COMPLIANCE **ALERT**

CORPORATE SYNERGIES®
A Foundation Risk Partners Company

Agencies Issue Proposed Mental Health Parity Rules with New Compliance Obligations

August 10, 2023

Action Required:

- Plan sponsors should continue to ensure they are in compliance with the MHPAEA.
- Your Corporate Synergies Account Manager can assist you with these requirements.

On July 25, 2023, the U.S. Departments of Labor, Treasury and Health and Human Services (the "Agencies") issued a large package of proposed rules and guidance providing helpful clarifications, but also new obligations, for plan sponsors and fiduciaries under the Mental Health Parity and Addiction Equity Act (MHPAEA). Additionally, the Biden administration issued a new Fact Sheet explaining why it believes these new MHPAEA rules will help increase utilization of mental health and substance use care.

What Does This Mean to You as an Employer?

The MHPAEA was established to prevent group health plans from imposing unfavorable benefit limitations on mental health and substance use coverage as compared to medical and surgical coverage. The proposed rule changes, if finalized as proposed, would expand the compliance obligations that employers and plan sponsors have with regard to the nonquantitative treatment limitations (NQTL) placed on such mental health and substance use coverage, and would clarify the rules pertaining to the NQTL comparative analysis requirement added to the MHPAEA by the Consolidated Appropriations Act of 2021. Additionally, among other requirements, these proposed rules would require plan sponsors to collect and evaluate healthcare outcomes data and take action to address material differences in access to mental health benefits as compared to medical and surgical benefits.■

↓ Full Explanation Follows ↓

Agencies Issue Proposed Mental Health Parity Rules with New Compliance Obligations

On July 25, 2023, the U.S. Departments of Labor, Treasury and Health and Human Services (the "Agencies") issued a large package of proposed rules and guidance providing helpful clarifications, but also new obligations, for plan sponsors and fiduciaries under the Mental Health Parity and Addiction Equity Act (MHPAEA). Additionally, the Biden administration issued a new Fact Sheet explaining why it believes these new MHPAEA rules will help increase utilization of mental health and substance use care.

The new MHPAEA regulatory package (the "Regulatory Package") includes:

- a News Release;
- a Technical Release;
- the 2022 Enforcement Fact Sheet;
- the 2023 MHPAEA Comparative Analysis Report to Congress;
- the MHPAEA Guidance Compendium; and
- a Proposed Regulation (the "Proposed Rules").

What is the Goal of these New Rules? How will the Regulatory Package Change the Law?

The rules in the Regulatory Package, including the Proposed Rules, seek to increase access to mental health and substance use disorder ("MH/SUD") coverage by:

(1) expanding the requirements for non-quantitative treatment limitations ("NQTL") (with the goal of ensuring that limits on the MH/SUD coverage are not too burdensome), and

(2) providing helpful rule clarifications and guidance to make it easier for plan sponsors to continue to offer such coverage and make it available to more participants.

Additionally, while the Proposed Rules are not yet final, and thus, do not change the law, if they are finalized as proposed, they will implement the "NQTL comparative analysis" requirement that was added to MHPAEA by the Consolidated Appropriations Act of 2021 (CAA). Both the Proposed Rules, and the rules in the Regulatory Package, will make it easier for plan sponsors to evaluate the design and application of NQTLs in their group health plans when completing this NQTL comparative analysis.

What Does MHPAEA Require? Must all Group Health Plans Comply?

Enacted in 2008, MHPAEA is a federal law that generally prevents group health plans (both fully insured and self-insured) and health insurers that provide MH/SUD benefits from imposing less favorable 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) will be eliminated if the Proposed Rules are finalized as proposed.

Notably, 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) non-quantitative treatment limitations (NQTLs). The NQTLs, which are the primary focus of the Proposed Rules, include the following types of limits: 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.

How is the "Parity" Mandate Currently Enforced?

MHPAEA's requirements are incorporated into ERISA, and these rules place responsibility for ensuring a plan's compliance with the parity mandate on a plan's fiduciaries. Specifically, if coverage does not meet the parity requirements imposed by MHPAEA, plan fiduciaries are expected to take action to bring the plan into compliance. Additionally, if the MH/SUD benefits offered are in violation of MHPAEA's requirements, the plan sponsor and plan fiduciaries are exposed to potential ERISA liability.

What are the Major Rule Changes in the Proposed Rules?

Focus on NQTLs and Healthcare Outcomes Generally:

The Proposed Rules seek to amend the existing MHPAEA regulations with a renewed focus on NQTLs, including the "healthcare outcomes" that result from such NQTLs. More specifically, like the existing MHPAEA regulations, both sets of rules require group health plans to analyze data pertaining to network composition, out-of-network reimbursement rates, prior authorization rules and medical management standards to show the requisite level of parity, and both sets of rules will continue to require that parity exist in plan design. The Proposed Rules, however, seek to add language that would require that parity exist in both plan design and "healthcare outcomes."

