GROOM LAW GROUP

Publications

Mental Health Parity: Departments Up the Ante in New MHPAEA Final Rules

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The Departments of Labor, Health and Human Services, and Treasury ("Departments") released the Mental Health Parity and Addiction Equity Act ("MHPAEA") Final Rule yesterday. This long-awaited rule implements the requirements of the Consolidated Appropriations Act, 2021 ("CAA"), which established a new mandate on the Departments to: (1) investigate group health plans' and health insurance issuers' compliance with "non-quantitative treatment limits" ("NQTLs"); (2) publish the names of non-compliant plans and issuers in a report to Congress; and (3) provide guidance on how to properly document NQTLs. In comparison to the 2023 Proposed Rule that we summarized here, the Final Rule imposes less burdensome requirements on plans and issuers, but the Final Rule will continue to pose significant compliance challenges for plans and issuers with new requirements related to the documentation and justification of NQTLs. Plans and issuers must continue to perform and document NQTL comparative analyses (i.e., the requirement has been effective since 2021), and these new rules will require plans and issuers to update existing NQTL comparative analyses documentation to comply with these new requirements.

The Groom team will have a webinar next Wednesday, September 18 and provide additional information as we continue our review of the Final Rule. In the meantime, we have provided major takeaways below:

1. Effective Date

- Plans and issuers offering group health insurance coverage must comply with a number of the Final Rule's requirements by the first day of the first plan year beginning on or after January 1, 2025 (e.g., for calendar year plans, the plan/issuer offering group health insurance coverage must comply by January 1, 2025). These

requirements primarily relate to the design and application of the NQTLs for mental health/substance use disorder (MH/SUD) being no more restrictive than medical/surgical (M/S), the effect of noncompliance, the disclosure requirements, and the comparative analysis content requirements that do not relate to outcomes data.

- Plans and issuers offering group health insurance coverage have until the first day of the first plan year beginning on or after January 1, 2026 (e.g., for calendar year plans, the plan/issuer offering group health insurance coverage must comply by January 1, 2026) to comply with the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related comparative analyses requirements.
- Issuers offering individual health insurance coverage have until the first day of the first policy year beginning on or after January 1, 2026 to comply with the new requirements.

2. Application of the Substantially All/Predominant Mathematical Test to NQTLs was not finalized.

- The Proposed Rule would have required that plans and issuers demonstrate that an NQTL, such as pre-authorization for outpatient benefits, apply to two-thirds of all M/S outpatient benefits before it could apply to MH/SUD. Dropping this provision is a major victory because application of this mathematical test to NQTLs could have eliminated the ability to use common medical management techniques, and it was not required by the CAA.
- In the Final Rule, the Departments framed an alternative approach to the "substantially all" requirement and imposed: (1) additional requirements related to the design and application of NQTLs; and (2) data evaluation requirements. As part of the "design and application" requirement, plans and issuers must determine if information or standards are biased or not objective, which is prohibited. Usefully, the Departments specified: (1) generally recognized independent professional medical or clinical standards; and (2) reasonably and appropriately designed measures to detect or prevent and prove fraud and abuse are considered objective and may be used to justify a material difference in a comparative analysis. However, this allowance for generally recognized independent professional medical or clinical standards and reasonably and appropriately designed measures to detect or prevent and prove fraud and abuse in the final rule is different than the proposed rule's broader exception from compliance with the proposed no more restrictive requirement, the prohibition on discriminatory factors and evidentiary standards, and the relevant data evaluation requirements. The Final Rule provides several examples illustrating this parity standard.

3. The mandate to collect and evaluate outcomes data and the material difference standard were altered and finalized.

- Under the final rule, plans and issuers are obligated to collect and evaluate relevant data in a manner reasonably designed to assess the impact of an NQTL on access to MH/SUD benefits and M/S benefits. Plans and issuers must consider whether an NQTL, in operation, complies with the "no more restrictive" and the design and application requirements.
  - This data collection requirement may pose a substantial compliance challenge for plans and issuers. The Departments did not provide an exhaustive list of outcomes data that should be collected and evaluated, even though this was requested.
  - The preamble to the Final Rule indicates that the Departments intend to update the MHPAEA Self-Compliance Tool and provide additional information on the data plans and issuers should collect and evaluate.
- The Departments' clear focus in the Final Rule is on access to network providers. The Final Rule creates a "network composition" NQTL that reflects the Departments' ongoing enforcement position around network access and will require robust data measures related to out-of-network utilization, network adequacy measures (such as time and distance standards), and provider reimbursement comparisons to benchmarks.

GROOM INSIGHT: Depending on how the Departments apply these standards, this could have the practical effect of imposing network adequacy on self-insured group health plans, a requirement that could have far-reaching impacts on plan design, including the value of certain networks and the use of value-based structures like centers of excellence.

