New Mental Health Parity Rules—Putting Meat On the Bones

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MHPAEA Developments

On July 25, 2023, the following information was released:

- 2023 Proposed Rules for Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA) (published in Federal Register on August 3, 2023)
- Technical Release
- 2023 Report to Congress
- Enforcement Fact Sheet
- MHPAEA Guidance Compendium

Context for Proposed Rule:

Biden Administration Efforts to Improve Access to Mental Health care

White House: *"It is simply too hard to know where to start when you or a loved one experiences a mental health challenge."*

- 9-8-8 National Suicide & Crisis Lifeline (launched in 2022)
- FindSupport.Gov (online guide to getting support for mental health, drug, and alcohol issues)
- Proposed expansion of Medicare coverage of mental health services
- Proposals to make it easier for Medicaid to cover mental health services in schools
- President's Budget Proposals (would require legislation)
  - Increase DOL and HHS funding to enforce parity requirements
  - Extend parity requirements to Medicare

Find Support

Find Help for Mental Health, Drugs, or Alcohol if You Have Private Insurance Through Your Employer or Union

Visit your health insurance plan's website and look for a section to find a doctor. You can also call the phone number on the back of your insurance card. Many will list a number for mental health and substance use (sometimes called behavioral health) or a nurse line. You can ask them for help finding and getting services.

You will be responsible for any co-pays, coinsurance, or deductibles that your plan has–just like going to the doctor for your physical health. Your health information is private and protected and cannot be shared with your employer. Learn about health insurance costs (PDF | 1.6 MB).

- If you're comfortable, ask your doctor, social worker, loved ones, or a trusted friend if they know any health care professionals or programs.
- Use the SAMHSA search for health care professionals and programs or call 1-800-662-4357 any time day or night. The call line has people who can speak with you in English or Spanish.
- Ask your employer's human resources department if they have an Employee Assistance Program (EAP). An EAP is a free and confidential service that your company pays for. The service can help employees with mental health, drug or alcohol use, grief, and trauma.

Context for Proposed Rule: Senate Finance Committee Activity

- March 2023: Senators Michael Bennet (D-CA) and Ron Wyden (D-OR) introduced the *Better Mental Health Care for Americans Act*.
  - Expands parity requirements to Medicare; requires Medicare Advantage provider directory changes; facilitates increased access to care for Medicare beneficiaries.
- May 2023 Senate Finance Committee hearing on Barriers to Mental Health Care.
  - Focus was concern that patients have difficulty accessing mental health care.
  - Senators spoke about the importance of *enforcing regulations* and expanding access to mental health care.
  - Senate Finance Committee a report on Medicare Advantage "ghost networks." Concern that inaccurate provider directories hinder access to mental health services.
- Focus on Medicare driven by Committee jurisdiction, but sentiment stems from personal experience with commercial plans.

Summary of Developments

- Proposed Rule:
  - creates three new requirements for NQTLs;
  - requires “meaningful benefits” in each classification (expansion of 2013 Rule);
  - reorganizes and expands CAA 2021 NQTL comparative analysis requirements;
  - provides detail on DOL action for inadequate NQTL comparative analysis;
  - confers ERISA 104(b)(4) status on NQTL comparative analysis;
  - sunsets opt-out for state & local governmental plans.
- Report to Congress—similar to 2022 Report and identifies two additional NQTLS as enforcement concerns

Review: 2013 Rule

QTLs and NQTLs are subject to separate provisions within the 2013 Rule.

- **QTLs** that apply to MH/SUD benefits are required to be "no more restrictive" than the "predominant" QTLs that apply to "substantially all" Med/Surg benefits in a classification (the "substantially all/predominant test").
  - "substantially all" means at least two-thirds
  - "predominant" means more than one-half
- Six benefit classifications: inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; and prescription drugs.
- NQTLS are subject to a "comparable to/no more stringently than" rule with respect to the application of any processes, strategies, evidentiary standards, or other factors as compared to Med/Surg benefits in the same classification.

