ALSTON & BIRD

HEALTH & WELFARE PLAN LUNCH GROUP

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September 2023 Agenda

- Washington Update
- 2023 Short-term Limited Duration and Fixed Indemnity Proposed Regulations
- 2023 Mental Health Parity Proposed Regulations
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- Grab Bag Report and Reminders

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Health & Welfare Benefits
MONTHLY UPDATE

WASHINGTON UPDATE

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New Proposed STLDI and Fixed Indemnity Regulations

Health & Welfare Benefits
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Proposed Rule for STLDI and Fixed Indemnity Coverage

Core purpose of proposed rule is to reduce confusing STLDI and fixed indemnity coverage with ACA-compliant coverage. Proposed rule published by federal regulators on July 12, 2023 would:

- Cut back the current 36-month max renewal limit on STLDI to three months with one month extension (also includes an anti-stacking provision);
- Redefine "excepted benefits" status for hospital indemnity and other fixed indemnity supplement benefits;
- Impose new notice requirements;
- Change the tax treatment of all fixed indemnity health policies, including specified disease coverage.

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Fixed Indemnity Coverage and "Excepted Benefits"

- Currently, certain benefits are "excepted" under HIPAA rules and excluded from the ACA requirements if:
  - the benefits are provided under a separate policy/certificate/contract;
  - no coordination of the benefits and exclusions under any plan maintained by same sponsor; and
  - benefits paid w/o regard to whether benefits are provided under plan maintained by same sponsor.
- If finalized, proposed rule would
  - reinterpret and expand the meaning of "noncoordinated" benefits in group and individual markets
    - Coverage that complements/fill in gaps of other coverage offered by same plan sponsor (or same insurer in the individual market) would no longer be an "excepted benefit."
  - eliminate variation in the amount of benefits by services/items, severity of illness/injury, or any other characteristics particular to a course of treatment, for individual and group coverage alike.
    - Currently, individual coverage allows benefits to vary on a per service and/or per period basis; group coverage can vary on a per-period basis and vary the amount of benefit based on the triggering event.
- General Effective Date: Applies to new policies sold or issued starting 75 days after a final rule is published.
  - Policies sold or issued before the General Effective Date: plan years (coverage periods in the individual market) beginning on or after Jan. 1, 2027.

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New Notice Requirements for Fixed Indemnity

- Proposed rule addresses the consumer confusion issue by adding a new notice requirement for fixed indemnity group coverage and amending the existing notice requirement for individual coverage.
- Notice states that coverage is not "comprehensive health insurance" and doesn't have to include Federal consumer health insurance protections.
  - Must be prominently displayed on first page of any marketing, application, and enrollment materials (paper or electronic) provided at or before enrollment or re-enrollment, and on first page of individual policies
  - Seeking comment on alternate language that would use the header "WARNING."
- Effective date for new notice requirement: 75 days after final rule is published.

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Tax Treatment for Hospital and Other Fixed Indemnity and Specified Disease

- Current understanding (see Rev. Rul. 69-154):
  - Premiums paid on after-tax basis: benefits received are tax-free.
  - Premiums paid on pre-tax basis (either employer contributions or employee pretax salary reduction): tax status depends on unreimbursed medical expenses.
    - Amounts not exceeding related unreimbursed medical expenses are tax-free.
    - Amounts exceeding related unreimbursed medical expenses are taxable.
- Proposed rule: If premiums are paid pre-tax (either employer-paid or pre-tax salary reduction), entire amount of benefit would be taxable income, regardless of the amount of the employee's unreimbursed medical expenses.
  - Benefits would also be subject to employment taxes.
- Effective Date: The later of the date of publication of the final rule or Jan. 1, 2024.

What if New Reg is Finalized as is . . .

- Limits on types of fixed indemnity coverage
- All pre-tax health indemnity coverage creates taxable benefits
- Non-coordination rules eliminate
  - Mini-MEC Coverage
  - Major-medical look-alike plans
  - Double dip wellness programs
  - HDHP indemnity combinations
- Requests comments on treatment of specified disease coverage
- Requests comments on level funded premium (LFP) plans

MHPAEA Developments

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

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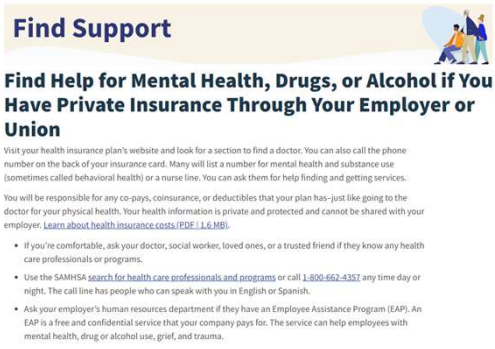
Context for Proposed Rule:

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.

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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.

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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.

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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.

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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.

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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.

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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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Case Developments: Mulready

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Mulready . . . . .A Big Win for ERISA Preemption and Plan Sponsors

- *PCMA v. Mulready*
  - 10th Cir holds ERISA preempts aspects of Oklahoma's PMB law
  - Comes on the heels of the Supreme Court's decision in *Rutledge* regarding Arkansas' PBM law
  - Supreme court stated in Rutledge that there are two types of state laws that are preempted:
    - Laws that require providers to structure benefit plans in particular ways
    - Laws that have an acute but indirect economic impact such that it forces providers to adopt a certain scheme of substantive coverage

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Mulready . . . . .A Big Win for ERISA Preemption and Plan Sponsors

- Mulready (Oklahoma insurance commissioner) claimed no preemption because the laws regulate PBMs—not plans.
- Court rejected this.
- At issue:
  - Geographic standards imposed on networks (Network Access Standards)
  - Prohibition against requirements or incentives for using a particular requirement (Discount Prohibition)
  - Any willing pharmacy requirement (AWP)
  - Prohibitions regarding terminations of pharmacists from network if on probation

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Mulready . . . . .A Big Win for ERISA Preemption and Plan Sponsors

- Court held that the network related provisions were all preempted because impermissibly mandated a particular benefit structure
  - In essence, PBMs in Oklahoma could only offer a single network tier without any customization
  - ERISA's savings clause not addressed because Mulready did not raise it
- Distinguished from *Rutledge*
  - Arkansas law merely regulated pricing terms in contracts between PBM and pharmacies
  - Citing Rutledge---"ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."

