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Compliance Focus

Mental Health Parity – Agency Guidance & Enforcement

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On July 25, the Departments of Labor, Health and Human Services, and the Treasury issued several mental health parity-related documents, including a set of proposed rules, a technical release requesting comments/feedback on requirements specific to network composition, and a comparative analysis report and fact sheet summarizing recent enforcement efforts for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The various documents make it clear that enforcement of the mental health parity rules is a priority for the administration as part of their commitment to improving access to behavioral health treatment and services. They also suggest that many plans are not currently meeting the MHPAEA parity requirements and that comparative analyses collected to-date by the agencies have generally been insufficient.

All these documents are linked in the agencies' news release found here:
https://www.dol.gov/newsroom/releases/ebsa/ebsa20230725

The MHPAEA requirements, including the plan design and administration requirements as well as the written comparative analysis, can be complex to navigate and implement. Most employers do not have the expertise needed to design a group health plan as required, are not directly involved in claims processing, and do not have access to the level of information needed to prepare a sufficient comparative analysis. Therefore, employers must rely heavily on carriers, TPAs and other service providers to offer a compliant plan design, to properly administer claims, and to evaluate and document compliance in a detailed comparative analysis. For fully-insured plans, the carrier is directly responsible for compliance and will generally only offer plans that comply with the MHPAEA (or will face direct consequences for failure to comply). However, for self-funded plans, the employer is primarily responsible for compliance and will need to take efforts to ensure that TPAs, PBMs and other service providers involved in designing and administering the plan on the employer's behalf are competent and willing to comply with the MHPAEA requirements and to prepare a comparative analysis on behalf of the plan, or at least provide the data needed to prepare the comparative analysis.

Background

The MHPAEA requires group health plans offering mental health (MH) or substance abuse (SA) benefits to provide such benefits "in parity" with (equal to or better than) the medical/surgical coverage available under the group health plan. The MHPAEA does not require group health plans to provide MH or SA benefits, but if they do offer such benefits beyond what is considered preventive under the Affordable Care Act (ACA), the parity

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requirements apply. The MHPAEA applies to both fully-insured and self-funded group health plans, but not excepted benefits or retiree-only plans.

If a group health plan provides medical/surgical benefits and MH or SA benefits, the plan's MH or SA benefits are subject to the following parity requirements (as compared to the plan's medical/surgical benefits):

- Same or more generous annual/lifetime limits;
- Equal financial requirements and quantitative treatment limitations; and
- Equal treatment for non-quantitative treatment limitations (e.g., prior authorization, medical necessity, provider network standards, fail first or step therapy policies, experimental treatment limitations, etc.).

The parity of any financial requirements, quantitative treatment limitations, and non-quantitative treatment limitations (NQTLs) is determined on a classification-by-classification basis for six different classifications, as seen in the table below. Plans must provide MH or SA benefits in parity for all classifications in which medical/surgical benefits are available.

Inpatient, in-network
Inpatient, out-of-network
Outpatient, in-network*
Outpatient, out-of-network*
Emergency Care
Prescription Drugs

**Outpatient services may be sub-classified into (a) office visits and (b) all other outpatient items and services, but plans generally cannot further sub-classify generalists and specialists.*

More detail on the MHPAEA can be found in our mental health parity guide (created prior to this most recent guidance): https://www.benefitcomply.com/resources/wp-content/uploads/2023/05/Mental-Health-Parity-Guide_2023-v2.pdf

Proposed Rules – Primarily Focused on NQTLs

The proposed rules do not significantly change the framework of the parity requirements. However, they do propose, amongst other things, to: clarify existing definitions; add additional examples to the non-exhaustive list of NQTLs; add further requirements for analyzing parity for NQTLs; set specific requirements for achieving parity for network composition; and build on what is required to be analyzed and documented via the comparative analysis. The proposed rules clarify that if a plan provides any benefits for a specific MH or SA condition or disorder, the plan must provide meaningful benefits for that condition or disorder in every classification in which medical/surgical benefits are provided. In addition, the proposed rules indicate that telehealth benefits are subject to the requirements of the MHPAEA. Several of the key proposed changes are further summarized below.

These proposed rules if finalized, would be effective for plan years beginning in 2025.