Proposed Rule Overview: Three Basic Requirements

- "No more restrictive"
  - An NQTL that applies to MH/SUD benefits can be no more restrictive than the predominant NQTL that applies to substantially all (2/3) Med/Surg benefits within the same MHPAEA benefit classification. "Predominant" means "most common or frequent" rather than more than one-half.
- Design & application
  - The processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits must be comparable to, and applied no more stringently than, those used in designing and applying the NQTL to Med/Surg benefits within the same classification.
- Outcomes Data
  - Collect and evaluate relevant data in a manner reasonably designed to assess the impact of NQTLs on access to MH/SUD benefits and Med/Surg benefits. A "material difference" in outcomes represents a "strong indicator" of a NQTL violation generally and establishes an *actual* violation for network composition specifically.

Stated Purpose of Proposed Rule

- Benefits for MH/SUD benefits are not subject to more restrictive lifetime or annual dollar limits, financial requirements, or treatment limitations with respect to those benefits than the predominant dollar limits, financial requirements, or treatment limitations that are applied to substantially all medical/surgical benefits covered by the plan.
- Plans must not design or apply financial requirements and treatment limitations that impose a greater burden on access to MH/SUD benefits under the plan than they impose on access to generally comparable Med/Surg benefits.
- All statutory and regulatory provisions with respect to MHPAEA should be interpreted in a manner consistent with the stated purpose.

Note: Although the statement of purpose may appear broad and generic, it evidences the Departments' intent to take a "holistic" approach to enforcement to make sure that there is actual parity in operation--requiring a plan to establish that it provides appropriate access to MH/SUD benefits.

New Definitions

- Mental health benefits
  - new definition limits effect of state law
  - specifically requires the definition to align with “generally recognized independent standards of current medical practice”—i.e., most current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)
- New definitions for “factors,” “processes,” “strategies,” and “evidentiary standards”
  - All terms were used in 2013 Rule but not defined.
  - All terms are used in the NQTL comparative analysis.

Substantially All/Predominant applied to NQTLs

- 2013 Final Rule:
  - For QTLS, “substantially all” means 2/3 and “predominant” means more than 1/2.
  - For NQTLs, the rule is “comparative to/applied no more stringently than,” with allowance for “recognized clinically appropriate standards of care”.
  - 2013 Final Rule allowed comparable NQTLs to be applied, even if an NQTL was applied to more MH/SUD than Med/Surg.
- NQTLs under 2023 Proposed Rule:
  - “Substantially all” means 2/3 and “predominant” means “most common or frequent variation” of the Med/Surg form of the NQTL. Calculations are based on projected payments for the plan year.
  - 2023 Proposed Rule prohibits an NQTL applied to MH/SUD if it doesn’t apply to 2/3 Med/Surg in same classification AND is the predominant NQTL for Med/Surg in the classification.

Example: Prior Authorization

Facts

- Plan requires prior authorization for all inpatient, in-network Med/Surg and for all inpatient, in-network MH/SUD.
- Inpatient, in-network Med/Surg is approved for periods of 1, 3, and 7 days ("variations"), with 7 days as the most common (*i.e., "predominant"*).
- For Inpatient, in-network MH/SUD, 1 day is the most common (*i.e., "predominant"*) routine approval.
- The difference is not due to independent professional medical or clinical standards or fraud/waste/abuse prevention.

Conclusion

- Meets the "substantially all" test because NQTL applies to all Med/Surg in the classification.
- Fails the "predominant" test because 7 days, not 1 day, is the most common variation of the NQTL applied to Med/Surg, while the more restrictive 1-day variation applies to MH/SUD.
- In operation, the NQTL variation imposed on MH/SUD is more restrictive than the predominant NQTL variation applied to substantially all Med/Surg in classification, and the difference is not based in independent professional medical or clinical standards or fraud/waste/abuse prevention.

Query: when does a variation in a NQTL become so significant that it is actually a separate NQTL? The Proposed Rule does not address this.

Example: Concurrent Review

Facts

- Plan requires concurrent review for all inpatient in-network facility stays.
- First level concurrent review applies to all stays; escalated to 2nd level if medical necessity determination cannot be made.
- Written process requires only deny/approve from 2nd level reviewer, but in operation plan conducts a peer-to-peer review(a "variation" of the NQTL) for MH/SUD benefits while not requiring a peer-to-peer for Med/Surg.
- The difference is not due to independent professional medical or clinical standards or fraud/waste/abuse prevention.