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Mulready . . . . .A Big Win for ERISA Preemption and Plan Sponsors

- What's next?
  - Remand back to district court
  - Perhaps another appeal to 10th or Supreme Court
  - Will it stand?
  - What impact will it have on other state laws?

Other Cases and Claims

- Suits against Claims Administrators for breach of fiduciary duty related to fees/compensation
  - *Owens & Minor v. Anthem; Kraft Heinz Company v. Aetna*
    - Complaints not only focus on claims processing practices that allegedly generate additional income but they focus on failures to provide access to claims data
    - *Owens & Minor* claims that Anthem violated CAA's gag clause prohibition

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Other Cases and Claims

- Application of *Thole* doctrine to welfare plans (Article III standing)
  - *Knudsen v. MetLife*
    - Participants claimed that MetLife failed to properly apply prescription drug rebates to plan participants, which resulted in higher premiums and cost share
    - District Court dismissed by applying *Thole*
      - Premiums and benefits do not fluctuate based on the plan's profits and losses
      - Plan participants have no individual right to the general pool of plan assets
      - Therefore, participants did not suffer an injury themselves
        - No allegation that they didn't receive the promised benefits
  - *Winsor v. Sequoia Benefits and Insurance Services*
    - Participants claimed that administrator breached fiduciary duty by improperly receiving commissions from the insurers that the administrator chose, which resulted in higher costs for the participants
    - District Court dismissed by applying *Thole*
      - No allegations to support the claim that costs would be lower otherwise (sponsor is free to determine the premiums and cost share)
      - Participants have no beneficial interest that increases or decreases dependent on the management of the funds
      - Therefore, participants did not suffer an injury
      - No allegations that they didn't receive the promised benefits

Compliance Grab Bag

Surprise Billing IDR Process Temporarily Halted

- In *Tex. Med. Ass'n v. United States HHS*, 2023 U.S. Dist. LEXIS 135310, (N.D. Tex. August 3, 2023), the court invalidated:
  - the increased fee to participate in IDR for 2023 $350 (up from $50); and
  - the batching rule that makes it more difficult to batch multiple, qualified IDR dispute items and services to be considered jointly as part of a single determination.
- HHS has suspended the IDR process pending further guidance.

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Qualifying Payment Amount (QPA) Calculation in Interim Final Regulations Invalidated

- In the ongoing litigation by the Texas Medical Association, the court, invalidated additional provisions of the interim final regulations on QPA calculations in *Tex. Med. Ass'n v. United States HHS,* 2023 U.S. Dist. LEXIS 149393, (N.D. Tex. August 24, 2023).

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QPA Calculations Continued

- The following areas of the interim final regulations were invalidated by the court:
  - **Contracted Rates**: Issuers and plans when determining contracted rates cannot include "ghost rates" in calculating the QPA – ghost rates are rates for items and services that are not provided, and providers have no intention to provide.
  - **Specialties**: Median contacted rates must be calculated by provider specialty. Issuers and plans cannot include out-of-specialty rates.
  - **Total Maximum Payment**: QPA calculations must include bonuses and incentives.
  - **Self-funded Plans**: Cannot use the median contracted rates based on the TPA's or ASO's book of business.
  - **Single Case Agreements**: Single case agreements must be factored into QPA.

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HIPAA Reproductive Health Care Disclosures

- Vanderbilt University Medical Center (VUMC) is under investigation by HHS' Office of Civil Rights (OCR) over disclosures of patient records to the Tennessee Attorney General ("AG").
- As part of a fraud investigation under the Tennessee Medicaid False Claims Act, the AG issued three separate Civil Investigation Demands (CIDs) to VUMC.
- The CIDs requested 106 patient records along with internal communications to a mental health facility.
  - The records related to gender affirming care provided by VUMC.
  - All 106 patients were covered under either the state employees' health plan or TennCare, the state's Medicaid plan.

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HIPAA Reproductive Health Care Disclosures

- The OCR investigation was initiated after patients filed a class action in state court against VUMC alleging that the disclosures violated 45 C.F.R. §164.512(f)(ii)(C), disclosures for law enforcement purposes.
- Disclosures for law enforcement purposes under the privacy regulations are permitted if:
  - The information sought is relevant and material to a legitimate law enforcement inquiry;
  - The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
  - De-identified information could not reasonably be used
- The patients claim that none of the disclosure requirements in 45 C.F.R. §164.512(f)(ii)(C) were met and VUMC should not have complied.