Specifically, the Proposed Rules would require plans and issuers to collect and evaluate healthcare outcomes data and take action to address material differences in access to MH/SUD benefits as compared to M/S benefits, with a specific focus on ensuring that there are not any material differences in access as a result of the application of their network composition standards. It should be noted that these amendments in the Proposed Rules mainly focus on parity with respect to NQTLs. Accordingly, the current rules regarding quantitative treatment limitations or financial requirements remain mostly unchanged.

Data Gathering Requirement and Technical Release:

There is a specific data collection requirement for network composition that "includes, but is not 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)." The Technical Release that was issued along with the Proposed Rules provides technical details, includes a request for information concerning this data gathering, and discusses a possible safe harbor on network composition based on this data gathering.

Clarifications on the CAA's NQTL Comparative Analysis Requirement:

Further, in implementing the CAA's NQTL comparative analysis requirement, the Proposed Rules provide additional clarification on the content requirements for NQTL comparative analyses and further specify how plans and issuers must make these comparative analyses available to the Agencies, including applicable State agencies, enforcing MHPAEA.

Specifically, the Proposed Rules set forth six specific content requirements for these analyses:

- A description of the NQTL
- Identification and definition of the factors used to design or apply the NQTL
- A description of how factors are used in the design or application of the NQTL
- A demonstration of comparability and stringency, as written
- A demonstration of comparability and stringency in operation
- Findings and conclusions

Additionally, group health plans would need to prepare and provide a written list of all NQTLs imposed under the plan, along with a general description of information used in preparing each comparative analysis. These analyses should address material differences in outcomes and any measures taken to mitigate disparities. The plan's named fiduciary is required to certify and confirm compliance with these content requirements.

Proposed Changes to MHPAEA Definitions Generally:

The Proposed Rules both amend existing definitions and add new definitions with the goal of providing clarity and guidance to group health plans when offering MH/SUD benefits.

Notably, the Proposed Rules seek to amend the definitions of "Mental Health Benefits" and "Substance Use Disorder Benefits." While, in the past, the Agencies gave group health plans considerable discretion in how they would define covered conditions under a plan for MHPAEA compliance purposes, the Agencies would now require group health plans to treat a condition as an MH or SUD if it is listed in any of the diagnostic categories in the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

This means, for example, that any group health plan that covers autism spectrum disorder must treat it as a mental health condition in compliance with MHPAEA. As a result, coverage for applied behavioral analysis (ABA) therapy will be subject to the Proposed Rules and cannot be excluded if the plan otherwise provides coverage for autism treatment..

New Examples of NQTLs:

While the Proposed Rules do not include a formal definition of what constitutes an NQTL, the Rules' examples of NQTLs were updated to include the following:

- Including "prior authorization requirements" as an example of a medical management standard limiting or excluding benefits based on medical necessity or appropriateness.
- Expanding the description of NQTLs related to network composition to include standards for provider and facility admission, reimbursement rate determinations, credentialing and procedures for ensuring an adequate number of providers and facilities.
- Broadening the method for determining out-of-network rates from just "usual, customary, and reasonable charges" to include other methods, such as application of external benchmarks.

New NQTL Compliance Requirements:

The Proposed Rules also implement a new three-pronged test for MHPAEA compliance with respect to NQTLs. These rules provide:

1) NQTLs must not be "more restrictive" when applied to MH/SUD benefits as compared to M/S benefits. This requires group health plans to conduct a "predominant/substantially all" test (a test currently required for quantitative treatment limitations). This means that for an MH/SUD NQTL to be permissible, it must apply to at least two-thirds of the medical benefits in the same classification (i.e., inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs). In addition, only the predominant (i.e., most frequent) variation of the NQTL can apply. This will likely significantly limit the plan's ability to apply certain NQTLs, such as clinical utilization review techniques, to MH/SUD benefits. However, the new rules acknowledge that certain NQTLs may be based on independent professional medical or clinical standards or standards related to fraud, waste and abuse. In such cases, the NQTLs would not be considered in violation of this "no more restrictive" requirement.

2) Group health plans must meet specific requirements related to the design and application of NQTLs. This requires that the "processes, strategies, evidentiary standards, and other factors" used to apply the NQTL to a MH/SUD benefit must be comparable to what is used to apply an NQTL to M/S benefits. The new rules would now require that plans consider them when designing the NQTL in the first place. The rule establishes that group health plans are prohibited from relying on any factor or evidentiary standard that discriminates against MH/SUD benefits, as evidenced by less favorable treatment of such MH/SUD benefits.

