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Departments Issue Final MHPAEA Regulations

On September 9, 2024, the Departments of Health and Human Services , Labor, and the Treasury (collectively, the "Departments") released final rules pertaining to the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") with the aim of ensuring that individuals who seek treatment for mental health ("MH") or substance use disorder ("SUD") reasons do not face greater burdens than they would face when seeking coverage for medical/ surgical reasons. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes.

Background

Briefly, MHPAEA:

- Provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.
- Prohibits separate treatment limitations that apply only to MH/SUD benefits.
- Provides that nonquantitative treatment limitations ("NQTLs") may not be imposed on MH/SUD benefits in any classification unless they are comparable and applied no more stringently for MH/SUD benefits than for medical/surgical benefits under the terms of the plan (or health insurance coverage) as written and in operation. Examples of NQTLs include prior authorization and medical management requirements. The focus here is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity.
- Imposes certain disclosure requirements, including a requirement that group health plans conduct a comparative analysis of all NQTLs imposed on MH/SUD benefits and make that analysis available to the Departments and participants and beneficiaries (including their authorized representatives) upon request.

MHPAEA applies to:

- Employers with at least 51 employees offering a group health plan that provides coverage for any MH/SUD benefits; and
- Small employers with fully insured group health plans that are required to provide all essential health benefits, including MH/SUD benefits.

The Final Rules

The following summarizes some of the highlights applicable to employers sponsoring group health plans subject to MHPAEA.

Terms

The final rules amend the definitions of the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits" by removing a reference to state guidelines. The definition of whether a condition or disorder is a MH condition or SUD must follow the most current version of the International Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders. If generally recognized independent standards of current medical practice do not address how to treat a condition, disorder, or procedure, plans and carriers may define it in accordance with applicable federal and state law.

The regulations reinforce that the following conditions are MH conditions:

- eating disorders, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder;
- autism spectrum disorder; and
- gender dysphoria.

Additionally, the final rules add new definitions for the following terms: evidentiary standards, factors, processes and strategies.

Requirements for NQTLs

Under the final regulations, a plan or carrier may not impose any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical/surgical benefits in the same classification. For this purpose, a plan or carrier must satisfy two sets of requirements:

1. The design and application requirements; and
2. The relevant data evaluation requirements.

Design and Application Requirements

The general rule of the design and application requirements requires an examination of the processes, strategies, evidentiary standards, and other factors used in designing and applying an NQTL to MH/SUD benefits in the classification to ensure they are comparable to, and are applied no more stringently than, those used in designing and applying the limitation with respect to medical/surgical benefits in the same classification.

The final regulations also prohibit the use of discriminatory factors and evidentiary standards to design an NQTL to be imposed on MH/SUD benefits.

Whether information, evidence, sources, or standards are considered to be biased is based on all the relevant facts and circumstances and whether they systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits. Historical plan data/information from a time when the plan or coverage was not subject to or was not in compliance with MHPAEA is generally biased if it systematically disfavors access or is specifically designed to disfavor access to MH or SUD benefits as compared to medical/surgical benefits, and the plan has not taken the steps necessary to correct, cure, or supplement the data or information. Generally recognized independent professional medical or clinical standards and carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH/SUD benefits are not biased.

Relevant Data Evaluation Requirements

To ensure an NQTL applicable to MH/SUD benefits in a classification is no more restrictive than the predominant NQTL applied to substantially all medical/surgical benefits in the same classification, plans and carriers must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on relevant outcomes related to access to MH/SUD benefits and medical/surgical benefits and must carefully consider the impact. For NQTLs related to network composition standards, a plan or carrier must collect and evaluate relevant data in a manner reasonably designed to assess the NQTLs' aggregate impact on relevant outcomes related to access to MH/SUD benefits and medical/ surgical benefits.

As the relevant data for any given NQTL will depend on the facts and circumstances, the final rules provide flexibility for plans and carriers to determine what should be collected and evaluated, as appropriate.

The Departments may also request other data in addition to what a plan or carrier determines to be relevant data for any particular NQTL included in their comparative analyses.

If the evaluated relevant data suggest that the NQTL contributes to material differences in access to MH/SUD benefits as compared to medical/surgical benefits, it will be considered a strong indicator of a MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to medical/surgical benefits.

Differences in access to MH/SUD benefits are not treated as material if they are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect, prevent, or prove fraud and abuse. If material differences in access exist, the plan or carrier must take reasonable action, as necessary, to address them to ensure compliance with MHPAEA in operation.