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HIPAA Reproductive Health Care Disclosures

- The patients also allege that the disclosures violated VUMC's 2022 Privacy Policy regarding disclosures to law enforcement and were not properly described in VUMC's Notice of Privacy Practices.
- This case highlights the difficulties HIPAA covered entities face in complying with HIPAA and state law enforcement demands when disclosing reproductive health data.
- Below are links to recent guidance from OCR regarding disclosures of information relating to reproductive health care and proposed regulations:
  - https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/phi-reproductive-health/index.html
  - https://www.federalregister.gov/documents/2023/04/17/2023-07517/hipaa-privacy-rule-to-support-reproductive-health-care-privacy#:~:text=The%20proposal%20would%20modify%20existing,which%20such%20health%20care%20is

Health & Welfare Benefits
MONTHLY UPDATE

State Law Bans on Transgender Care for Minors Updates

- 11th Circuit:
  - A panel of the 11th Circuit allowed Alabama's ban to go into effect while the courts hear challenges to the law.
  - A federal district court had earlier issued an injunction staying the enforcement of Georgia ban.
  - Georgia filed for a stay of the injunction on September 1, 2023, after the 11th Circuit's ruling on the Alabama ban.
  - A federal district court had also issued an injunction staying the enforcement of Florida's ban. Florida has also fled an appeal.
- Texas:
- Texas Supreme Court lifed a temporary injunction on September 1, 2023, permitting enforcemet of the ban while the courts hear challenges to the law.

State Law Bans on Transgender Care for Minors Updates

- 6th Circuit:
  - On September 1, a panel of the 6th Circuit held oral arguments in a combined appeal regarding Tennessee and Kentucky bans.
  - Currently both bans are in place pending appeal
- 7th Circuit:
  - A federal district court issued a temporary injunction staying enforcement of Indiana's ban in June 2023.
- 8th Circuit:
  - A federal district court struck down Arkansas' ban in June 2023, and the state filed an appeal to the 8th Circ.

Health & Welfare Benefits
MONTHLY UPDATE

2024 Cost-of-living Adjustments for H&W Benefits

BENEFIT,	2024	2023
HSA contribution max (including employee and employer contributions)	$4,150/$8,300 Rev. Proc. 2023-23	$3,850/$7,750 in 2023
HSA additional catch-up contributions	$1,000	$1,000
HDHP annual deductible minimum	$1,600 ($3,200 family)	$15,00 in 2023
Limit on HDHP OOP expenses	$8,050 ($16,100 family)	$7,500 ($15,000 family)
ACA limit on OOP expenses	$9,450 ($18,900 family)	$9,100 ($18,200 family)
Limit on amounts newly available under an Excepted Benefit HRA	$2,100	$1,950

2024 Cost-of-living Adjustments for H&W Benefits Projected

BENEFIT	2024	2023
Health FSA salary reduction max [projected]	$3,200	$3,050
Health FSA carryover max [projected]	$640	$610
Transit and parking benefits [projected]	$315	$300

Health & Welfare Benefits
MONTHLY UPDATE

ACA Pay or Play Affordability Threshold for 2024

- Pay or play penalty threshold for affordability with be 8.39% for 2024, down from 9.12% for 2023.
- The Federal Poverty Level (FPL) for US mainland will be $14,580 for 2024 and for employers that use the FPL Safe Harbor, the required employee contribution for self-only coverage cannot exceed $101.94 per month, down from $103.28 for 2023.

ALSTON & BIRD

Health & Welfare Benefits
MONTHLY UPDATE

David Wit, et al v. United Behavioral Health

- Ninth Circuit Court of Appeals Decision August 2023
  - A panel of the 9th Circuit vacated a prior opinion from January 2023, and replaced it with a new opinion finding:
    - The plaintiffs had Article III standing to bring their claims for breach of fiduciary duty and denial of benefits.
    - The district court did not err in certifying the three classes to pursue the fiduciary duty claim.
    - The district court erred in certifying the denial of benefit classes and the panel reversed the certification.

Health & Welfare Benefits
MONTHLY UPDATE

David Wit, et al v. United Behavioral Health (UBH)

- The panel held that, by certifying the denial of benefits classes without limiting the classes to those with claims that UBH denied under a specific Guidelines provision or provisions challenged in this litigation that applied to the claimant's own request for benefits, the certification order improperly enlarged or modified plaintiffs' substantive rights in violation of the Rules Enabling Act.
- The panel reversed the district court's judgment on the denial of benefits claim.
  - The panel held that, on the merits, the district court erred to the extent it determined that the ERISA plans required the Guidelines to be coextensive with generally accepted standards of care.
  - To the extent the judgment on plaintiffs' breach of fiduciary duty claim was based on the district court's erroneous interpretation of the ERISA plans, it was also reversed.

David Wit, et al v. United Behavioral Health (UBH)

- The panel remanded for the district court to answer the threshold question of whether the fiduciary duty claim was subject to the plans' administrative exhaustion requirement and, if so, whether the requirement was satisfied by unnamed class members or should otherwise be excused.
- Given the remand to the district court, further appeals are likely as the plaintiffs called the litigation the century's 'most important ERISA case.'

Health & Welfare Benefits
MONTHLY UPDATE

Reminders

Health & Welfare Benefits
MONTHLY UPDATE

Medicare Creditable Coverage

- Medicare Part D notices (either creditable or non-creditable coverage) are due prior to October 15 (October 14th).
- Online disclosure to CMS is due no later than 60 days after the beginning date of the plan year (contract year, renewal year, etc.) and upon change of the plan's creditable coverage status.
- NOTE: prescription drug cost reductions for Medicare enrollees in the Inflation Reduction Act may impact analysis of whether employer sponsored prescription drug coverage is creditable

Health & Welfare Benefits
MONTHLY UPDATE

Annual Enrollment Notices

- Remember to distribute the 2024 Annual Enrollment Notices
  - The 2023-2024 revised CHIP Notice may be found at: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

Health & Welfare Benefits
MONTHLY UPDATE

Confirm EOI Approval Before Collecting Premiums

- With annual enrollment coming up, employers may want to review their procedures to ensure that EOI has been approved by life and disability insurers before premiums for the increases are withheld from the employees' pay.
- DOL and Prudential Insurance Company of America ("Prudential) reached a settlement regarding the denial of life insurance claims when the employee/eligible dependent did not submit evidence of insurability (EOI), but the employer still collected premiums for the supplemental coverage over an extended period.