Conclusion

- Meets the "substantially all" test because NQTL applies to all Med/Surg in the classification.
- Fails the "predominant" test because non-applicable of peer-to-peer review at 2nd level is the is the most common/frequent variation of the NQTL applied to Med/Surg and is not applied to MH/SUD. Compelling the "additional action" of peer-to-peer review to MH/SUD is a more restrictive application of the NQTL.
- In operation, the NQTL variation imposed on MH/SUD is more restrictive than the predominant NQTL variation applied to substantially all Med/Surg in classification, and the difference is not based in independent professional medical or clinical standards or fraud/waste/abuse prevention.

Design & Application

- An NQTL cannot be imposed "under the terms of the plan as written and in operation" unless any ***processes***, ***strategies***, ***evidentiary standards***, or other ***factors*** used in designing and applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the ***processes***, ***strategies***, ***evidentiary standards***, or other ***factors*** used in designing and applying the NQTL with respect to Med/Surg in the classification.
- Nearly identical to 2013 Final Rule—the term "designing" has been proposed for 2023 to align with CAA 2021 comparative analysis.
- Plan cannot rely on a ***factor*** or ***evidentiary standard*** if the basis of the ***factor*** or ***evidentiary standard*** "discriminates against" MH/SUD as compared to Med/Surg. Impartially applied independent professional medical or clinical standards or standards to detect or prevent fraud, waste, and abuse are specifically listed as nondiscriminatory.

New Definitions

Factors: all information, including processes and strategies (but not evidentiary standards), that a plan considered (even if rejected) or relied upon to design an NQTL, or to determine whether or how the NQTL applies to benefits under the plan.

Processes (a type of factor): actions, steps, or procedures a plan uses to apply NQTL, including actions, steps, or procedures established by the plan as requirements for a participant to access benefits.

Strategies (a type of factor): practices, methods, or internal metrics that a plan considers, reviews, or uses to design an NQTL.

Evidentiary standards (not a type of factor): any evidence, sources, or standards that a plan considered/relied on in designing/applying a factor for an NQTL, including specific benchmarks or thresholds. May be empirical, statistical, or clinical in nature.

Factors

Factors: all information, including processes and strategies (but not evidentiary standards), that a plan considered (even if rejected) or relied upon to design an NQTL, or to determine whether or how the NQTL applies to benefits under the plan. Include but not limited to:

- provider discretion in determining a diagnosis or type or length of treatment;
- clinical efficacy of any proposed treatment or service;
- licensing and accreditation of providers;
- claim types with a high percentage of fraud;
- quality measures;
- treatment outcomes;
- severity or chronicity of condition;
- variability in the cost of an episode of treatment;
- high cost growth;
- variability in cost and quality;
- elasticity of demand;
- geographic location.

Processes—a type of Factor

Processes: actions, steps, or procedures a plan uses to apply NQTL, including actions, steps, or procedures established by the plan as requirements for a participant to access benefits. Examples:

- procedures to submit information to authorize coverage for item/service prior to receiving or while treatment is ongoing (including requirements for peer or expert clinical review);
- provider referral requirements;
- development and approval of a treatment plan;
- specific procedures used by plan to administer the application of NQTL, such as
  - how a panel of staff members applies the NQTL (including qualifications of staff, allocation of number of staff and time),
  - consultations with panels of experts in applying the NQTL, and
  - reviewer discretion in adhering to criteria hierarchy when applying an NQTL.

Strategies—a type of Factor

Strategies: practices, methods, or internal metrics that a plan considers, reviews, or uses to design an NQTL. Examples:

- development of clinical rationale used in approving/denying benefits;
- deviation from generally accepted standards of care;
- reliance on treatment guidelines;
- selection of information deemed reasonably necessary to make a medical necessity determination;
- rationales used in selecting/adopting certain threshold amounts, professional protocols, and fee schedules;
- creation and composition of staff that deliberate/decide on NQTLs design, including plan's decisions for:
  - Staff qualifications and number of staff/amount of time allocated;
  - breadth of sources and evidence considered;
  - consultations with panels of experts in NQTL design;
  - composition of panels used for NQTL design.

