

## Publications

# Parity or Bust: Tri-Agencies Propose Sweeping Changes to Mental Health Parity Requirements

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On July 25, 2023, the Departments of Health and Human Services, Labor and Treasury (“Tri-Agencies”) issued sweeping [new guidance](#) on the Mental Health Parity and Addiction Equity Act (“MHPAEA”), including a Proposed Rule, a technical release proposing data requirements and an enforcement safe harbor, and the 2023 MHPAEA Comparative Analysis Report to Congress (“2023 Report to Congress”). Comments on the Proposed Rule and technical release are due October 2.

The Proposed Rule would substantially re-write the existing MHPAEA regulations, which apply to group health plans and health insurance issuers, primarily the rules related to nonquantitative treatment limitations (“NQTLs”). NQTLs – including prior authorization, concurrent review, provider reimbursement, network adequacy, and others – would be required to meet a new three-part test. For the first time, the Proposed Rule would apply the mathematical test that currently applies to financial requirements and quantitative treatment limitations (“QTLs”) (the “substantially all”/“predominant” test) to NQTLs. The Proposed Rule, if finalized, would apply on the 1st day of the 1st plan year beginning on or after January 1, 2025.

Key provisions and issues include the following:

- **Substantially All/Predominant Test.** The Proposed Rule requires that for a plan or issuer to apply an NQTL to mental health/substance use disorder (“MH/SUD”) benefits, 2/3 or more of the medical/surgical (“M/S”) benefits in the same classification must be subject to the same NQTL. There are limited exceptions to this requirement for benefit structures that apply limits that reflect independent professional medical or clinical standards or that guard against fraud, waste, and abuse.

- **Mandated Outcomes Data.** The Proposed Rule, consistent with the Tri-Agencies’ enforcement approach, would mandate that plans collect and evaluate outcomes data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD benefits.
- **Material Differences in Outcomes Data.** The Proposed Rule would specify that “material differences” in outcomes data will be viewed as a strong indicator of noncompliance to the extent that outcomes are more stringent for MH/SUD benefits than for M/S benefits. For the network composition NQTL, a “material difference” in outcomes data will be considered noncompliance.
- **Meaningful Benefits.** The Proposed Rule would require the provision of “meaningful benefits” for the treatment of a particular MH/SUD benefit in each classification, as determined in comparison to the benefits provided for M/S conditions in that classification. The Proposed Rule give examples of Applied Behavior Analysis (“ABA”) therapy and nutrition counseling exclusions as not meeting the meaningful benefit requirement.
- **ERISA Plan Fiduciaries Must Certify Comparative Analysis.** For self-insured 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 Rule.
- **“Sea Change” in MHPAEA Compliance.** Demonstrating compliance with MHPAEA already poses significant challenges for both plans and issuers, with extensive and ongoing investigations being conducted pursuant to the Consolidated Appropriations Act, 2021 (“CAA”). The Proposed Regulations go far beyond merely implementing the CAA’s NQTL documentation requirements and the agency positions taken during investigations since the CAA’s enactment. If finalized as written, we are concerned that the new rules could far exceed these documentation requirements, effectively prohibit common medical management techniques, and create significant additional compliance challenges and investigation risk.

## I. Background

### A. Statute

MHPAEA was enacted in 2008, substantially expanding the original parity law from 1996. The key provision of the MHPAEA statute is the requirement that “financial requirements” (e.g. deductible, copays, coinsurance) and “treatment limits” (e.g. limits on number of visits, days of coverage) can only apply to MH/SUD benefits if they apply to substantially all M/S benefits in an amount no more restrictive than the predominant level of the financial requirement or treatment limit. Notably, the statute does not include a parity requirement for NQTLs, like prior authorization, concurrent review, and network admission standards.

### B. Interim Final Rules and NQTL Requirement

Interim final rules (“IFR”) were issued by the agencies in February 2010, effective for plan years beginning on or after July 1, 2010, and were later finalized in November 2013. The IFR and final MHPAEA regulation included an NQTL requirement not specified in the statute. The NQTL rule provides that NQTLs applied to MH/SUD benefits must be comparable to, and no more stringent than, the NQTL applied to M/S benefits in the same classification.