Health & Welfare Benefits
MONTHLY UPDATE

DOL Settlement with Prudential

- The settlement prohibits Prudential from denying claims based on the failure to submit EOI if it has accepted at least three months of premiums for coverage and requires Prudential to notify employers not to collect premiums until EOI has been approved.
- In addition, the settlement provides existing participants additional protections to ensure that coverage is not denied more than a year after they started paying premiums based on insurability, or based on evidence that they were no longer insurable after they first began making premium payments.
- Prudential Financial agreed to reprocess denied claims dating back to June 2019 and provide benefits for the claims previously denied based solely on lack of evidence of insurability.

DOL Settlement with Prudential Continued

- The settlement also says that after receiving the notice, employers may be liable to the beneficiaries of the policy if the employer collects premiums for an employee or eligible dependent before confirming EOI approval.
- Press release:
  - US Department of Labor reaches settlement with Prudential Insurance Company of America to revise life insurance practices that denied claims | U.S. Department of Labor (dol.gov)
- Settlement Agreement: SOL20230649.pdf (dol.gov)

Health & Welfare Benefits
MONTHLY UPDATE

Questions

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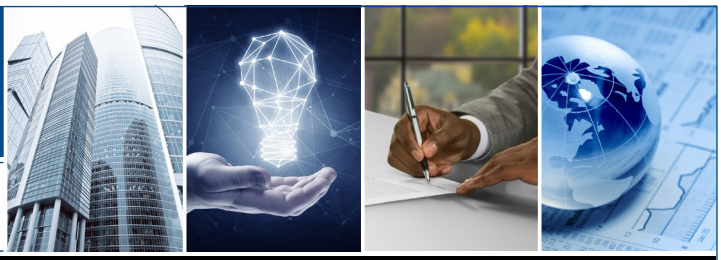

Employee Benefits & Executive Compensation ADVISORY ■

AUGUST 29, 2023

Agencies Issue Extensive MHPAEA Guidance: Plan and Issuer Action Required

On July 25 the Departments of Labor, Treasury, and Health and Human Services issued a proposed rule on requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA). The Proposed Rule, if finalized in its current form, will impose significant new compliance obligations on group health plans and health insurance issuers and would be effective for plan years beginning on or after January 1, 2025.

The focus on the Proposed Rule is on nonquantitative treatment limitations (NQTLs) under MHPAEA. Along with the Proposed Rule, the departments issued a technical release (TR) related to the Proposed Rule's data collection requirements, a report to Congress, an enforcement fact sheet, and an MHPAEA guidance compendium.

EXECUTIVE SUMMARY

This advisory contains background regarding MHPAEA; a detailed analysis of the Proposed Rule, the TR, and the report to Congress; and Practice Pointers, but the following is a summary of the key provisions. We will refer to just "group health plans" or "plans" in this advisory with the understanding that the MHPAEA requirements also apply to health insurance issuers.

NQTLs Must Meet Three Requirements

Of most significance, the Proposed Rule provides that a plan must satisfy three newly stated requirements to impose NQTLs on mental health and substance use disorder (MH/SUD) benefits.

First, an NQTL that applies to MH/SUD benefits can be no more restrictive than the predominant NQTL that applies to substantially all medical/surgical (Med/Surg) benefits within the same MHPAEA benefit classification. This "no more restrictive" requirement borrows the mathematical "substantially all/predominant test" that currently exists for financial requirements and quantitative treatment limitations (collectively QTLs) under the 2013 MHPAEA final rule.

Second, 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 MHPAEA benefit classification. This requirement codifies the departments' current view of what must be established in an NQTL comparative analysis.

Third, the Proposed Rule would require the use of outcomes data in analyzing NQTLs. The Proposed Rule would require extensive collection of data, such as claims denials, for an NQTL and then compare data outcomes for both MH/SUD and Med/Surg benefits. A "material difference" in outcomes represents a "strong indicator" of an NQTL violation, and certain action would need to be taken and documented. While this data collection requirement applies to all NQTLs, there are additional unique data collection requirements for the "network composition" NQTL. For this NQTL, material differences in the data would go beyond a strong indicator of an MHPAEA violation but would establish that there *was* an actual violation. The TR goes into detail regarding the extensive data that plans would need to collect to establish parity/comparability for the network composition NQTL. Based on this outcomes data, the TR notes the possibility of creating a safe harbor for this specific NQTL. The TR asks for comments on that data collection and safe harbor.

The Proposed Rule does contain important exceptions for "independent professional medical or clinical standards" as well as standards to prevent "fraud, waste, and abuse." Those exceptions apply to each of these three NQTL requirements.

Meaningful Benefits in Each MHPAEA Benefit Classification

The 2013 MHPAEA final rule provides that if a plan provides MH/SUD benefits in one of the MHPAEA benefit classifications, it must provide MH/SUD benefits in all MHPAEA benefit classifications. The Proposed Rule would amend and expand this requirement to require that a plan provide "meaningful benefits" in each classification compared to Med/Surg benefits. The Proposed Rule contains two examples providing clarification of this "meaningful benefits" requirement.

Content of an NQTL Comparative Analysis

The Consolidated Appropriations Act, 2021 (CAA 2021) required each plan to have a written NQTL comparative analysis with five elements: (1) the identification of NQTLs and the MH/SUD and Med/Surg benefits the NQTLs apply to; (2) the factors used to determine application of the NQTLs; (3) the evidentiary standards used to develop the factors; (4) an analysis of processes, strategies, evidentiary standards, and factors demonstrating comparability; and (5) specific findings and conclusions. The Proposed Rule reorganizes and expands on these elements, incorporating a demonstration of the three requirements for NQTLs as part of the comparative analysis.

