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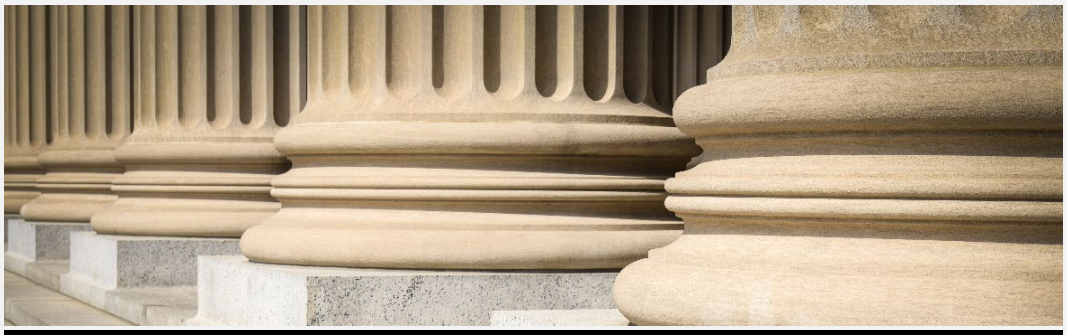

Rewards Policy Insider
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Guidance on CAA Mental Health Parity Reporting Requirement

Agency guidance is now available on the new reporting requirement for group health plans relating to compliance with Mental Health Parity rules for nonquantitative treatment limitations ("NQTLs"). The "comparative analyses" of NQTLs for medical, surgical, mental health, and substance use disorder benefits, enacted as part of the Consolidated Appropriation Act's (CAA) transparency requirements for group health plans, must be provided to federal and state regulators "upon request."

Action Needed

The frequently asked questions ("FAQs") issued jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury, note that DOL maintains a mental health parity self-compliance tool. This self-compliance tool includes a section on NQTLs. The FAQs note that this section outlines a process for conducting comparative analyses of NQTLs and advises that "plans and issuers that have carefully applied the guidance in the self-compliance tool should be in a strong position to comply with the [CAA's] requirement to submit comparative analyses upon request."

Because the FAQs reaffirm that the comparative analyses requirements are now in effect and that Federal or state regulators could request them at any time, plans and issuers that have not done so already may want to consider immediately using the FAQs and self-compliance tool to begin preparing the required comparative analyses and to begin acting on any findings.

While all NQTLs are subject to these requirements, the FAQs identify the following as the near-term focus of the DOL's enforcement efforts:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

Background

Briefly, group health plans that offer mental health (MH) or substance use disorder (SUD) benefits may not impose more stringent limitations on such benefits than those that apply to medical and surgical benefits. This parity requirement does not just apply with respect to cost-sharing requirements and numeric limits on visits to specific types of providers but also to NQTLs such as medical management and pre-authorization requirements. These NQTL rules are complex and can pose unique compliance and enforcement challenges.

Prior to the CAA, the self-compliance tool – which was last updated in 2020 – recommended that plans and issuers analyze NQTLs and document those analyses as a "best practice." As stated in the FAQs, because of the CAA this is no longer just a "best practice" – it is required.

If asked by the relevant regulatory authority for its comparative analyses, the plan or issuer also will have to provide:

- The specific plan or coverage terms regarding NQTLs;
- The factors used to determine that the NQTLs will apply;
- The evidentiary standard used for each factor; and
- The specific findings and conclusions reached, including anything indicating whether the plan is or is not in compliance with the relevant requirements.

What is Required for the Comparative Analyses?

According to the FAQs, the regulatory agencies will not treat a comparative analysis as sufficient unless it contains a detailed, written, and reasoned explanation of the specific plan terms and practices at issue, as well as the bases for the plan's or issuer's conclusion that the NQTLs comply with the Mental Health Parity and Addiction Equity Act (MHPAEA.) The analyses must include a "robust discussion" of each of the following elements:

1. A clear description of the specific NQTL, plan terms, and policies at issue.
2. Identification of the specific 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.
3. 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. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
4. 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.
5. The analyses, as documented, should explain 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.
6. If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications 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.
8. 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 identified above within each affected classification, 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.

9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

Clearly not sufficient, according to the FAQs, is "a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, standards, or other factors…."

What Happens if a Comparative Analyses is Insufficient?

According to the FAQs, if sufficient information is not provided to review the comparative analyses, then the regulators will advise the plan or issuer of what else it must provide to be responsive.

If the comparative analysis is sufficient, but the regulators determine the plan is not complying with the relevant Mental Health Parity requirements, the plan or issuer will have 45 days to provide additional comparative analyses that demonstrate compliance. If the regulators determine the plan is still not in compliance at the end of this 45-day period, the plan or issuer will have 7 days to notify all plan participants that it is not in compliance with applicable mental health parity rules. Additionally, federal regulators will share their findings with the applicable state regulators.

Who Else Can Request A Plan's or Issuer's Comparative Analyses?

The CAA specifies that the Departments of Labor, HHS, and Treasury can request a plan's or issuer's comparative analyses. The appropriate state regulator can as well. But what about plan participants?