### C. The CAA’s New Requirements

Effective February 2021, the CAA established a new requirement that the Tri-Agencies audit at least 20 group health plans and health insurance issuers, per year, for compliance with the NQTL requirements. Plans and issuers are now required to provide their NQTL documentation to the DOL or HHS, upon request. In addition, the CAA adopted a new five-step approach to documentation of NQTL compliance, which purported to follow the DOL’s MHPAEA Self-Compliance Tool.

The CAA also established a new corrective action plan (“CAP”) process and requirement for remediation if plans and issuers are unable to demonstrate that NQTLs are in parity. Specifically, if the DOL or HHS determines that a plan or issuer is not in compliance with the CAA, the plan or issuer must specify the actions it will take to come into compliance no later than 45 days after the initial determination of noncompliance. If the DOL or HHS concludes that the plan or issuer is still not in compliance with MHPAEA based on the CAP, the plan or issuer must notify all individuals enrolled in the plan or health insurance coverage of such noncompliance within seven days of the final determination of noncompliance.

Significantly, the DOL and HHS are required to report their audit findings in a public report to Congress each year, including identifying noncompliant plans and issuers by name. The initial report (2022) focused on the 177 requests for plans and issuers and found that no plans or issuers submitted sufficient documentation upon request. The CAA also requires that the Tri-Agencies issue new regulations on the NQTL requirements.

## II. Proposed Rule Provisions

Below, we include a summary of the key provisions of the Proposed Rule.

### Definitions

The Proposed Rule would revise and add new definitions for key terms for evaluating MHPAEA compliance (such as re-defining M/S benefits and MH/SUD benefits, and newly defining factors, evidentiary standards, processes, and strategies).

### Substantially All/Predominant Test

The Proposed Rule would newly apply the actuarial tests used for QTL and financial requirement compliance (i.e., the substantially all and predominant level tests) to NQTLs. Specifically, under the Proposed Rule, the Tri-Agencies explain that a plan or issuer cannot apply any NQTL to a MH/SUD benefit in any classification that is more restrictive (in operation or as written) than the predominant NQTL applying to substantially all M/S benefits in the same classification.

**GROOM INSIGHT:** The Tri-Agencies have materially reduced the ability of plans and issuers to apply an NQTL to MH/SUD benefits by adding a threshold evaluation of whether the NQTL meets the substantially all and predominant tests to the current evaluation of the comparability of the process used in applying an NQTL.

First, plans and issuers must conduct the substantially all test. Specifically, plans and issuers would be required to determine the portion of plan payments for M/S benefits that are expected to be subject to the NQTL in a classification (based on the dollar amount of all plan payments for such benefits in a plan year) by using any reasonable method of calculation. The method of calculation is dependent on the size of the plan. As part of the “reasonable method,” plans and issuers must document their relied upon data set selection and projection assumptions. The Proposed Rule does not require this parity analysis to be performed each plan year, unless a change is made in plan benefit design or utilization that would affect an NQTL.

The Tri-Agencies indicate an NQTL applies to “substantially all” M/S benefits in a classification if it applies to at least 2/3 of those benefits, regardless of whether the NQTL is triggered by a particular factor or evidentiary standard. If an NQTL does not apply to at least 2/3 of benefits in a classification, then that NQTL may not be applied to any MH/SUD benefits in the same classification.

Second, the Tri-Agencies explain that if an NQTL applies to substantially all of the M/S benefits in a classification, then the plan or issuer must determine the predominant variation of the NQTL applied to M/S benefits. The Proposed Rule defines “predominant” as the most common or frequent variation. The Tri-Agencies explain a “variation” is distinct from financial requirements or QTLs. The Tri-Agencies consider the most common or frequent variation to be the variation that applies to the highest portion of M/S benefits subject to the NQTL within a classification (based on expected plan payments).

The Proposed Rule provides two distinct exceptions from the substantially all/predominant test for independent professional medical or clinical standards and standards to detect or prevent and prove fraud, waste, and abuse.

The first exception is for NQTLs that impartially apply generally recognized independent professional medical or clinical standards, consistent with generally acceptable standards of care, to both M/S and MH/SUD benefits. If a plan fails to impartially apply these standards or deviates from these standards, then the exception is unavailable. The Tri-Agencies explain that this exception has been proposed to ensure appropriate care for participants and beneficiaries.