Other Provisions

The Proposed Rule provides further detail on actions the departments may take if they find an NQTL comparative analysis lacking. The departments, for example, can require that the plan eliminate the NQTL as it applies to MH/SUD benefits. Specific time periods are provided for responding to a department's initial request for an NQTL comparative analysis and follow-up requests.

For ERISA-covered plans, the Proposed Rule provides that the NQTL comparative analysis is an instrument under which a plan is established or operated under Section 104(b)(4) of ERISA and must be provided to participants and beneficiaries within 30 days of a written request. If not provided, the plan administrator could face up to a $110 per day penalty for not providing that comparative analysis.

Previously, state and local governmental plans could opt out of MHPAEA. The Consolidated Appropriations Act, 2023 ended that opt-out and provided a sunset timetable. The Proposed Rule would implement those sunset provisions.

Report to Congress

In many respects, the departments' 2023 MHPAEA Comparative Analysis Report to Congress is like the 2022 MHPAEA Report to Congress. Both reports noted that even though plans were required to have a written NQTL comparative

analysis by February 10, 2021, many plans were still unprepared to submit their comparative analyses upon request. And when the comparative analyses were provided, they failed to contain what the departments viewed as required information. The DOL states that it has "not seen a marked improvement in the sufficiency of the initial comparative analyses received" since 2022.

The 2023 report reiterated four NQTLs the DOL is concentrating its enforcement efforts on, as announced in 2021 FAQs. The 2023 report also added two new NQTLs. Those that were identified in 2022 were (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; and (4) out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges). Added to this list in the 2023 report are (5) impermissible exclusions of key treatments for mental health conditions and substance use disorders; and (6) adequacy standards for MH/SUD provider networks.

The DOL noted its continuing focus on service providers and seeking any plan correction through those service providers. The DOL stated it was expanding its approach by "sending request letters or subpoenas to three more service providers, including some of the largest in the country."

BACKGROUND

The Legislation

MHPAEA was enacted on October 3, 2008 and broadly requires that group health plans and health insurance issuers ensure that the financial requirements and treatment limitations that apply to MH/SUD benefits are no more restrictive than those that apply to Med/Surg benefits. MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-funded and fully insured arrangements. The Affordable Care Act, through the requirement to offer "essential health benefits," also made MHPAEA apply to small non-grandfathered fully insured plans.

The 2013 Final Rule

A final rule was issued in 2013 that contained separate provisions for QTLs and NQTLs.

QTLs are "quantitative" or numeric aspects of group health plans such as deductibles, copays, co-insurance, maximum out-of-pocket, and visit limits. The 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. This is referred to as the "substantially all/predominant test."

The final rule established six benefit classifications. The QTL substantially all/predominant test must be applied to each classification:

- Inpatient, in-network.
- Inpatient, out-of-network.
- Outpatient, in-network.
- Outpatient, out-of-network.
- Emergency care.
- Prescription drugs.

The final rule allowed certain limited subclassifications for drug tiering, in-network tiering, and an outpatient subclassification for office visits.

The Proposed Rule confirms that these classifications and subclassifications apply equally to NQTLs.

> ***Practice Pointer:*** A group health plan cannot expand this list of classifications and subclassifications. For example, there is no separate classification for telehealth. The Proposed Rule emphasizes this point: "The departments expect plans and issuers to treat telehealth benefits the same way they treat those benefits when provided in person in determining the classification or sub-classification in which a particular benefit belongs." There are often different QTLs (copays and co-insurance) that apply to telehealth, raising QTL issues, and often the MH/SUD benefits offered through telehealth might be more limited than those offered for Med/Surg benefits, raising NQTL issues.

For QTLs, the final rule defined "substantially all" as two-thirds and "predominant" as more than one-half. If a QTL does not apply to substantially all Med/Surg benefits in a classification, it cannot apply to any MH/SUD benefits in that classification. For example, if in-network, outpatient Med/Surg services were equally divided between copays and co-insurance (i.e., 50/50), based on claims, then there is no cost-sharing that applied to substantially all (i.e., 2/3) Med/Surg benefits and no cost sharing could then apply to MH/SUD benefits. If, however, copays applied to substantially all Med/Surg benefits in that classification, then an analysis would look to the predominant copay. If, for example, the Med/Surg in-network primary physician office visit copay was $20 and the specialist copay was $40, then based on plan payments, a determination would need to be made on the predominant copay. If the predominant copay was $20, then only a $20 copay could be charged for an MH/SUD in-network office visit and the specialist copay could not be charged. The substantially all/predominant test now takes on added meaning since the Proposed Rule adopts this test for NQTLs in a slightly modified fashion.

The final rule set forth parity protections for NQTLs as well. NQTLs are any limitations on the scope or duration of treatment that are not expressed numerically. The final rule and subsequent guidance provided the following illustrative (nonexclusive) list of NQTLs. This list would be slightly modified under the Proposed Rule.

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative.
- Prior authorization or ongoing authorization requirements.
- Concurrent review standards.
- Formulary design for prescription drugs.
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design.
- Standards for provider admission to participate in a network, including reimbursement rates.
- Plan methods for determining usual, customary, and reasonable charges.
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols).
- Exclusions of specific treatments for certain conditions.
- Restrictions on applicable provider billing codes.
- Standards for providing access to out-of-network providers.

- Exclusions based on failure to complete a course of treatment.
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan.

The final rule provided that a plan may not impose an NQTL on MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to Med/Surg benefits.