- The Departments removed the language suggesting that a material difference in outcomes data constitutes an automatic MHPAEA violation for the network composition NQTL.
  - The Departments specified plans and issuers could evaluate utilization rates, network adequacy data, and reimbursement rates to evaluate whether this NQTL is compliant with the Final Rule. The Departments further noted they may specify the type, form, and manner of data required to be evaluated in future guidance.
- The Final Rule includes a provision that a material difference in outcomes data is viewed as a "strong indicator" of noncompliance. The Final Rule obligates plans and issuers to take reasonable steps to address material differences in access to MH/SUD benefits resulting from application of NQTLs if relevant data indicates such NQTLs contribute to these differences. A robust list of steps plans and issuers will be asked to take is set out in the preamble and, for the network composition NQTL, includes efforts to add providers to networks, streamlining credentialing requirements, increasing provider compensation, adopting telehealth, outreach to participants to find network providers, and improving provider directory accuracy.
  - The definition of a "material" difference is not clearly defined. The Departments indicated it will be a fact-specific determination. However, the Departments explained differences in MH/SUD benefit access will not be treated as material if such distinctions are attributable to generally recognized independent professional medical or clinical standards or reasonable fraud and abuse prevention or detection measures.

GROOM INSIGHT: The lack of definition of "material" differences effectively means that plans and issuers must establish the basis for *any* difference in outcomes, relying solely on the objective factors that the Final Rule permits. So, reliance on internal metrics or goals in justifying a difference in outcomes would presumably not be sufficient and would lead to the difference being viewed as "material."

4. The meaningful benefits standard was finalized.

- This standard essentially works as a benefit mandate and a requirement to provide meaningful benefits for each covered MH/SUD condition in every benefit classification in which M/S benefits are provided. As finalized, the standard remains vague.
- A plan or issuer will not provide "meaningful" benefits under the Final Rule unless it provides benefits for a "core treatment" for a MH/SUD condition or disorder in each classification in which the plan (or coverage) provides benefits for a M/S core treatment.
- This is a provision to watch. As MHPAEA was not intended to be a benefit mandate, stakeholders may seek review of this standard post-*Loper Bright*.

GROOM INSIGHT: The "core treatment" definition relies on generally accepted standards of care, which could pose significant challenges in plan design for plan sponsors of self-insured plans that want a customized plan design who will likely have to rely on third-party clinical data to guide any custom exclusion or limitation on MH/SUD treatment benefits the plan seeks to adopt. While issuers/TPAs are better positioned to address these issues generally, we expect that issuers/TPAs will be required to rely on third-party clinical literature, rather than their own clinical experience, in justifying what is considered the generally accepted standard of care.

5. The comparative analysis requirement to evaluate the impact of NQTLs was finalized.

6. The requirement for fiduciaries to certify MHPAEA Comparative Analysis compliance was altered and finalized.

- The Proposed Rule would have imposed an unprecedented duty on plan fiduciaries to certify compliance with the NQTL content requirements. This would have imposed tremendous liability on plan sponsors for compliance with technical requirements.

- The Final Rule changes the standard and focuses on the requirement for plan fiduciaries to engage in a prudent selection and monitoring process for selecting a vendor to perform and document an NQTL comparative analysis. The Final Rule provides that the comparative analysis must include a certification that the fiduciary engaged in a prudent process to select a qualified service provider(s) to perform and document a comparative analysis in connection with the imposition of any NQTLs applied to MH/SUD benefits under the plan, in accordance with MHPAEA, and satisfied the duty to monitor the service provider(s). This provision attempts to conform to ERISA's more typical fiduciary standard for selecting plan vendors.

GROOM INSIGHT: While plan sponsors will not have to become experts in the various clinical and procedural information that constitute many NQTLs, they will have to develop a means for selecting quality service providers to perform and document the analysis. There may be more pressure on TPAs to respond to the requests and testing methodology of the service provider performing the comparative analysis (if the NQTL service provider is different from the TPA).

7. The Final Rule revised or added definitions for key terms, including: "medical/surgical benefits"; "mental health benefits"; "substance use disorder benefits"; "evidentiary standards"; "factors"; "processes"; and "strategies."

- Plans and issuers must define whether a condition or disorder is an MH condition or SUD in a manner that is consistent with the most current version of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Notably, the Departments removed the reference to state guidelines in the definitions of MH benefits, SUD benefits, and M/S benefits.

8. DOL or HHS may require cessation of an NQTL.

- The Final Rule provides that the DOL or HHS may prohibit a plan or issuer from imposing an NQTL if the Department issues a final determination that the NQTL is noncompliant. The plan or issuer will be obligated to demonstrate the NQTL's compliance with MHPAEA or take appropriate action to remedy the violation.

9. The sunset provision for a MHPAEA opt-out for self-funded, non-federal governmental plans was finalized.

For more information about the Final Rule, please see the resources below:

- Final Rules, available at https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/requirements-related-to-mhpaea-final-rules.pdf
- Fact Sheet, available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Participants and Beneficiaries, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-participants-and-beneficiaries.pdf
- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Providers, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-providers.pdf

- New Mental Health and Substance Use Disorder Parity Rules: What They Mean for Plans and Issuers, available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/new-mhpaea-rules-what-they-mean-for-plans-and-issuers.pdf
- White House Fact Sheet, available at https://www.whitehouse.gov/briefing-room/statements-releases/2024/09/09/fact-sheet-biden-harris-administration-lowers-mental-health-care-costs-by-improving-access-to-mental-health-and-substance-use-care/
- News Release, available at https://www.dol.gov/newsroom/releases/ebsa/ebsa20240909
- Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rules Webinar, available at https://www.dol.gov/sites/dolgov/files/ebsa/temporary-postings/mhpaea-final-rules-09192024.pdf#zoom=200