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New 3-Part Test for NQTLs

NQTLs are permitted for MH or SA benefits if they are no more stringent than those applied to medical/surgical benefits OR if they are consistent with generally recognized independent professional medical clinical standards or standards related to fraud, waste and abuse. To ensure these general requirements are met, the proposed rules set forth a new 3-part test for NQTLs. The tests do not have to be performed in any particular order, but NQTLs are not considered to meet the parity requirements unless all 3 tests are met.

1 – NQTLs must be no more restrictive than those that apply for medical/surgical benefits.

Any NQTL applied to MH and SA benefits in a classification cannot be more restrictive than the predominant variation of the NQTL applied to substantially all medical/surgical benefits. This portion of the test is new for NQTLs but follows the test that is currently in place for financial requirements and quantitative treatment limitations. For each classification, a plan must calculate the portion of plan payments for medical/surgical benefits that are subject to an NQTL. Then the plan must determine whether the NQTL applies to substantially all medical/surgical benefits in the classification, and if so, find the predominant variation of the NQTL that applies to medical/surgical benefits to determine whether and to what extent the NQTL may apply to MH or SA benefits in that classification.

2 – Design and application requirements.

A plan may not impose an NQTL for MH or SA benefits in any classification unless any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SA benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits. A key consideration in determining compliance with this requirement would be whether any process, strategy, evidentiary standard, or other factor restricts access more so to MH or SA benefits than to generally comparable medical/surgical benefits.

3 – Relevant data evaluation requirement.

The plan must collect information to assess relevant data that show the outcomes that result from the application of an NQTL, evaluate those outcomes and take reasonable action as necessary to address any material differences in access. The relevant data that a plan would be required to collect and evaluate for all NQTLs (as part of the comparative analysis) includes, but is not limited to, the number and percentage of relevant claims denials, as well as any other data relevant to the NQTLs as required by State law or private accreditation standards. In addition, for network composition (discussed further below), relevant data would include, but would not be limited to, 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 (including as compared to billed charges).

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Network composition

As a part of the 3-part test described above, the proposed rules would impose some additional requirements specific to network composition. The proposed rules require plans to collect and evaluate relevant outcomes data and address any material differences in access between mental health and substance use disorder benefits and medical/surgical benefits. If any material differences are found, the plan would need to take action to try and address such differences. Specific to network composition, such actions may include the following:

- Making special efforts to contract with a broad range of mental health and substance use disorder providers who are available, including authorizing greater compensation or other inducements to the extent necessary;
- Expanding telehealth arrangements to manage regional shortages;
- Notifying participants on the website, employee brochures, and the summary plan description (SPD) of a toll-free number for help finding in-network providers;
- Ensuring that service providers reach out to the treating professionals and facilities to see if they will enroll in the network; and
- Ensuring network directories are accurate and reliable.

After taking such action(s), if the relevant data continues to reveal material differences in access (e.g., due to provider shortages), the plan should document the actions taken to demonstrate why any remaining disparities continue to exist due to provider shortages rather than their NQTLs related to network composition.

The agencies provided a Technical Release along with the proposed rules describing a possible safe harbor for plans meeting certain standards relating to network composition and requesting comments on how best to address network composition parity requirements.

Comparative analysis

The proposed rules clarify existing content requirements, providing much more detail about what is expected to be evaluated and included in the written analysis, and then also requires plans to include and evaluate relevant data as part of their comparative analyses to ensure compliance with MHPAEA. To further enforce awareness of compliance, for plans subject to ERISA, the comparative analysis would 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 proposed rules.

The guidance clarifies that a written comparative analysis is not required to be prepared annually but should be re-done if there is a change in plan design or usage that would affect an NQTL. However, the agencies make it clear that they are losing patience with the analyses not being ready upon request. A thorough, compliant analysis

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cannot be quickly pulled together within the timeframe required to comply with a request from an agency or plan participant, so it is necessary for employers to complete it and have it ready and on file (prior to any request).

For plans that fail to provide a complete and thorough analysis, and then fail to correct any insufficiencies within the timeframe required by the applicable agency, the agencies may direct the plan not to impose any NQTL that cannot be adequately shown to be in parity with medical/surgical benefits. In addition, the plan (or sponsoring employer) may be listed in the agencies' enforcement report to Congress and may have to notify plan participants with something similar to the following:

> "Attention! The [Department of Labor/Department of Health and Human Services/Department of the Treasury] has determined that [insert the name of group health plan or health insurance issuer] is not in compliance with the Mental Health Parity and Addiction Equity Act."