The second exception is for NQTLs that are reasonably designed to detect or prevent and prove fraud, waste, and abuse based on indicia established through objective and unbiased data. The Tri-Agencies explain that such NQTLs must be narrowly designed. This exception is designed to safeguard participant and beneficiary interests and improve overall efficiency of the healthcare system.

The Tri-Agencies emphasize that the two exceptions are not intended to create a “loophole” to undermine the requirement that NQTLs be applied in compliance with the parity requirements.

**GROOM INSIGHT:** Applying the QTL test to NQTLs would represent the most significant change from the current NQTL rule.

If finalized, this would likely limit plans and issuers' ability to impose certain NQTLs altogether. For example, it is unlikely that most plans and issuers impose prior authorization on 2/3 of benefits in the outpatient M/S classification. Therefore, it is unlikely they would be permitted to impose prior authorization on benefits in the outpatient MH/SUD classification, even if the application of prior authorization to MH/SUD benefits results from consistent application of an identical process and factors. Similarly, it is unlikely that most plans and issuers impose concurrent review on 2/3 of benefits in the inpatient M/S classification. Therefore, it is unlikely they would be permitted to impose concurrent review on benefits in the inpatient MH/SUD classification.

In addition, it is unclear how the "predominant" rule would work in practice. The Proposed Rule defines "predominant" as the most common or frequent variation of an NQTL. But it is not clear what the Tri-Agencies mean by "variation." For example, is a per diem versus a diagnosis-related group ("DRG") payment methodology a "variation" of the provider reimbursement NQTL? Is negotiating payment rates above the base fee schedule, versus simply offering the base fee schedule, a "variation" of the provider reimbursement NQTL?

Finally, allowing an exception for NQTLs that impartially apply generally recognized independent professional medical or clinical standards appears to support reliance on clinical standards for NQTLs. However, cost has generally been an element considered for the use of medical management tools, and it appears that this may no longer support use of such utilization management for MH/SUD benefits.

## Design and Application of NQTLs

The Proposed Rule would require additional requirements related to the design and application of NQTLs. Plans and issuers cannot impose an NQTL, unless, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in "designing and applying" the NQTL to MH/SUD in the classification are comparable to, and are applied no more stringently than M/S.

For determining comparability and stringency, a plan or issuer may not rely 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 as compared to M/S benefits.

Information is considered to discriminate against MH/SUD benefits if it is biased or not objective, in a manner that results in less favorable treatment of MH/SUD benefits, based on all the relevant facts and circumstances. Such relevant facts and circumstances include, but are not limited to, the source of the information, the purpose or context of the information, and the content of the information.

Impartially applied generally recognized independent professional medical or clinical standards and standards reasonably designed to detect or prevent and prove fraud, waste, and abuse are *not* considered to discriminate against MH/SUD benefits.

**GROOM INSIGHT:** This new nondiscrimination standard is consistent with HHS' Essential Health Benefit regulation and the Affordable Care Act's section 1557 regulation, which apply nondiscrimination standards to clinical/medical management policies. In addition, allowing an exception for NQTLs that impartially apply generally recognized independent professional medical or clinical standards appears to support reliance on clinical standards for NQTLs, but as discussed below regarding outcomes data, this does not guarantee compliance with the NQTL rule.

## Required Use of Outcomes Data

When designing and applying an NQTL, a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD benefits and M/S benefits and consider the impact as part of the plan's analysis of whether the limitation, in operation, complies with the NQTL rule (i.e., substantially all/predominant and design and application rules). The Tri-Agencies may specify in guidance the type, form, and manner of collection and evaluation for the data. Relevant data includes:

- the number and percentage of claims denials and any other data relevant to the NQTL required by State law or private accreditation standards.
- relevant data for NQTLs related to network composition standards includes 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 Proposed Rule provides an exception from having to collect and evaluate outcomes data for plans and issuers that impartially apply independent professional medical or clinical standards and standards reasonably designed to detect or prevent and prove fraud, waste, and abuse.

**GROOM INSIGHT:** Requiring the use of outcomes data is not entirely surprising, given that the Tri-Agencies have already required this under sub-regulatory guidance and as part of their investigations. In addition, the focus on network composition data is also consistent with their recent focus in investigations. That said, the new outcomes data requirements do constitute a significant change in the current NQTL rule, which, notwithstanding the Tri-Agencies' enforcement position, remains focused on the processes used to implement the NQTL, not the outcomes of the NQTL's application.

