing NQTL compliance.

If a plan/insurer fails to demonstrate compliance in that 45 day period then, within 7 days of the determination of noncompliance, the Tri-agency will notify all individuals enrolled in the plan or policy of the non-compliance.

Although recent years have seen increased guidance from the Tri-Agencies on MHPAEA, there remain many uncertainties on when a NQTL might violate MHPAEA.

The CAA has provisions similar to the 2016 21st Century Cures Act, which required the Tri-Agencies to take certain steps to promote understanding and compliance with MHPAEA. The CAA requires the Tri-Agencies to develop a "compliance program guidance document" which will provide de-identified examples of NQTL compliance and non-compliance and other recommendations to advance NQTL compliance.

That document will also provide information on how plans and insurers may disclose information in compliance with MHPAEA. The deadline for issuing this guidance is eighteen months after enactment (late June 2022).

The guidance will also provide further information on the process and timelines for participants and beneficiaries to file complaints with respect to alleged MHPAEA violations. The compliance program guidance document will be updated once every two years.

While specific regulatory guidance is still in the works, the agencies have provided guidance as to what they expect in the Comparative Analysis in the form of FAQ guidance. (ACA FAQs 45). Specifically, with regard to the format of the Comparative Analysis, the agencies have stated that:

- Comparative analysis for each NQTL must be sufficiently detailed and reasoned
- Conclusory or generalized statements without specific supporting evidence and detailed explanations are insufficient
- Include supporting information (e.g., claim processing policies, samples of claims)
- Follow guidance in the MHPAEA Self-Compliance Tool

D. SUMMARY AND ACTION ITEMS

For self-insured plans now is the time to perform a MHPAEA NQTL comparative analysis if one has not already been performed. Even where an NQTL comparative analysis has been performed, it needs to be reviewed under the requirements provided in the CAA's amendments to MHPAEA.

As noted above, the Tri-Agencies could be asking for such an analysis as early as February 10, 2021. And for the last several years DOL has requested the analysis as part of its group health plan audit protocol.

The Tri-Agencies goal, however, appears to be one of better overall compliance. That said, DOL will take action if it discovers noncompliance. Violations of MHPAEA under ERISA are limited to what is known as "equitable relief."

That can include requiring a plan to reprocess claims if they were improperly denied or not fully reimbursed because of a noncompliant NQTL. Depending on the volume of claims involved, reprocessing can be a burdensome and expensive proposition.

There is, however, no civil monetary penalty for MHPAEA violations under ERISA. DOL also has limited jurisdiction over insured plans although when it discovers a violation it will work with insurers and state departments of insurance to bring policies into compliance.

Under the Code there can be an excise tax for MHPAEA violations of $100 per day for each individual to whom a failure relates.

There has also been a significant uptick in MHPAEA litigation by private parties under ERISA. These cases often involve NQTLs and having a NQTL analysis establishing compliance could go a long way in preventing those claims or defending them if they are brought. ■