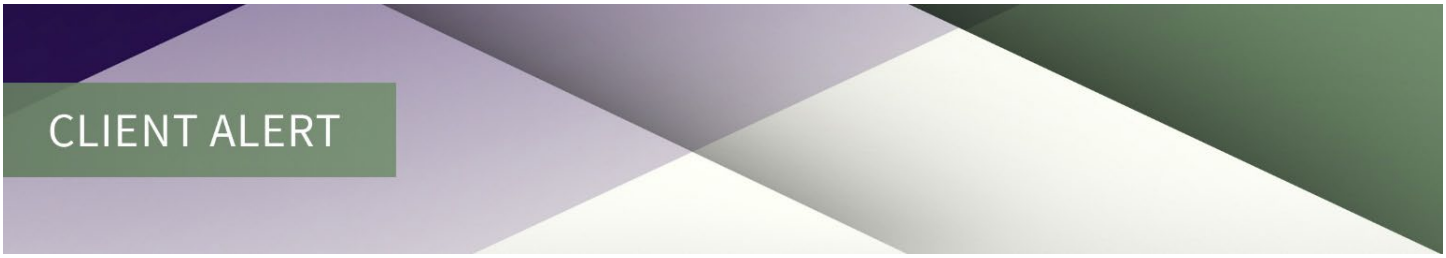

Mental Health Parity Guidance: Looking Ahead

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On July 25, 2023, the Departments of the Treasury, Labor, and Health and Human Services (collectively, the Departments) issued long-awaited guidance relating to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The guidance includes (i) proposed new regulations and amendments to existing regulations implementing the MHPAEA, including guidance related to the nonquantitative treatment limitation (NQTL) comparative analyses requirements under the MHPAEA, (ii) the second MHPAEA Comparative Analysis Report to Congress, and (iii) Technical Release 2023-01P requesting public comments on the types of information plans should include in their NQTL analyses related to network composition.

Background

The Mental Health Parity Act of 1996, as expanded by the MHPAEA, generally requires parity between medical and surgical (M/S) benefits and mental health and substance use disorder (MH/SUD) benefits in three categories: (i) lifetime and annual dollar limits, (ii) financial requirements (e.g., deductibles and copayments) and quantitative treatment limitations (e.g., number of visits), and (iii) NQTLs (*e.g.,* medical management standards or network provider standards). Nothing in the mental health parity statutes require self-funded group health plans to provide MH/SUD benefits. However, plans that do provide such coverage must comply with the parity standards, with limited exceptions.[1]

In 2021, the Consolidated Appropriations Act 2021 (CAA) expressly mandated health plans that incorporate NQTLs to perform and document a comparative analysis and to provide that analysis to the Departments (or to an applicable state authority) upon request. Plans must also provide the analysis to participants enrolled in the plan upon request. Similar to

[1] MHPAEA generally applies to group health plans and health insurance issuers. This summary focuses primarily on the application of MHPAEA to sponsors of self-funded group health plans.

requirements that mandate production of documents such as a Summary Plan Description, failure to produce the analysis to participants upon request can be enforced with financial penalties.

The CAA also requires the Departments to report to Congress annually on the results of their review of NQTL analyses. The Departments issued the First Report to Congress in 2022, indicating that none of the comparative analyses they reviewed in the prior year were initially sufficient. Such findings made clear that employers struggled to understand the existing rules and how to document compliance. This lack of guidance, coupled with an increased number of audits by the Department of Labor's Employee Benefit Security Administration (EBSA), have frustrated plan sponsors attempting to comply.

The recent guidance provides insight into the Departments' approach to enforcement going forward, as MHPAEA compliance remains a significant priority of the current administration. Self-funded plan sponsors should take note of the proposed regulations (which, if finalized, would be effective for plan years beginning on and after January 1, 2025), the comments requested in the Technical Release, and the Departments' findings reported to Congress. While likely to increase the burden on plan sponsors, the guidance should provide a more cohesive framework for assessing compliance.

Proposed Regulations

New Rules for NQTLs: Three-Part Test

NQTLs are generally nonfinancial or nonnumerical limitations applied to benefits.[2] Under the MHPAEA, any processes, strategies, evidentiary standards, or other factors used in applying an NQTL to MH/SUD benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the same classification. The list of six classifications defined by law include (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

[2] Examples of NQTLs include: medical management standards (such as prior authorization) limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative; formulary design for prescription drugs; for plans with multiple network tiers (such as preferred providers and participating providers), network tier design; standards related to network composition, including standards for provider and facility admission to participate in a network, methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan; plan methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates; 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 based on failure to complete a course of treatment; 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.