## Material Differences in Outcomes Data

To the extent the relevant data show material differences in access to MH/SUD benefits as compared to M/S benefits, the differences will be considered a "strong indicator" that the plan or issuer violates the NQTL Rule (i.e., substantially all/predominant and design and application rules).

In such instances, the plan or issuer (1) must take reasonable action to address the material differences in access as necessary to ensure compliance, in operation; and (2) must document the action that has been or is being taken by the plan or issuer to mitigate any material differences in access to MH/SUD benefits as compared to M/S benefits.

**GROOM INSIGHT:** The Proposed Rule does not define "material," but the Tri-Agencies seek comment on how to define a material difference in access. It would be helpful if the final regulations provide more clarity around the term "material"; although, the Tri-Agencies could define "material" in such a way as to effectively eliminate NQTLs that have even minor differences in outcomes as between MH/SUD and M/S benefits.

## Special Outcomes Data Rule for NQTL for Network Composition

When designing and applying NQTLs related to network composition standards, a plan fails to meet the requirements of the NQTL Rule (i.e., substantially all/predominant and design and application), in operation, if the relevant data show material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits in a classification.

**GROOM INSIGHT:** This is an enhanced rule for network composition. If the network composition outcomes data show "material" differences, there is no "strong indicator" of noncompliance. Rather, the plan simply fails to meet the requirements of the NQTL rule. Given the potential for significant variation in provider reimbursement depending on geography and other market factors outside the plan or issuer's control, including patient behavior regarding the selection of out-of-network providers, this rule represents a significant departure from current guidance and could materially alter plans and issuers' compliance with the network composition NQTLs.

## Separate Treatment Limitation

The Proposed Rule would clarify that plans or issuers may not impose any treatment limitation that is applicable only with respect to MH/SUD benefits and not to any M/S benefits in the same benefit classification.



## Meaningful Benefits

The Proposed Rule would require provision of “meaningful benefits” for the treatment of a particular MH/SUD condition in each classification, as determined in comparison to the benefits provided for M/S conditions in the classification. The Tri-Agencies provide examples for how to comply. Two salient examples are those applying to limitations on ABA therapy and nutrition counseling.

First, the Tri-Agencies provide a hypothetical situation where a plan covers treatment for autism spectrum disorder (“ASD”) and covers outpatient, out-of-network developmental evaluations for ASD but excludes all other outpatient treatment benefits for ASD, including ABA therapy, when provided out-of-network. The plan also generally covers the full range of outpatient treatments out-of-network for M/S benefits. The Tri-Agencies conclude that this plan would violate parity requirements because it fails to provide meaningful benefits for the treatment of ASD when covering only one type of benefit in the outpatient, out-of-network classification while generally covering a full range of M/S benefits in the same classification.

Second, the Tri-Agencies provide an example where a plan generally covers the diagnosis and treatment of eating disorders, a MH/SUD benefit, but specifically excludes nutrition counseling from coverage, including in the outpatient, in-network classification. Nutrition counseling is a primary treatment for eating disorders. The plan also generally covers primary treatments for M/S conditions benefits in the outpatient, in-network classification. The Tri-Agencies conclude this plan also would violate the parity requirements by failing to provide meaningful eating disorders benefits in the outpatient, in-network classification when compared to the plan’s coverage of M/S benefits in that classification.

The Tri-Agencies also request comments on this proposal, including whether and how to define “meaningful benefits” for purposes of this provision as well as other potential alternatives.

**GROOM INSIGHT:** The two examples are consistent with the position that the Tri-Agencies have taken in investigations related to ABA therapy and nutrition counseling. However, other than those two examples, the Proposed Rule does not provide guidance on how to define “meaningful benefits.” It would be helpful if final regulations provide more clarity around the term “meaningful benefits.” In addition, the adoption of a “meaningful benefit” standard changes the analysis from a subjective analysis under the NQTL rule, to a de facto benefit mandate that cannot be justified in an NQTL analysis even if relatively strict limitations on the scope of services for M/S benefits apply.