CAA 2021

CAA 2021 was enacted on December 27, 2020 and expressly required group health plans to perform and document a comparative analysis of the design and application of NQTLs. Beginning 45 days after CAA 2021's enactment (February10, 2021), a group health plan was required make its comparative analysis available upon request from any department. The comparative analysis must have five different pieces of information as described in the Executive Summary. FAQs issued in April 2021 clarified these requirements and stated that at a minimum a comparative analysis must have a "robust discussion" of nine different elements.

- A clear description of the specific NQTL, plan terms, and policies at issue.
- Identification of the specific MH/SUD and Med/Surg benefits the NQTL applies to within each benefit classification and a clear statement of which benefits identified are treated as MH/SUD and which are treated as Med/Surg.
- Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits are subject to the NQTL, including any weighting of factors.
- To the extent the plan defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
- An explanation of any variation in the application of a guideline or standard used by the plan between MH/SUD and Med/Surg benefits and a description of the process and factors used for establishing that variation.
- If the application of the NQTL turns on specific decisions in the administration of the benefits, the plan should identify the nature of the decisions, the decision-makers, the timing of the decisions, and the qualifications of the decision-makers.
- If the plan relies on any experts, the analysis should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied on each expert's evaluations.
- A reasoned discussion of the plan's findings and conclusions on the comparability of the processes, strategies, evidentiary standards, factors, and sources identified within each affected classification, and their relative stringency, both as applied and as written. The discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
- The date of the analysis and the name, title, and position of the person or persons who performed or participated in the comparative analysis.

As noted in the 2022 and 2023 reports to Congress, the departments found that every initial comparative analysis reviewed was insufficient.

THE PROPOSED RULE AND TECHNICAL RELEASE

Purpose of the Rule

The Proposed Rule begins with a new statement of purpose to ensure that:

- 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 affecting MHPAEA should be interpreted in a manner consistent with the stated purpose.

> ***Practice Pointer:*** Although the statement of purpose for the Proposed Rule 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 participants and beneficiaries appropriate access to MH/SUD benefits.

New and Revised Definitions

The Proposed Rule would remove perceived flexibility in defining mental health benefits, medical surgical benefits, and substance use disorder benefits by limiting the effect of any reference to state law and specifically requiring the definition to align with "generally recognized independent standards of current medical practice." While plans could still reference state law, they could only do so to the extent state law is consistent with those standards—specifically the most current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

> ***Practice Pointer:*** In the past, some plans have tried to classify autism spectrum disorders and eating disorders as a Med/Surg condition rather than an MH/SUD condition. The preamble to the Proposed Rule notes that since autism and eating disorder are in the DSM as MH/SUD conditions, they must be covered as MH/SUD conditions and cannot be treated as Med/Surg even if state law might provide otherwise.

There are new definitions for "factors," "processes," "strategies," and "evidentiary standards," which are all currently used in the NQTL comparative analysis. These terms were also used in the 2013 final rule but not defined.

Factors include all information that a group health plan relied on to design an NQTL. The preamble emphasized that "factors" should be read broadly and include all information, including processes and strategies, that were relied on in developing the NQTL. Processes and strategies are then treated as subsets of factors. Factors would also include information that was considered but rejected. This definition has a nonexhaustive list of factors such as 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, and geographic location.

Processes are actions, steps, or procedures that a group health plan uses to apply an NQTL. Processes can include actions, steps, or procedures established by the plan for a participant or beneficiary to access benefits. For example, processes can include things such as the actual written and operational steps of a preauthorization process or a

concurrent review process. They could also include the development and approval of a treatment plan. This definition provides other nonexclusive examples of processes.

Strategies are practices, methods, or internal metrics that a plan considers, reviews, or uses to design an NQTL. Some examples of strategies provided in this definition include the development of the clinical rationale used in approving or denying benefits, deviation from generally accepted standards of care, the selection of information deemed reasonably necessary to make a medical necessity determination, and rationales used in selecting and adopting certain threshold amounts, professional protocols, and fee schedules.

Evidentiary standards are any evidence, sources, or standards that a group health plan considered or relied on in designing or applying a factor in an NQTL. They include specific benchmarks and thresholds. Evidentiary standards may be empirical, statistical, or clinical in nature. They include items such as recognized medical literature, professional standards and protocols, published research studies, payment rates for items and services (such as publicly available databases of the "usual, customary, and reasonable" rates paid for items and services), clinical treatment guidelines, and internal plan data or criteria for assuring a sufficient mix and number of network providers. The Proposed Rule emphasizes in several places that evidentiary standards are used to develop factors and are not factors themselves.

> ***Practice Pointer:*** Although the definitions are only in the Proposed Rule, factors, processes, strategies, and evidentiary standards are all key aspects of what the departments currently view as central requirements of an NQTL comparative analysis. Using these definitions as part of a comparative analysis should satisfy the departments that correct definitions are being used.

Although not contained in the definitions section of the Proposed Rule, there is a change in wording in the nonexhaustive sample list of NQTLs. What was previously described as "[s]tandards for provider admission to participate in a network, including reimbursement rates" has been replaced and expanded with "standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including 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." The preamble notes that, in the departments' view, the standards that govern how a network is constructed and defined is a critical NQTL affecting the delivery and availability of MH/SUD benefits. The Proposed Rule contains specific new provisions for network composition.