The proposed regulations set forth a three-part test for analyzing NQTLs:

1. **No More Restrictive:** This provision would restrict plans from applying any NQTL to MH/SUD benefits in any classification that is more restrictive than the predominant NQTL that applies to substantially all M/S benefits in the same classification. Similar to the existing steps required to establish parity with respect to financial requirements and quantitative limits, this test would involve determining (i) the portion of plan payments for M/S benefits subject to an NQTL in a classification, (ii) whether the NQTL applies to substantially all M/S benefits in the classification, (iii) if the NQTL applies to substantially all M/S benefits in a classification, the predominant variation of the NQTL that applies to M/S benefits in the classification, and (iv) whether the NQTL, as applied to MH/SUD benefits in the classification, is more restrictive than the predominant variation of the NQTL as applied to substantially all M/S benefits.

2. **Requirements Related to Design and Application:** For purposes of concluding that the processes, strategies, evidentiary standards, or other factors used in designing and applying an NQTL to MH/SUD benefits in a particular classification are not applied more stringently than the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to M/S benefits, plans would be prohibited from relying upon any factor or evidentiary standard if the information, evidence, sources, or standards on which the factor or evidentiary standard is based discriminates against MH/SUD benefits. Discrimination is based on facts and circumstances, for example, if the information is biased or derived from outdated data. Independent professional medical or clinical standards, and standards related to fraud, waste, and abuse, would not be considered discriminatory.

3. **Required Data Collection/Network Composition Analysis:** This provision would require a plan to collect and evaluate data for all NQTLs, including the number of claim denials. To the extent material differences exist, plans would be required to take reasonable action to address such differences. As part of this requirement and in addition to the data required to be collected for all NQTLs, plans would have an obligation to collect network composition data, such as in-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates. Network composition standards are a focus of the Departments, and the proposed rules identify that a safe harbor to satisfy such rules may be forthcoming.

Meaningful Benefit Obligation

The proposed regulations would require a plan providing any benefits for an MH/SUD condition in a classification to provide meaningful benefits for treatment of that condition. By way of example, the proposed regulations indicate that a plan covering outpatient, out-of-network developmental evaluations for autism spectrum disorder (ASD), but excluding all other benefits for outpatient treatment of ASD, including Applied Behavior Analysis (ABA) therapy, when provided on an out-of-network basis, would violate the meaningful benefit rule.

Content of Comparative Analyses

The proposed regulations provide additional clarity regarding the content of NQTL analyses. Under existing law, certain content must be included for each NQTL imposed on MH/SUD benefits, including: (1) a description of the NQTL; (2) the identification and definition of the factors used to design or apply the NQTL; (3) a description of how factors are used in the design or application of the NQTL; (4) a demonstration of comparability and stringency, as written; (5) a demonstration of

comparability and stringency in operation; and (6) findings and conclusions. Sub-regulatory guidance also provides that analyses should include an assessment of expert qualifications (if experts were relied upon).

New regulations would expand the content requirements to include additional discussion of the NQTLs in practice and to codify the sub-regulatory guidance. Plans would also be required to include a certification by one or more named fiduciaries who have reviewed the analysis, stating whether they found the comparative analysis to be in compliance with the content requirements of the rules. As plan terms change, new analyses would presumably need to be performed and certified.

Request for Information

The Technical Release solicits comments on the specific data that would need to be collected and evaluated for NQTLs related to network composition. There are four types of data the agencies are considering:

1. **Out-of-Network Utilization:** Data on the percentage of covered and submitted out-of-network claims for MH/SUD benefits as compared to M/S benefits.

2. **Percentage of In-Network Providers Actively Submitting Claims:** Data on the frequency with which different types of in-network MH/SUD providers and M/S providers submitted claims for unique participants, including both the percentage of in-network providers who submitted no in-network claims and the percentage of in-network providers who submitted claims for fewer than five unique participants.