## Determination of Noncompliance

If a plan or issuer receives a final determination from the DOL or HHS that the plan or issuer is not in compliance with the requirements with respect to an NQTL, the DOL or HHS may direct the plan or issuer not to impose the NQTL, unless and until the plan or issuer demonstrates to the DOL or HHS compliance with the NQTL requirements or takes appropriate action to remedy the violation. The proposal provides several examples.

**GROOM INSIGHT:** It is not entirely clear what the Tri-Agencies are relying on as the source of DOL’s or HHS’ authority to order a plan not to impose an NQTL until the NQTL violation has been remedied. This amounts to an additional remedy that does not appear in the statute.

## ERISA Section 104(b)

Compliance with the NQTL disclosure requirements is not determinative of compliance with any other provision of applicable Federal or State law, including ERISA section 104(b). ERISA section 104(b) requires ERISA plans to furnish specified documents to plan participants upon request within 30 days. The Proposed Rule seeks to clarify that the comparative analyses and other information required under the CAA are considered instruments under which a plan is established and operated and must be disclosed under ERISA section 104(b). Additionally, the Tri-Agencies indicate that this information constitutes documents, records, and other information that is relevant to a claimant’s claim for benefits and thus must be provided by plans and issuers upon request and free of charge.

**GROOM INSIGHT:** This enhanced disclosure requirement under ERISA exposes plans and issuers to risks associated with the disclosure of highly detailed information that can serve as the basis for private litigation (e.g., confidential and proprietary information regarding plan and issuer performance potentially subject to disclosure to plan participants and providers). This appears to go far beyond information currently required to be disclosed under ERISA.

## Comparative Analysis Content Requirements

For each NQTL applicable to MH/SUD benefits under a plan or coverage, the comparative analysis performed by the plan or issuer must include, at minimum, the following elements:

- Description of the NQTL, including identification of the predominant NQTL applicable to substantially all M/S benefits in each classification with an explanation of how the plan determined which variation is the predominant NQTL as compared to other variations, as well as how the plan identified the variations of the NQTL;
- Identification and definition of the factors used to design or apply the NQTL, including a detailed description of the factor, and a description of each evidentiary standard (and the source of each evidentiary standard);
- Description of how factors are used in the design and application of the NQTL;
- Demonstration of comparability and stringency as written;
- Demonstration of comparability and stringency in operation;
- Findings and conclusions; and
- For ERISA plans: A certification by one or more named fiduciaries.

**GROOM INSIGHT:** Many, but not all, of these content requirements were already included in the Tri-Agencies' sub-regulatory guidance under the CAA. Notably, for ERISA plans, the comparative analysis would need to include a certification by one or more named fiduciaries who have received the comparative analysis, stating whether they found the comparative analysis to be in compliance with the content requirements.

## Comparative Analysis Submission Requirements

The Proposed Rule would also formalize the following requirements related to submission of comparative analyses to the Secretary of DOL or HHS upon request:

- **Initial request:** Upon an initial request by the DOL or HHS for the comparative analysis, the plan or issuer must provide the comparative analysis within 10 business days (or an additional period of time specified by the DOL or HHS).
- **Insufficiency letter:** After a comparative analysis is deemed to be insufficient, information must be provided to the DOL or HHS by the plan or issuer within 10 business days after the DOL or HHS specifies the additional information to be submitted (or an additional period of time specified by the DOL or HHS).
- **Initial determination of noncompliance:** Upon an initial determination of noncompliance, the plan or issuer must respond to the DOL or HHS and specify the actions the plan or issuer will take to bring the plan or coverage into compliance, and provide to the DOL or HHS additional comparative analyses not later than 45 calendar days after the DOL's or HHS' initial determination that the plan or issuer is not in compliance.

## Notice of Final Determination of Noncompliance

If the DOL or HHS makes a final determination of noncompliance, the plan or issuer must notify all participants and beneficiaries enrolled in the plan or coverage that the plan or issuer has been determined to not be in compliance with respect to such plan or coverage. Such notice must be provided within seven calendar days of receipt of the final determination of noncompliance, and the plan or issuer must provide a copy of the notice to the DOL or HHS, and any service provider involved in the claims process.