Evidentiary Standards—*not* a type of factor

Evidentiary standards: any evidence, sources, or standards that a plan considered/relied on in designing/applying a factor for an NQTL, including specific benchmarks or thresholds. May be empirical, statistical, or clinical in nature, and include:

- sources acquired/originating from objective 3rd party, such as:
  - recognized medical literature, professional standards and protocols (e.g., comparative effectiveness studies, clinical trials),
  - published research studies
  - payment rates for items and services (e.g., publicly available databases of UCR rates)
  - clinical treatment guidelines
- internal plan or issuer data, such as
  - Claims/utilization data/criteria for assuring sufficient mix/number of network providers
- benchmarks or thresholds, such as:
  - measures of excessive utilization
  - cost levels
  - time or distance standards
  - network participation percentage thresholds

Outcomes Data

- In designing and applying a NQTL, the Proposed Rule requires plans to
  - collect and evaluate relevant data to assess impact of NQTL on MH/SUD compared to Med/Surg;
  - consider the impact as part of analysis of whether the NQTL, in operation, complies with "substantially all/predominant" test and the "comparable to/no more stringently than" rule.
- *All NQTLs.* "Relevant data" includes:
  - number/percentage of claims denials
  - data required by state law or private accreditation standards.
- *Network Composition NQTLs.* Additional data collection includes:
  - in-network and out-of-network utilization rates;
  - network adequacy metrics (including time/distance data, and data on providers accepting new patients); and
  - provider reimbursement rates (including as compared to billed charges).

Outcomes Data— “Material Differences”

- *All NQTLs other than Network Composition NQTLs.*
  - If analysis of outcomes data reveals “material differences” in access to MH/SUD as compared to Med/Surg, then Proposed Rule states this is a “strong indicator” of MHPAEA violation.
  - Must take “reasonable action” to mitigate, and document mitigation efforts.
  - Discussion of reasonableness of action would be part of the comparative analysis.
- *Network Composition NQTLs.*
  - “Material differences” in access to MH/SUD as compared to Med/Surg is, in fact, a MHPAEA violation.
- “Material differences” not defined; comments requested.

Technical Release

Further clarifies data collection and seeks comments. Four data collection requirements:

- Out-of-network utilization;
- Percentage of in-network providers actively submitting claims;
- Time and distance standards to obtain MH/SUD services as compared to Med/Surg;
- Reimbursement rates of in-network MH/SUD providers as compared to Med/Surg providers.

Technical Release--Possible Safe Harbor?

- TR raises possibility of future safe harbor for the network composition NQTL. If a plan meets or exceeds future specified standards on the four data elements, plan would not be subject to an enforcement action with respect to network composition NQTL for a period of time specified in future guidance.
- Possible safe harbor would be for two calendar years beginning with the time the comparative analysis is requested and would include a "variety of metrics":
  - standards for provider and facility admission to participate in a network or for continued network participation,
  - methods for determining reimbursement rates,
  - credentialing standards, and
  - procedures for ensuring the network includes an adequate number of each category of provider and facility to provide covered services under the plan or coverage.
- Reliance on proposed safe harbor would be contingent on not making changes that would affect the network composition NQTL. Certain other NQTL modifications would be prohibited as well.
- Proposed safe harbor would set a "high bar" but may involve a phased-in approach in which plans can demonstrate progress toward meeting or exceeding the standards over the course of multiple plan years.

Other Provisions

- Proposed Rule provides detail on DOL actions for inadequate NQTL comparative analysis.
  - E.g., can require that the plan eliminate the NQTL as it applies to MH/SUD benefits.
  - Specific time periods provided for responding to a Department's initial request for an NQTL comparative analysis and follow up requests.
- Section ERISA 104(b)(4) status for NQTL comparative analysis, meaning analysis must be provided to participants/beneficiaries within 30 days of a written request. If not provided, the plan administrator could face up to a $110 per day penalty.
- Proposed Rule would implement the CAA 2023 sunset provisions for state and local governmental plan MHPAEA opt-out.

2023 Report to Congress

- Similar to 2022 Report:
  - Plans are still unprepared to submit NQTL comparative analyses upon request.
  - When provided, NQTL comparative analyses generally failed to contain what the Departments viewed as required information.
  - DOL states it has “not seen a marked improvement in the sufficiency of the initial comparative analyses received” since 2022.
- Reiterates four NQTLs where DOL is concentrating its enforcement efforts and adds two more:
  - Prior authorization requirements for in-network and out-of-network inpatient services
  - Concurrent care review for in-network and out-of-network inpatient and outpatient services
  - Standards for provider admission to participate in a network, including reimbursement rates
  - Out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges)
  - Impermissible exclusions of key treatments for mental health conditions and substance use disorders (added in 2023)
  - Adequacy standards for MH/SUD provider networks (added in 2023)

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Questions