3. **Time and Distance Standards:** Data on the percentage of participants who would be able to access one or more providers of specified types within a specified time and distance by county-type designation, one (or more) in-network providers within MH/SUD provider categories (including psychiatry, inpatient care, residential treatment, mobile crisis units, opioid treatment providers, child and adolescent providers, geriatric providers, eating disorder providers, and ASD providers) and one (or more) in-network providers within certain M/S provider categories.

4. **Reimbursement Rates:** Data comparing in-network payments and billed charges for MH/SUD benefits and M/S benefits in the inpatient, in-network and outpatient, in-network classifications (for office visits and all other benefits), as well as the allowed amounts for specific Current Procedural Terminology (CPT) codes that are reimbursed to specific types of MH/SUD providers and M/S providers, comparing them to each other, as well as to Medicare rates (which are commonly used as a benchmark for developing in-network rates), or a similar benchmark.

The Technical Release also indicates that the Departments contemplate the creation of a safe harbor with respect to NQTLs related to network composition. If a plan satisfies the safe harbor, the data collection would provide sufficient evidence to demonstrate to the Departments that participants have comparable access to in-network MH/SUD and M/S providers. Satisfaction of the safe harbor would not reduce or eliminate the obligation to comply with analyses related to NQTLs other than network composition.

Report to Congress

The Report to Congress summarizes recent enforcement efforts by EBSA. While the Report to Congress helps explain the EBSA's priorities, it also highlights the continued confusion around how to produce a sufficient NQTL analysis. Between

February 2021 and July 2022, EBSA sent out 182 letters requesting comparative analyses of more than 450 NQTLs across 102 investigations. Over the same period, EBSA issued 138 insufficiency letters, 53 initial determination letters and three final determination letters for violations. Plans receiving final determinations of noncompliance are required pursuant to the CAA to notify all enrolled participants of the failure, which could raise the risk of legal action by participants.

On the other hand, EBSA reported that a number of plans, and notably, their service providers, have agreed to make prospective changes to address 70 unique NQTLs. Such enforcement action has the potential to affect a significant number of plans that may not be under review. As highlighted in the Report to Congress, EBSA expanded an initiative targeting service providers that administer many plans for possible impermissible exclusions of key MH/SUD treatments (such as exclusions of ABA therapy to treat ASD, medication-assisted treatment and medications for treating opioid use disorder, urine drug testing, if part of treatment for a mental health condition or substance use disorder, and nutritional counseling to treat mental health conditions such as eating disorders). EBSA reported that, in many cases, the service provider agreed to remove potentially impermissible exclusions applied to many plans, without requiring EBSA to issue requests for comparative analyses to plan clients.

Going forward, EBSA identified the following six priorities, with items five and six being new since the First Report to Congress was issued in 2022:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent care 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;
4. Out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges);
5. Impermissible exclusions of key treatments for mental health conditions and substance use disorders (**NEW**); and
6. Adequacy standards for MH/SUD provider networks (**NEW**).

Takeaways for Plan Sponsors

1. Although the regulations are in proposed form, plan sponsors should begin to review and understand the potential changes, which could have significant impact. The existing and proposed rules are technical and have the potential to be time-consuming, and understanding the baseline rules and requirements will be helpful.
2. Plan sponsors should engage with their third-party administrators and review their services contracts. For many plan sponsors, examination of MHPAEA compliance would be tricky, if not impossible, without the availability of data from a third-party administrator. The Departments acknowledge as much, going so far as to solicit comments on “how best to ensure all the entities involved in the design and administration of a group health plan’s benefits provide the necessary information to plans and issuers to support their efforts to comply with MHPAEA.” In the meantime, plan sponsors should determine what responsibilities the administrator has been delegated or agreed

to perform. Plan sponsors should also review their service contract to ensure that they will have access to any data needed to perform sufficient analyses.

3. Plan sponsors should review their plan design for potential problem areas and ensure that the existing NTQL comparative analysis matches the current plan design. Plan sponsors should be prepared to address any inconsistencies or design issues.

4. Most importantly, if an NQTL comparative analysis has not been performed, plan sponsors should take steps to perform and document the analysis. Mental health parity remains a top enforcement area for EBSA. If an NQTL comparative analysis is requested by EBSA, plan sponsors have limited time to produce it, and as a result, preparation will be key to compliance.

If you have any questions regarding this client alert, please contact the following attorneys or the Willkie attorney with whom you regularly work.

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