According to the FAQs, in the case of plans subject to ERISA, the plan or issuer must provide the comparative analyses to plan participants, beneficiaries, and enrollees upon request. Also, for non-grandfathered group health plans, the FAQs note that claimants can request the comparative analyses as part of an appeal of an adverse benefit determination.

Is More Guidance Forthcoming?

The FAQs indicate the regulatory agencies will continue to engage with stakeholders to determine what, if any, additional guidance on these new requirements is needed.

IRS Publishes "Fact Sheet" on Tax Credit for Certain Employers that Provide Paid Leave for Receiving and Recovering from COVID-19 Vaccinations

State and local government employers, along with private employers with fewer than 500 employees, can claim a refundable credit against their Medicare payroll tax

liabilities for paid sick or family leave that employees take for various reasons from April 1 through September 30, 2021, including receiving and recovering from a COVID-19 vaccine. A new IRS "Fact Sheet" provides information on calculating and claiming the credit.

As reported in Rewards Policy Insider (RPI) 2021-6, there are no federal laws requiring paid leave for COVID-19 vaccines (although some state and local governments, including California and New York, have enacted such mandates). However, the American Rescue Plan Act (ARPA) added time an employee takes to obtain the COVID-19 vaccine and/or recover from any side effects to the definitions of sick and family leave wages for purposes of the temporary tax credits for paid sick and family leave. The tax credit for paid sick leave wages is equal to the sick leave wages paid for COVID-19 related reasons for up to two weeks (80 hours), limited to $511 per day and $5,110 in the aggregate, at 100 percent of the employee's regular rate of pay. The tax credit for paid family leave wages is equal to the family leave wages paid for up to twelve weeks, limited to $200 per day and $12,000 in the aggregate, at two-thirds of the employee's regular rate of pay.

Claiming the Paid Sick and Family Leave Credits

According to the IRS Fact Sheet, eligible employers (i.e., state and local government employers and private employers with fewer than 500 employees) report their total paid sick and family leave wages for each quarter on their federal employment tax return, usually Form 941, Employer's Quarterly Federal Tax Return. Most employers use Form 941 to report income tax and social security and Medicare taxes withheld from employee wages, as well as the employer's own share of social security and Medicare taxes.

In anticipation of claiming the credits, eligible employers can keep the federal employment taxes that they otherwise would have deposited, including federal income tax withheld from employees, the employees' share of social security and Medicare taxes and the eligible employer's share of social security and Medicare taxes with respect to all employees up to the amount of credit for which they are eligible.

If an eligible employer does not have enough federal employment taxes set aside for deposit to cover amounts provided as paid sick and family leave wages (plus the eligible health plan expenses and collectively bargained contributions and the eligible employer's share of social security and Medicare taxes on the paid leave wages), the eligible employer may request an advance of the credits by filing Form 7200, Advance Payment of Employer Credits Due to COVID-19.

White House Encourages All Employers to Give Time Off for COVID-19 Vaccines

On April 21 President Biden called on employers of all sizes "to do everything they can to help their employees – and their communities – get vaccinated." This specifically includes offering paid leave for employees to get the COVID-19 vaccination and recover from any side-effects, even if the employer does not qualify for these tax credits.

Furthermore, according to a White House Fact Sheet:

> President Biden is … calling on employers to use their unique resources to provide information about how people can get vaccinated and why people should get vaccinated. Consistent with U.S. Department of Health and Human Services' "We Can Do

This" national campaign, he is also calling on employers to make commitments to provide accurate and timely information and incentivize all Americans to get vaccinated. These commitments could include discounts for vaccinated individuals, product giveaways or brand rewards, messaging in-store, point-of purchase promotions, direct outreach to customers, or Public Service Announcements (PSAs) about the importance of vaccinations.

New Retirement Legislation on the Move in Congress

The House Committee on Ways and Means on May 5 unanimously approved a bipartisan retirement bill sponsored by Chairman Richard Neal and Ranking Member Kevin Brady, and a full House vote on the bill is expected sometime later this year. The Senate Finance Committee has tentative plans to act on a similar bipartisan bill, co-sponsored by Senators Ben Cardin and Rob Portman, in the summer or fall.

The Securing a Strong Retirement Act of 2021 (aka, the "SECURE Act 2.0") is a combination of proposals included in a bill Congressmen Neal and Brady introduced in the last Congress, a bill that Senators Rob Portman and Ben Cardin introduced in 2019, and other proposals.

Some of the proposals that are part of the Ways and Means Committee-approved version of SECURE 2.0 include:

- Requiring new 401(k) plans to provide for auto-enrollment at a base contribution of at least 3%, and increasing by 1% per year to a cap of 10%;
- Increasing the catch-up contribution limit to $10,000 for participants who are at least 62, but not 65 and older;
- Requiring catch up contributions to be made on a Roth (i.e., after-tax) basis;
- Increasing the required minimum distribution (RMD) age gradually to 75 and reducing from 50% to 25% the excise tax on failing to take RMDs;
- Permitting employees with student loan debt to receive employer matching contributions to their retirement accounts even if they are not making retirement plan contributions; and
- Providing flexibility for plan fiduciaries to not attempt recovery of inadvertent benefit overpayments from participants.

The Ways and Means Committee's official section-by-section summary of the bill is available here.

Watch Rewards Policy Insider for updates.