The Substantially All/Predominant Test as Applied to NQTLs

As mentioned in the Executive Summary, for NQTLs the Proposed Rule would apply the substantially all/predominant test that currently applies to QTLs. If finalized, this test might dramatically affect plan design. The previous understanding of the 2013 final rule was that a plan could have an NQTL, such as prior authorization, that applies to some but not all MH/SUD benefits and applies to some but not all Med/Surg benefits. Then, if the factors, processes, strategies, and evidentiary standards in developing and applying the NQTL were comparable for MH/SUD and Med/Surg benefits, there was no MHPAEA violation even if the NQTL applied to more MH/SUD than Med/Surg benefits. There is an example of this concept in the final rule. That example is deleted in the Proposed Rule and replaced by one incorporating the substantially all/predominant test and the proposed required analysis of data outcomes.

The first part of this test is that any NQTL that applies to MH/SUD benefits in a classification must apply to substantially all Med/Surg benefits in that classification. "Substantially all" is defined as two-thirds. While the Proposed Rule gives several examples of the "predominant" requirement of this test, it does not provide an example solely dedicated to just the substantially all part of the test. But looking at the actual Proposed Rule itself, it could affect NQTLs such as

preauthorization especially for outpatient benefits (whether in network or out of network). If the preauthorization requirement does not apply to at least two-thirds of the Med/Surg benefits in the applicable classification, then it cannot be imposed on MH/SUD benefits in that classification.

> ***Practice Pointer:*** Intensive outpatient treatment and partial hospitalization are usually treated as outpatient benefits for MH/SUD purposes. Those treatments are often subject to preauthorization. Under the Proposed Rule, preauthorization could not be required for these benefits in an outpatient, in-network classification unless preauthorization was required for two-thirds of Med/Surg benefits in that classification. We believe that many plans will have difficulty meeting this threshold. Under the Proposed Rule, all outpatient NQTLs will need to be examined closely. There are, however, important exceptions for "independent professional medical or clinical standards," as well as standards to prevent "fraud, waste, and abuse."

The substantially all determination is made based on the dollar amounts expected to be paid for Med/Surg benefits in the particular classification for the plan year. Any reasonable method may be used. In the preamble, the departments make several observations on this testing. They refer to the rules on QTL testing and the credibility of data with distinctions made between self-funded, large group market, and small group market plans. They state that in making any projections plans should "document the assumptions used in choosing a data set and making projections." Similar to QTL testing, they indicated that testing is not required each plan year "unless there is a change in plan benefit design or utilization that would affect an NQTL within a classification."

The departments acknowledge that the substantially all/predominant test does not always fit neatly into an NQTL context and ask for further comments, including on whether there are systems in place to perform this testing.

If the substantially all part of the test is met, then a plan may still only apply the predominant Med/Surg form of the NQTL. The Proposed Rule defines "predominant" as "the most common or frequent variation of the NQTL" (this is slightly different than the "more than one-half" standard for "predominant" in QTL testing). There is also no definition of what constitutes a variation of an NQTL. As with the substantially all part of the test, which variation of the NQTL is predominant is also based on projected plan payments.

The Proposed Rule does provide two examples. The first is a preauthorization requirement that applies to all inpatient, in-network benefits—both MH/SUD and Med/Surg. Med/Surg benefits are approved for periods of one, three, and seven days, after which a treatment plan must be submitted. Based on projected plan payments, preauthorizations for seven days is the most common duration. For MH/SUD, preauthorizations are most commonly given for only one day. In this example, the departments find an MHPAEA violation. The plan satisfies the substantially all requirement since preauthorization is required for every benefit in the inpatient, in-network classification. The plan, however, fails the predominant test because the most common approval for MH/SUD is one day instead of the predominant seven days for Med/Surg. This example does assume that the difference in duration is not the result of independent professional medical or clinical standards or standards to detect or prevent and prove fraud, waste, and abuse.

In another example, concurrent review is required for every inpatient, in-network facility stay. In each instance there is a first-level concurrent review, and if the first-level reviewer is unable to make a medical necessity determination to allow a continued stay, it is escalated to a second-level review. At this second level, the plan, in operation, conducts a peer-to-peer review for MH/SUD benefits while not requiring a peer-to-peer for Med/Surg. Here again, the concurrent review requirement applies to all benefits in the specific category so the substantially all test is satisfied. The predominant variation of the concurrent review NQTL at the second level of review for Med/Surg is not to apply a peer-to-peer requirement. Accordingly, the departments conclude the peer-to-peer requirement in operation for MH/SUD benefits at the second level would be an MHPAEA violation. Once again, the example assumes that the

application of peer-to-peer for MH/SUD is not the result of any impartially applied independent professional medical or clinical standards or standards to detect or prevent and prove fraud, waste, and abuse.

> ***Practice Pointer:*** Distinctions between NQTLs for purposes of the substantially all part of the test and variations in NQTLs for the predominant part of the test may be difficult. It is unclear when a variation in an NQTL becomes so significant that it is actually a separate NQTL.

The Design and Application Requirement

The Proposed Rule contains a design and application requirement that applies the factors, processes, strategies, and evidentiary standards requirements that plans have been laboring over for the past two and one-half years in documenting an NQTL comparative analysis. This requirement states that 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 nonquantitative treatment limitation to mental health or substance use disorder 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 limitation with respect to medical/surgical benefits in the classification." This language is almost identical to the 2013 final rule, but that rule was limited to "applying" the NQTL, and the word "designing" has been added in the Proposed Rule. The preamble notes that this provision is intended to codify the departments' "consistent interpretation" on the current requirements for NQTLs and to bring it in harmony with the CAA 2021 statutory requirements.

The Proposed Rule adds a provision that a plan cannot rely on a factor or evidentiary standard if the basis of the factor or evidentiary standard "discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits." Impartially applied independent professional medical or clinical standards or standards to detect or prevent fraud, waste, and abuse are specifically listed as *non*discriminatory.