3) Group health plans must collect, evaluate, and address relevant data on access to MH/SUD benefits as compared to M/S benefits. This includes the number and percentage of claim denials, as well as network composition standards, including utilization rates, provider reimbursement rates, and other data on providers (e.g., time and distance data). There is an exception for group health plans that are unable to address material differences due to provider shortages. Such plans can avoid being cited for noncompliance with MHPAEA if they can demonstrate that they made other efforts to comply with the law. Plans that wish to rely on this exception will need to document actions taken to otherwise address these disparities.

It should be noted that this three-pronged test eliminates much of the discretion that group health plans are currently able to rely on when designing and applying NQTLs. In the past, the Agencies required that group health plans focus on the processes and strategies when designing their NQTLs and acknowledged that the outcomes were not expected to be the same—this is no longer the case with the focus on "outcomes" in the new rules.

Requirement to Provide Comparative Analyses and Notices:

The Proposed Rules provide that group health plans must be prepared to provide their comparative analyses to the Agencies upon request. Plans will be given 10 business days to submit the comparative analysis. Extensions may be granted on a case-by-case basis. If a group health plan's comparative analysis is deemed insufficient, the Agencies will specify additional information that must be submitted to address the request.

It should be noted that ERISA group health plans must also make comparative analyses available to participants, beneficiaries, and authorized representatives within 30 days upon request, which was not required under the CAA. Group health plans should be

performing and documenting their comparative analyses given the short turnaround time group health plans have for submitting their comparative analyses to the Agencies. Comparative analyses should be kept current and reflect the plan's current plan's terms and conditions and plan design.

If the plan is found to be noncompliant after an initial review, it must provide a corrective action plan and additional comparative analyses demonstrating compliance within 45 calendar days of the determination. A final determination of noncompliance will trigger the requirement for the plan to provide a standalone notice to participants and beneficiaries, as well as relevant parties, within seven calendar days. The notice must contain specific information, including the plan's noncompliance status, actions taken for correction, and contact information for questions and complaints.

It's likely that providing this notice to participants and beneficiaries could lead to litigation in this area. While the Proposed Rules do not provide for an additional private right of action under MHPAEA, participants and beneficiaries can presumably sue under ERISA Section 502(a) for benefits due under the terms of the plan.

When Would the Proposed Rules Go into Effect?

The Proposed Rules would apply on the first day of the first plan year beginning on or after January 1, 2025. Until that date, group health plans will need to continue complying with the existing MHPAEA regulations and guidance.

With respect to the CAA's comparative analysis requirement, however, the Agencies emphasize that the statutory provisions added by the CAA have been in effect since February 10, 2021, and that group health plans should continue performing and documenting comparative analyses in accordance with the CAA's requirements.

Can Plan Sponsors Continue to Use the 2020 MHPAEA Self-Compliance Tool?

Yes. One important piece of guidance that was not included in the new Regulatory Package was an updated MHPAEA Self-Compliance Tool. This Tool was released by the DOL in 2020. While we expect the Agencies to issue an updated Tool, Plans should continue to utilize the 2020 Tool until an updated version is issued when assessing MHPAEA compliance and drafting the required comparative analysis.

What Should Plan Sponsors Do Next?

What follows are some key takeaways from the new Regulatory Package:

- The Agencies expect plans to have already performed and documented NQTL analyses, and that these analyses are up-to-date and consistent with the plan's current terms. Failure to have sufficiently documented NQTL analyses could violate MHPAEA even if the plan otherwise complies with MHPAEA in design and operation.
- While many sponsors of self-insured health plans have been attempting to comply with this requirement by obtaining standard or template NQTL analyses prepared by their third-party administrators (TPAs), the Proposed Rules make it clear that these standard documents will no longer suffice. Accordingly, such plan sponsors should ask their TPAs whether they will be updating their NQTL comparative analysis documents in response to this guidance and consider whether to hire a vendor to independently conduct and document the required analyses.
- Plans' named fiduciaries have a duty to ensure that the plan complies with MHPAEA. If the Proposed Rules are finalized as proposed, named fiduciaries will have a new obligation to review completed NQTL analyses and certify that they're in compliance. Plan documents and other plan policies and procedures may need to be updated accordingly.

As far as next steps, the Agencies are seeking feedback on all aspects of the Proposed Rules, including clarifications that would assist plan sponsors with performing and documenting sufficient NQTL comparative analyses, and comments that would help with understanding challenges that plan sponsors face in this process. Comments on the Proposed Rules are due by October 2, 2023, and can be submitted electronically here. ■

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