The notice must include the following content requirements:

- A statement prominently displayed on the first page, in no less than 14- point font: “Attention! Department of the [insert applicable Department] has determined that [insert the name of group health plan or issuer] is not in compliance with the Mental Health Parity and Addiction Equity Act.”;
- A summary of changes the plan or issuer has made as part of its corrective action plan specified to the DOL or HHS following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed;
- A summary of the DOL’s or HHS’ final determination that the plan or issuer is not in compliance with MHPAEA including any provisions or practices identified as being in violation of MHPAEA, additional corrective actions identified by the DOL or HHS in the final determination notice, and information on how participants and beneficiaries can obtain from the plan or issuer a copy of the final determination of noncompliance;
- Any additional actions the plan or issuer is taking to come into compliance with MHPAEA, when the plan or issuer will take such actions, and a clear and accurate statement explaining whether the DOL or HHS has indicated that those actions, if completed, will result in compliance; and
- Contact information for questions and complaints, and a statement explaining how participants and beneficiaries can obtain more information about the notice, including: (1) the plan’s or issuer’s phone number and an email or web portal address; and (2) the Employee Benefits Security Administration’s or the Centers for Medicare and Medicaid Services’ phone number and email or web portal address.

## III. Technical Release (Network Composition NQTLs)

The DOL also issued a technical release, which sets forth a specific data-driven approach for assessing whether the NQTLs related to network composition that a plan or issuer imposes with respect to MH/SUD benefits comply with applicable requirements.

The Tri-Agencies envision that future guidance on the data collection requirements for network composition would have two components. First, the Tri-Agencies intend to address the type, form, and manner of the data that plans and issuers would be required to collect and evaluate, along with other relevant data as appropriate, as part of their comparative analyses for NQTLs related to network composition if the Proposed Rule provision is finalized.

Second, the guidance would define standards for the data elements specified by the Tri-Agencies and set forth a potential enforcement safe harbor for plans and issuers that include data in their comparative analyses demonstrating they meet or exceed all the standards with respect to NQTLs related to network composition, for a specified period of time.

## Required Data Collection

There are four specific types of data that they are considering requiring plans and issuers to collect and evaluate as part of their comparative analyses for NQTLs related to network composition:

1. **Out-of-network utilization:** Percentage of covered and submitted out-of-network claims for MH/SUD benefits as compared to M/S benefits, for the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the comparative analysis was conducted;
2. **Percentage of in-network providers actively submitting claims (to address ghost networks):** 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, beneficiaries, and enrollees during a period. For this data element, the Tri-Agencies contemplate requiring plans and issuers to collect and evaluate data for different types of providers (and make comparisons between a type of MH/SUD provider and an analogous type of M/S provider for six full calendar months that ended 90 days prior to the month in which the comparative analysis was conducted);
3. **Time and distance standards:** Specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include data on the percentage of participants, beneficiaries, and enrollees who can access, 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 autism spectrum disorder providers) and one (or more) in-network providers within certain M/S provider categories. The Tri-Agencies envision using the same county-type designations used for Medicare Advantage plans and Qualified Health Plans on the Federally Facilitated Exchanges, including large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations;

4. **Reimbursement rates:** 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.

For all four specific types of relevant data, the Tri-Agencies envision future guidance specifying the data that would need to be collected and evaluated in the aggregate for all plans or policies using the same network of providers or schedule of reimbursement rates.

The Technical Release provides that any future guidance would specify a prospective date by which comparative analyses would be required to include the specified data elements. This prospective applicability date would allow a sufficient period of time for plans and issuers to collect and evaluate the data required by the future guidance and to include an evaluation of the data in their comparative analyses for NQTLs related to network composition.

**GROOM INSIGHT:** It is helpful that the Tri-Agencies are proposing to clearly define what type of data they are expecting for network composition. It is also helpful that the data would be in the aggregate for all plans or policies using the same network of providers or schedule of reimbursement rates. As noted above, some of the metrics regarding outcomes data can depend heavily on patient and provider preferences outside the control of plans and issuers, which may limit the flexibility that plans and issuers currently have in applying the network composition NQTLs.

## Enforcement Safe Harbor

The potential enforcement safe harbor would, if satisfied, provide sufficient evidence to demonstrate to the Tri-Agencies that participants, beneficiaries, and enrollees in the plan or coverage would have comparable access to in-network MH/SUD and M/S providers.

