COMPLIANCE ALERT

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The Crucial Role of Comparative Analyses Under the Mental Health Parity Proposed Rule and Technical Guidance

On July 25, 2023, the agencies released an extensive proposed rule related to the Mental Health Parity and Addiction Equity Act (the "Proposed Rule") as well as a Technical Release requesting comments on certain proposed data requirements for nonquantitative treatment limitations ("NQTLs") and the potential for an enforcement safe harbor if certain data requirements are met. The Proposed Rule clarifies and solidifies requirements for group health plans and health insurance issuers ("plans and issuers") to perform comparative analyses of the NQTLs imposed under their plans. To do this, plans and issuers must collect and evaluate data to reasonably assesses the impact of NQTLs on access to mental health and substance use disorder ("MH/SUD") benefits and medical/surgical ("Med/Surg") benefits and demonstrate compliance with the MHPAEA as written and in operation. The Proposed Rule focuses on the following, which will directly impact plan design and analyses of those designs:

- Applying the "substantially all" standard to NQTLs
- Revising comparative analyses requirements
- Enhancing definitions to better assist plans
- Solidifying compliance deadlines

(1) APPLYING THE "SUBSTANTIALLY ALL" STANDARD TO NQTLS

The first significant change under the Proposed Rule is the application of the "substantially all" standard to NQTLS. Previously, this standard applied only to quantitative treatment limitations (QTLs). Specifically, group health plans that provide both Med/Surg and MH/SUD benefits may not apply any treatment limitation to MH/SUD benefits in any classification that is more restrictive (as written or in operation) than the predominant treatment limitation that applies to substantially all Med/Surg benefits in the same classification. The standard or test is determined separately for each type of treatment limitation. As a reminder, the six permitted classifications under the MHPAEA are: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. Additionally, there is a special rule for outpatient sub-classifications. For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

Thus, any NQTL that imposes conditions, terms, or requirements that limit access to benefits under the terms of the plan or coverage is considered restrictive, and an NQTL that applies to MH/SUD benefits can be no more restrictive than those that apply to Med/Surg benefits. The Proposed Rule provides an illustrative, non-exhaustive list of NQTLs, which includes medical management standards such as medical necessity or prior authorization, formulary design for prescription drugs (including multi-tier networks), network composition and standards, preferred provider networks, methodology for determining out-of-network rates, fail first or step-therapy requirements, and geographic location or provider type restrictions.

Moreover, an NQTL is considered to apply to substantially all Med/Surg benefits in a classification of benefits if it applies to at least two-thirds of all Med/Surg benefits in that classification (determined without regard to whether the nonquantitative treatment limitation was triggered based on a particular factor or evidentiary standard). If the NQTL does not apply to at least two- thirds of all Med/Surg benefits in a classification, then that type of NQTL cannot be applied to MH/SUD benefits in that classification.

When MH/SUD benefits are offered in any classification of benefits for that MH/SUD condition must be provided in every classification in which Med/Surg benefits are provided. Such benefits must be meaningful benefits for treatment of the condition or disorder in each such classification, as determined in comparison to the benefits provided for Med/Surg conditions in the classification. If the plan provides benefits in a classification and imposes any separate financial requirement or treatment limitation (or separate level of a financial requirement or treatment limitation) for benefits in the classification, then the rules apply separately with respect to the classification for all treatment limitations (or financial requirements).

(2) REVISING COMPARATIVE ANALYSES REQUIREMENTS

The devil is in the details, and the Proposed Rule enhances the content requirements for the comparative analyses required under the CAA, 2021 and existing DOL guidance. Comparative analyses must include a high level of detail to demonstrate a plan's compliance with the MHPAEA (as written and in operation). Some exceptions apply for independent professional medical or clinical standards and standards to prevent and prove fraud, waste, and abuse.

Generally, plans are required to:

- Describe NQTLs applicable to MH/SUD and Med/Surg benefits with regard to the benefits in each classification;
- Identify the factors used and evidentiary standards relied upon to design the NQTLs (including the source from which each evidentiary standard is derived);
- Describe how the factors are used in the design and application of the NQTL;
- Demonstrate comparability and stringency as written and in operation; and
- Address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH/SUD benefits and Med/Surg benefits within each classification, and the relative stringency of their application, both as written and in operation.

The Proposed Rule expands upon each of the above categories to describe information the DOL expects to see demonstrated in the comparative analyses. Further, the Proposed Rule requires the use of outcomes data when NQTLs are designed so that plans can establish that relevant data was used in a manner reasonably designed to assess the impact of any NQTL on access to MH/SUD benefits and Med/Surg benefits and to determine whether the plan complies in operation. This includes analyses of claims denials, in-network and out-of-network utilization rates (including provider claim submissions), network adequacy (time and distance data, information on providers accepting new patients), and provider reimbursement rates relevant to any NQTLs. As the Proposed Rule suggests, any material difference in this data for Med/Surg and MH/SUD benefits would be a strong indicator of noncompliance and, therefore, plans would be required to both take reasonable action to address the material differences in access and document any such action that has been taken to mitigate these material differences in access to MH/SUD benefits.

