COMPLIANCE **ALERT**

CORPORATE SYNERGIES®
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Agencies Issue Final Mental Health Parity Rule, Solidifying NQTL Compliance Obligations

September 18, 2024

Action Required:

- **Employers and plan sponsors of both fully insured and self-insured health plans should reach out to their insurers and TPAs to inquire about whether they can assist with completing the NQTL comparative analysis on their behalf.**
- **Fully insured plan sponsors need to confirm their carrier acknowledges and agrees to provide this comparative analysis.**
- **Self-insured plan sponsors should ensure that their administrative services agreement addresses responsibility for completion of the comparative analysis.**

On September 9, 2024, the U.S. Departments of Labor, Treasury and Health and Human Services (the "Agencies") issued a final regulation ("Final Rule") clarifying how employers, plan sponsors, insurers and plan fiduciaries must comply with the NQTL comparative analysis requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the Consolidated Appropriations Act, 2021 (CAA). Additionally, the Agencies issued a Fact Sheet and News Release explaining the new Final Rule and explaining how they expect it to increase utilization of mental health and substance use care.

What Should Employers and Plan Sponsors Do Next?

Regardless of whether MHPAEA compliance has been a priority for employers and plan sponsors in the past, sponsors of both fully insured and self-insured health plans should reach out to their insurers and TPAs to inquire about whether they can assist with completing the NQTL comparative analysis on their behalf. While many of the provisions of the Final Rule are not applicable until 2026, the comparative analysis requirement is currently in effect and MHPAEA enforcement continues to be a top priority for the Agencies.

For sponsors of fully insured plans, it's important to confirm that the insurer has agreed to provide the NQTL comparative analysis for the plan, and that this has been properly acknowledged in the agreement with the carrier.

For sponsors of self-insured plans, they should confirm that any administrative services agreements with their TPAs directly address responsibility for MHPAEA compliance, including the NQTL comparative analysis, and if necessary because the TPA will not complete the analysis, how the TPA will engage with any law firms, actuaries or other third-party vendors to complete the analysis. At Corporate Synergies, we will continue to monitor and update you on developments related to the Final Rule and MHPAEA compliance. ■

↓ Full Explanation Follows ↓

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On September 9, 2024, the U.S. Departments of Labor, Treasury and Health and Human Services (the "Agencies") issued a final regulation ("Final Rule") clarifying how employers, plan sponsors, insurers and plan fiduciaries must comply with the NQTL comparative analysis requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the Consolidated Appropriations Act, 2021 (CAA). Additionally, the Agencies issued a Fact Sheet and News Release explaining the new Final Rule and explaining how they expect it to increase utilization of mental health and substance use care.

How Does the New Final Rule Change the Law?

The Final Rule amends certain provisions of the existing MHPAEA regulations and adds new rules, including new definitions of key terms, to clarify content requirements, timeframes and other rules applicable to nonquantitative treatment limitation (NQTL) comparative analyses. The Final Rule reflects the Agencies' position on the NQTL comparative analysis obligation, which was made after reviewing over 9,000 comments received from the public during the comment period on the proposed rules (see our E-Alert on the proposed rules here). Notably, and as explained in more detail below, the Final Rule clarifies that sponsors of fully insured health plans can rely on their insurance carriers to complete the NQTL comparative analysis on their behalf, while sponsors of self-insured plans will be responsible for ensuring that this analysis is completed.

What does MHPAEA Require?

As background, the MHPAEA, enacted in 2008, is a federal law that generally prevents group health plans (both fully insured and self-insured) and health insurers that provide mental health and substance use disorder ("MH/SUD") benefits from imposing more restrictive benefit limitations on those benefits than on medical/surgical ("M/S") benefits. One exception, for self-insured non-federal governmental plans (which can elect to opt out of MHPAEA compliance), was eliminated by the Final Rule.

MHPAEA does not mandate that group health plans provide MH/SUD benefits. However, if a group health plan does provide MH/SUD benefits, then MHPAEA mandates that there be "parity" between MH/SUD benefits and M/S benefits.

Generally, this "parity" mandate prohibits any overly restrictive limitation on the access to, or the quality of, the plan's MH/SUD benefits. These limits come in two main forms or categories:

(1) quantitative or financial treatment limitations (for example, visit limits or monetary limits), and

(2) nonquantitative treatment limitations (NQTLs). The NQTLs, which are the primary focus of the Final Rule, include the following examples of types of limits (among others): medical management standards for medical necessity or appropriateness, restrictions regarding prescription drug formulary design, use of "step therapy" or "fail first" protocols and network admission standards.

The CAA amended MHPAEA to require that health plans and insurers conduct comparative analyses to measure the impact of NQTLs on plans' MH/SUD benefits as compared to their M/S benefits. This analysis includes evaluating standards related to network composition, out-of-network reimbursement rates, medical management and prior authorization NQTLs, among others. The CAA required plans and insurers to have these NQTL comparative analyses available if requested by government agencies by February 10, 2021, but then, in August of 2023, the Agencies added new rules, and expanded on and clarified the content requirements of these comparative analyses (discussed in more detail in our E-Alert here).

What are the Major Rule Changes and Clarifications in the Final Rule?