The Technical Release cautions that whether or not a plan or issuer satisfies or attempts to satisfy the terms of the enforcement safe harbor for any NQTL related to network composition does not relieve the plan or issuer of its obligations under MHPAEA to perform and document comparative analyses of the design and application of each NQTL imposed on MH/SUD benefits, to demonstrate compliance with MHPAEA, and to provide its comparative analyses to the Tri-Agencies or an applicable State authority upon request.

**GROOM INSIGHT:** Many plans and issuers were hoping an enforcement safe harbor would apply to all NQTLs. Here, the DOL is only proposing an enforcement safe harbor for the network composition NQTLs, and that safe harbor would not relieve the plan or issuer of any of the most burdensome documentation requirements currently expected by the Tri-Agencies, or required under the Proposed Rule.

## IV. 2023 Report to Congress

Finally, the Tri-Agencies issued the [2023 MHPAEA Report to Congress](#) that describes the Tri-Agencies’ enforcement efforts related to the NQTL comparative analyses required by the CAA. The report focuses on the Tri-Agencies’ enforcement efforts regarding NQTLs during the second year of implementation of the CAA requirements. In addition to enforcement findings, the report includes a list of common deficiencies in NQTL comparative analyses and examples of how deficiencies have been corrected. As required by the CAA, the report also identifies by name plans and issuers that received a final determination of noncompliance from DOL and CMS.

The report explained how MHPAEA has been a top enforcement area for the DOL and CMS. The DOL issued 182 letters requesting comparative analyses for over 450 NQTLs across 102 investigations. CMS also issued 26 letters requesting comparative analyses for 44 NQTLs from 24 plans and issuers. In response to the comparative analyses, the DOL issued 138 insufficiency letters for over 290

NQTLs, and CMS issued 35 insufficiency letters for 44 NQTLs. These insufficiency letters inform plans and insurers of specific deficiencies and request additional information.

The DOL issued 53 initial determination letters finding MHPAEA violations related to 76 NQTLs, 56 of which were unique NQTLs. In response to the DOL's initial determination, 32 plans and issuers submitted corrective action plans that would make changes to 36 NQTLs, 24 of which were unique. Additionally, 104 plans, service providers, and issuers agreed to make prospective changes to their plans that would address 135 NQTLs, 71 of which were unique NQTLs. These modifications would impact over four million participants' and beneficiaries' MH/SUD benefits across 39,000 plans. CMS also issued 15 initial determination letters to 15 NQTLs. In response, two plans and seven issuers submitted corrective action plans in response that covered 15 NQTLs.

The DOL sent three final determination letters finding those plans violated ERISA section 712 for three NQTLs, and CMS issued five final determination letters finding that seven NQTLs on MH/SUD benefits were not in parity as applied to M/S benefits. The names of these plans and issuers were identified in the report, as required by the CAA.

The report identifies the common deficiencies in the NQTLs that led to enforcement by the DOL and CMS. For the DOL, the report explains plans and issuers remained unprepared and could not produce a comparative analysis when requested by the regulators, the same issues addressed in the January 2022 report persist, plans and issuers had problems when explaining their factors, plans and issuers failed to explain how the NQTL was applied "in operation," and plans and issuers failed to demonstrate comparable application of the NQTLs. The report explains that for CMS, common deficiencies included insufficiencies involving information regarding the qualifications of NQTL decisionmakers, information and documentation concerning TPA involvement, information regarding factors, discussion of comparability and stringency of the NQTL, information regarding application variations, and documentation of sources, evidentiary standards, and guidelines. CMS also found regular deficiencies in issuers' and plans' failure to include supporting policies and procedures, to identify the benefits to which an NQTL was applied, and to include information on the comparative analysis.

Finally, the report identifies both DOL and CMS enforcement priority areas. The DOL has six enforcement priority areas, two of which were added after the January 2022 report, as follows:

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 MH/SUDs, which was added after the January 2022 report; and
6. Adequacy standards for MH/SUD provider networks (also added since the January 2022 Report).

CMS has two overall enforcement priority areas as well: (1) prior authorization and (2) concurrent review.

## V. Conclusion

If finalized, the Proposed Rule would substantially re-write the existing MHPAEA regulations. Most significantly, the Proposed Rule would apply the mathematical test that currently applies to financial requirements and quantitative treatment limitations, to NQTLs. In practice, this would likely require group health plans and health insurance issuers to eliminate certain NQTLs on MH/SUD benefits, including outpatient prior authorization and inpatient concurrent review.