The notice would need to include a summary of the agency's finding of non-compliance and information about how participants can obtain a copy, information for where to direct any questions or complaints, and contact information for the applicable agency. The notice would also be required to include a summary of any changes the plan has made as part of its corrective action plan, including an explanation of any opportunity for a participant to have a claim for benefits reprocessed.

Agency Enforcement Efforts

The EBSA and CMS are primarily responsible for enforcement of MHPAEA. The latest report indicates that EBSA is currently devoting about 25% of its workforce to MHPAEA enforcement, allowing them to perform approximately 150 audits during 2022.

The report indicates that EBSA's six priority areas are as follows (the last two are new since the last report):

- Prior authorization requirements for in-network and out-of-network inpatient services;
- Concurrent care review for in-network and out-of-network inpatient and outpatient services;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges);
- Impermissible exclusions of key treatments for mental health conditions and substance use disorders; and
- Adequacy standards for MH/SUD provider networks.

The audits primarily target large service providers, but some plan level audits took place based upon plan participant complaints. When issues and corrections were addressed at the service provider level, the agency then required the appliable service provider to notify and work with all its plan clients to make necessary changes at the plan level, including amendments to plan terms, notices to participants, and payment of wrongly denied claims.

The audits include a request and review of the plan's comparative analysis. The report indicates that many plans were unprepared to provide a complete analysis upon request. There was leniency for this in the first couple years of enforcement, but EBSA will expect a more complete analysis up front and quicker corrections for insufficiencies on a go-forward basis. That being said, the comparative analysis is simply a means to force plan sponsors to

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review and document the plan design and administration for compliance with MHPAEA. The report indicates that *"EBSA is increasingly concerned that some plans and issuers are most focused on the task of documenting a parity analysis and avoiding obvious red flags, rather than truly working to ensure parity in their MH/SUD benefits and coverage."* During its audits, the agencies found and required corrections for more exclusions for key treatments of certain conditions than expected. For example, ABA therapy, medication-assisted treatment (MAT) and medications for opioid use disorder (MOUD), and nutritional counseling for eating disorders.

Employer Action

The proposed rules recognize that many employers rely on carriers, TPAs and other service providers to design and administer their group health plan offerings. However, especially for self-funded group health plans, the proposed rules confirm the employer as plan sponsor is primarily responsible to ensure the plan is in compliance with the MHPAEA, including performing and documenting a comparative analysis for any NQTLs. But the proposed rules also indicate that service providers are often found to be co-fiduciaries under ERISA rules, in which case they would have some joint liability for non-compliance.

Employers should certainly take steps to review their plan design and ask their service providers what level of analysis has been done to ensure that any financial requirements (e.g., copays, coinsurance, deductibles) and quantitative treatment limitations (e.g., visit or treatment limits) are set up to be in parity with those that apply to medical/surgical benefits. This would include telehealth benefits.

For NQTLs, the employer's options are less clear. Most employers will not be able to identify and analyze NQTLs on their own, especially since employers have little to no involvement in the actual claims and appeals processes during which the NQTLs are generally applied.

Fully-Insured Group Health Plans

Employers offering fully-insured group health plans can generally rely on their carriers for plan design and administration in accordance with the MHPAEA since carriers are also directly subject to the requirements. It would still be a good idea for employers to ask their carriers for confirmation of MHPAEA compliance.

Self-Funded Group Health Plans

For employers offering level-funded or self-funded group health plans, the employer needs to play a bigger role in MHPAEA compliance. At a minimum, the employer should reach out to TPAs, PBMs and other service providers requesting information about efforts to comply with MHPAEA. In addition, the employer should push the service provider(s) to provide the employer with a comparative analysis for any NQTLs. If the service providers are not willing to provide the required comparative analysis, the employer should request that the service provider at least provide sufficient information for the NQTLS that the service provider is responsible for designing and applying so that the employer can work with a 3rd party to prepare the analysis independently. There are currently some vendor solutions to assist with preparing the analysis, but without access to the necessary data from the service providers (e.g., actual claims

processing information and outcomes), the comparative analysis prepared will be insufficient. Our understanding is that not all service providers are currently willing or even able to provide employers with the comparative analysis or even the data needed for the analysis, but we expect that many service providers will be pushed to provide more complete analyses, or least the needed data, over the next couple years. For now, some employers may choose to engage in 3rd party vendor solutions to prepare a comparative analysis without all the necessary information from service providers in hopes of at least having something to provide to participants upon request and to show a good faith effort if the analysis is required by the agencies.

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