The Final Rule was partly modified from the proposed rules to reflect the thousands of stakeholder comments received. As a result, the Final Rule amends existing regulations by:

- Establishing a "meaningful benefits" standard for the parity analysis. Specifically, the Final Rule requires a group health plan that offers any benefits for a MH/SUD condition in any classification to provide meaningful benefits for that MH/SUD condition in every classification in which M/S benefits are provided. Whether benefits are "meaningful" is determined by comparing the benefits provided for M/S conditions in the same classification. At a minimum, the plan must cover at least one core treatment for a covered MH/SUD condition in each classification in which the plan provides benefits for a core treatment for one or more M/S conditions. A "core treatment" is defined as "a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice." These classifications are: in-network

outpatient, in-network inpatient, out-of-network outpatient, out-of-network inpatient, emergency care and prescription drugs. These rules are effective for plan years beginning on or after January 1, 2026.

- Formally adopting specific content requirements and processes for NQTL comparative analyses, including specifying processes that plans can use for collecting and evaluating relevant data for each NQTL, and content requirements and processes for the plan's responses to Agency determinations of noncompliance, including the content requirements for the plan's notice to participants and beneficiaries after receiving a final determination of noncompliance from the relevant Agency.
- Prohibiting group health plans from using NQTLs that place greater restrictions on access to MH/SUD benefits as compared to M/S benefits.
- Formally adopting rules defining intellectual and neurodevelopmental disorders, including dementia and autism spectrum disorder, as MH conditions for the purposes of MHPAEA, even if applicable state laws define these conditions as M/S conditions.
- Adding new technical clarifications to elements of the NQTL comparative analysis testing process that are already in use under the CAA and existing guidance, for example, by prohibiting discriminatory or biased factors and evidentiary standards that may have been relied upon by plan administrators in justifying a particular NQTL.
- For plans subject to ERISA, requiring a named plan fiduciary to certify compliance and completion of the NQTL comparative analysis (discussed below).

How do the new Fiduciary Certification Rules Work?

Effective January 1, 2025, the Final Rule requires that for plans subject to ERISA, a named plan fiduciary must certify that they have engaged in a "prudent process" to select at least one qualified service provider (for example, a TPA) to complete the plan's comparative analysis. The plan fiduciary must also monitor the service provider's work. The Agencies expect plan fiduciaries to take an active role in this process by, among other things, reviewing the comparative analysis, understanding and confirming the relevant findings and conclusions, and seeking assurances from the plan's service providers that the plan's NQTLs and comparative analysis comply with MHPAEA.

When Does the Final Rule go into Effect?

While the Final Rule's requirements are generally applicable to group health plan years beginning on or after January 1, 2025 (including the fiduciary certification), the requirements related to plan data collection and analysis of material differences in benefit access—rules that will likely take more time to implement—are applicable for plan years beginning on or after January 1, 2026.

What is the Role of Insurers and TPAs in Ensuring Plan Compliance with the Final Rule?

The Agencies explain in the Final Rule that insurers and TPAs are the types of entities that are best situated to conduct the required NQTL comparative analyses. Specifically, the Agencies note that insurers and TPAs already manage the same claims administration framework and provider networks across many plans, and accordingly, these entities are best equipped to implement existing efficiencies to generate comparative analyses of NQTLs under their plan design and networks. The Agencies expect that greater reliance on these entities will reduce compliance burdens on employers and plan sponsors.

Fully Insured Plans: The Agencies observed that insurers are best suited to produce the comparative analysis. As the designers of the products and claims administrators, insurers for fully insured plans make decisions about which NQTLs to use and how to implement them. Further, insurers typically "own" the claims data and other data related to plan administration. Accordingly, the Agencies assume that insurers will complete the NQTL comparative analysis on behalf of fully insured plans.

Self-insured Plans: The Agencies note that TPAs and insurance companies providing administrative services only (ASO) agreements overwhelmingly design the plans, administer the networks, manage claims, provide plan services, and maintain and hold the data most relevant to the comparative analysis. Accordingly, even though TPAs are not directly subject to the MHPAEA requirements, they are typically in the best position to generate the NQTL comparative analyses on behalf of their self-insured clients. In light of this, the Agencies expect that TPAs will perform most of the work associated with the comparative analyses, because they can do so at the lowest cost and greatest scale. However, given that self-insured plans are directly responsible for the comparative analysis under MHPAEA, sponsors of such plans should ensure that their agreements with TPAs directly take into account their responsibility for completing this analysis, and if necessary, any additional steps needed to ensure compliance (for example, hiring a third-party vendor to complete the analysis).

What Should Employers and Plan Sponsors Do Next?

Regardless of whether MHPAEA compliance has been a priority for employers and plan sponsors in the past, sponsors of both fully insured and self-insured health plans should reach out to their insurers and TPAs to inquire about whether they can assist with completing the NQTL comparative analysis on their behalf. While many of the provisions of the Final Rule are not applicable until 2026, the comparative analysis requirement is currently in effect and MHPAEA enforcement continues to be a top priority for the Agencies.

For sponsors of fully insured plans, it's important to confirm that the insurer has agreed to provide the NQTL comparative analysis for the plan, and that this has been properly acknowledged in the agreement with the carrier.

For sponsors of self-insured plans, they should confirm that any administrative services agreements with their TPAs directly address responsibility for MHPAEA compliance, including the NQTL comparative analysis, and if necessary because the TPA will not complete the analysis, how the TPA will engage with any law firms, actuaries or other third-party vendors to complete the analysis. Sponsors of self-insured plans should also review any comparative analysis completed by a TPA or third-party vendor with their legal counsel. At Corporate Synergies, we will continue to monitor and update you on developments related to the Final Rule and MHPAEA compliance.

If you have any additional questions, please call your Corporate Synergies Account Manager or 866.CSG.1719.