Accordingly, the comparative analyses must:

- Identify the relevant data collected and evaluated;
- Evaluate the outcomes that resulted from the application of the NQTL to MH/SUD benefits and Med/Surg benefits, including the relevant data set forth in the Proposed Rule
- Provide a detailed explanation of material differences in those outcomes that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH/SUD benefits and Med/Surg benefits and the bases for such a conclusion; and

- Discuss any measures that have been or are being implemented by the plan or issuer to mitigate any material differences in access to MH/SUD benefits as compared to Med/Surg benefits, including the actions the plan or issuer is taking to address material differences in access to ensure compliance with MHPAEA.

The Technical Release addresses the requirements for completing comparative analyses, but seeks feedback on, among other things, the required data elements, the difficulty in providing data elements, information technology needed to collect the data elements (including cost), and whether plans have access to these data elements. Moreover, the Technical Release addresses the potential for an enforcement safe harbor if specific standards and data elements are met or exceeded by plans.

(3) ENHANCING DEFINITIONS TO BETTER ASSIST PLANS

To better facilitate complete, clear comparative analyses and compliance generally, the Proposed Rule aims to define terms previously not defined under the law and regulations. Specifically, Proposed Rule newly defines certain terms to help guide plans and carriers to ensure parity in aggregate lifetime and annual dollar limits, financial requirements, and quantitative and nonquantitative treatment limitations between mental health and substance use disorder benefits and medical/surgical benefits. This includes definitions for “DSM”, “ICD”, “evidentiary standards,” “processes”, “strategies, and “factors” and modifies the definitions of other terms for clarity, including “mental health,” “medical/surgical benefits”, treatment limitations, and “substance use disorder benefits.”

(4) SOLIDIFYING COMPLIANCE DEADLINES

The Proposed Rule solidifies the compliance deadlines for providing the comparative analyses to the DOL upon request. Specifically, they must be provided:

- Within 10 business days of receipt of a request (unless an additional period of time is specified by the DOL)
- If additional information is required after the comparative analyses are deemed insufficient, then the DOL will specify additional information that must be submitted, and it must be submitted so within 10 business days (unless an additional period of time is specified by the DOL)
- If the plan is determined to be out of compliance, the plan must respond to the DOL and specify the actions the plan will take to bring the plan into compliance and provide additional comparative analyses meeting the requirements within 45 calendar days after initial determination of noncompliance.
- If the DOL makes a final determination of noncompliance, within 7 calendar days of the receipt of the final determination, the plan must notify all participants and beneficiaries enrolled in the plan or coverage that the plan has been determined to be out of compliance with the MHPAEA. The plan must also provide the DOL, and any service provider involved in the claims process, with a copy of the notice provided to participants. Content requirements for the notice are included in the Proposed Rule.

The Proposed Rule specifies that copies of the comparative analyses may be requested (and must be provided to) participants and beneficiaries (or their provider or authorized representatives) who have received an adverse benefit determination related to MH/SUD benefits and any state authorities.

CONCLUSION

Once finalized, these requirements will apply to plan years beginning on or after January 1, 2025. Until then, the proposed rules require plans to continue to comply with existing MHPAEA laws and regulations, including completing their comparative analyses.

At this point, it is not a question of “if” the agencies will finalize the Proposed Rule, it is “when” it will be finalized. While the Proposed Rule and Technical Guidance go a long way to advise plans, third party administrators (TPAs) and pharmacy benefit managers (PBMs) of the goals of the agency, the Proposed Rules is unlikely to resolve many of the frustrations self-funded plan sponsors have dealt with since 2021 in either obtaining draft comparative analyses from their TPAs or PBMs or ensuring the comparative analyses meet the DOL’s expectations.

TPAs and PBMs hold virtually all of the information necessary to complete the analyses, but much of the details are kept as closely guarded secrets until the DOL requests the information.

Accordingly, self-funded plan sponsors must be more assertive with their TPAs and PBMs to ensure (1) the analyses are completed, (2) the analyses are made available as required, and (3) that the analyses include all of the required detail, data, and elements in the CAA, 2021 and the Proposed Rule. One way to do this is by negotiating the plan's ability to access or request all necessary data and documentation from the TPA or PBM during the contract negotiation process. Finally, as we wait release of the MHPAEA final rule plans are encouraged to ensure current MHPAEA comparative analyses are updated to meet the Proposed Rule requirements (even before it's finalized) as it brings the plan one step closer to meeting the expectations of the DOL.

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