Examples of possible actions that a plan or carrier could take to comply with the requirement to take reasonable action, as necessary, to address any material differences in access with respect to NQTLs related to network composition include, but are not limited to:

1. Strengthening efforts to recruit and encourage a broad range of available MH and SUD providers and facilities to join the plan's or carrier's network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network;

2. Expanding the availability of telehealth arrangements to mitigate any overall MH and SUD provider shortages in a geographic area;

3. Providing additional outreach and assistance to participants and beneficiaries enrolled in the plan or coverage to assist them in finding available in-network MH and SUD providers and facilities; and

4. Ensuring that provider directories are accurate and reliable.

Meaningful Benefits Standard

If a plan provides any benefits for a MH condition or SUD in any benefits classification, it must provide meaningful benefits for that condition or disorder in every classification in which meaningful medical/ surgical benefits are provided. Whether the benefits provided are meaningful is determined in comparison to the benefits provided for medical/surgical conditions in the same classification. Meaningful benefits require coverage of a core treatment (standard treatment or course of treatment by generally recognized independent standards of current medical practice) for that condition or disorder in each classification in which the plan or coverage provides benefits for a core treatment for one or more medical conditions or surgical procedures.

Comparative Analysis

Content

The final regulations require a comparative analysis of the design and application of each applicable NQTL. The analysis, at a minimum, must contain the following six content elements:

1. A description of the NQTL, including identification of benefits subject to the NQTL;

2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;

3. A description of how factors are used in the design or application of the NQTL;

4. A demonstration of comparability and stringency, as written;

5. A demonstration of comparability and stringency, in operation, including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences; and

6. Findings and conclusions.

Each plan (or carrier) must prepare and make available to the Secretary, upon request, a written list of all NQTLs imposed under the plan. For ERISA covered plans, this list must be provided to the named fiduciaries of the plan.

For plans subject to ERISA, the comparative analysis must include a certification by one or more named fiduciaries confirming the fiduciary's engagement in a prudent process to select one or more qualified service providers to perform and document a comparative analysis in connection with the imposition of any NQTLs that apply to MH/SUD benefits, as well as satisfaction of the duty to monitor those service providers.

Request and Review Process

The final regulations set forth the steps the Departments will follow to request and review a plan's or carrier's comparative analysis of an NQTL.

1. After an initial request for a comparative analysis, the plan or carrier must submit it to the relevant Secretary within 10 business days (or an additional period of time specified by the relevant Secretary).

2. If the Secretary determines the comparative analysis is insufficient, the Secretary will specify the additional information necessary, which must be provided by the plan or carrier within 10 business days (or an additional period of time specified by the relevant Secretary).

3. If the Secretary makes an initial determination of noncompliance, the plan or carrier has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses.

4. If the Secretary makes a final determination of noncompliance, the plan or carrier must notify all participants, beneficiaries, and enrollees enrolled in the plan or coverage not later than 7 business days after the Secretary's determination. The final rules set forth specific content for this notice and require that a copy of the notice be provided to the Secretary and relevant service providers and fiduciaries.

Plans and carriers must make a copy of the comparative analysis available when requested by any applicable state authority, a participant or dependent who has received an adverse benefit determination related to MH/SUD benefits. ERISA-covered plans must provide the analysis to participants and dependents within 30 days of a written request.

If a plan receives a final determination that an NQTL is not in compliance with the comparative analysis requirements, including because the plan has not submitted a sufficient comparative analysis to demonstrate compliance, the relevant Department may direct the plan to stop applying the NQTL until the plan is compliant, which could result in increased claim costs and additional fees from the plan's service providers. Not impose the NQTL with respect to MH/SUD benefits unless and until the plan or carrier demonstrates compliance or takes appropriate action to remedy the violation.

Sunset of MHPAEA Opt-Out

The final rules implement the sunset provision for self-funded non-federal governmental plans to opt out of compliance with MHPAEA effective June 27, 2023.

Effective Dates

The final rules generally apply to group health plans and group health insurance coverage on the first day of the first plan year beginning on or after January 1, 2025. This includes the new fiduciary certification requirement.

However, the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026.

Until the applicability date, plans and carriers are required to continue to comply with the existing requirements, including the CAA amendments to MHPAEA.

Employer Action

Plan sponsors should:

- Note that compliance with MHPAEA rules as they currently exist remains ongoing and is an enforcement priority of the Departments.

- Continue to carefully evaluate their health plans for compliance with MHPAEA, especially in light of new requirements, and be prepared to respond to requests by the Departments for this information. Notably, this will include an analysis of network adequacy. Coordination with carriers, TPAs and other service providers will be essential.

- Review their plan's current limits on MH/SUD and the plan's written comparative analysis to determine whether changes are required in light of recent enforcement efforts.

- Evaluate whether to make plan design changes beginning in 2025. (The meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026.)

It is important to note that, while all plan sponsors have the above responsibilities, in a fully insured arrangement, plan sponsors will not generally have flexibility as to plan design changes and carrier compliance will be crucial. For self-funded plans (including level-funded) it will be important that TPAs are able to support MHPAEA compliance.