Required Use of Outcomes Data

NQTLs other than network composition

In designing and applying an NQTL, the Proposed Rule would require plans to "collect and evaluate relevant data" to assess the impact an NQTL has on MH/SUD benefits compared to Med/Surg benefits. The manner and form of that data request (except for network composition) is left open to further guidance from the departments, but specifically mentioned are claims denials and data required by state law or private accreditation standards.

> ***Practice Pointer:*** This requirement would codify what the departments are already doing with MHPAEA examinations in practice. In their April 2021 FAQs, the departments noted that a plan should be prepared to provide, as part of an examination, "internal testing" performed as well as "samples of covered and denied MH/SUD and medical/surgical benefit claims." The DOL, in its investigations, insists that data analysis is part of the required stringency testing. The 2023 report emphasized that the DOL currently requests this sort of data in any examination. In fact, the DOL noted that "Data showing the effect of an NQTL's application were particularly important and sometimes operated as a 'green flag' signaling that an NQTL in question did not appear to apply more stringently to MH/SUD benefits relative to medical/surgical benefits."

If the analysis of the outcomes data reveals "material differences" in access to MH/SUD benefits compared to Med/Surg benefits, then the Proposed Rule states that this is a "strong indicator" that the NQTL violates MHPAEA. The Proposed Rule then requires the plan to take "reasonable action" to address the material differences and then document the action taken to mitigate those material differences. Neither the Proposed Rule nor the TR defines "material differences," but the departments have requested comments on how to define the term.

The preamble to the Proposed Rule states that, except for network composition, material differences alone would not be dispositive of a violation but reasonable action would need to be taken. The preamble further provides:

> Whether any particular action would be considered reasonable in response to any given material differences in access resulting from an evaluation of outcomes data would be determined based on the relevant facts and circumstances, including the NQTL itself, the relevant data, the extent of the material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits, and the impact of the material differences in access on participants and beneficiaries.

A discussion of that reasonable action would then be a required element of the plan's NQTL comparative analysis. The preamble notes that this inclusion in the comparative analysis would allow plans "to explain why material differences in access demonstrated by the outcomes data should not result in a violation of the rules for NQTLs."

Required data collection for the network composition NQTL and the TR

The Proposed Rule emphasizes the importance of the network composition NQTL in providing access to MH/SUD benefits. This NQTL is different from other NQTLs in two ways. First, material differences would not just be a strong indicator of an NQTL violation—they *would actually be* an NQTL violation. Second, the Proposed Rule states data collection requirements for this NQTL that are in addition to those required for all NQTLs. This additional data collection 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 compared to billed charges).

The TR provides further clarification on the departments' thinking on the data collection for this NQTL and seeks comments. Under the TR there would be four data collection requirements.

The first requirement would be out-of-network utilization. Data collection and evaluation would be required on the percentage of covered and submitted out-of-network claims for MH/SUD benefits compared to Med/Surg benefits. The TR proposes that the data collection and evaluation would be on the following out-of-network services:

- Inpatient, hospital-based services.
- Inpatient, non-hospital-based services (one focus here is comparing Med/Surg services for rehabilitation facilities and skilled nursing facilities with residential treatment facilities for MH/SUD services).
- Outpatient facility-based items and services (intensive outpatient and partial hospitalization are among those particularly noted here).
- Outpatient office visits.
- Other outpatient items and services.

The second requirement would be the percentage of in-network providers actively submitting claims. Here, the departments believe that plans have provider network directories that include providers not actually providing services and term this a "ghost network." Plans would be required to collect and evaluate the 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 and beneficiaries during a specified period. The TR designates the types of providers that the departments are considering requiring for this data collection.

The third requirement would be time and distance standards for participants and beneficiaries to obtain MH/SUD services compared to Med/Surg services. Time and distance standards are already required for Medicare Advantage

plans. The data collection and analysis would include data on the percentage of participants and beneficiaries who can access, within a specified time and distance by county-type designation, at least one in-network MH/SUD provider and at least one in-network MH/SUD provider. The TR specifies certain types of MH/SUD and Med/Surg providers the departments are considering for this data collection. For MH/SUD providers, the TR specifically mentions, among others, child and adolescent providers, geriatric providers, eating disorder providers, and autism spectrum disorder providers. The departments envision using the same county-type designations used for Medicare Advantage Plans.

The fourth requirement would be reimbursement rates of in-network MH/SUD providers compared to Med/Surg providers. Plans would be required to collect data on reimbursement rates for yet-to-be-specified types of MH/SUD providers and yet-to-be-specified types of Med/Surg providers. That data collection would be for specified CPT codes (the TR mentions four). The analysis would then determine any material differences between in-network payments (compared to billed charges) for MH/SUD benefits and Med/Surg benefits. There would also be a comparison of allowed amounts and a comparison against a Medicare benchmark.

Practice Pointer: The Proposed Rule's data collection requirement and the substantially all/predominant test would dramatically change the way NQTLs are analyzed. While factors, processes, strategies, and evidentiary standards would still be a part of validating NQTLs, these inherently contain some subjectivity and provide plans some leeway in designing NQTLs. Previously, the departments stated that comparable application of these criteria was the "test" and that outcomes were *not* determinative. Now, at least for the substantially all/predominant test and for the network composition NQTL, outcomes *will be* determinative.

The TR has approximately 75 issues that the departments have asked for specific comments (many with subparts). So it is likely that the data collection requirement for NQTLs will be further refined when the Proposed Rule is finalized.

The TR suggests that this data collection and analysis be performed by a third-party administrator (TPA) or other service provider in the aggregate for all plans that use the same network of providers or reimbursement rate.

If there is a material difference based on any of these four data collections, then the Proposed Rule would find that the plan's network composition NQTL is not valid. That does not mean automatic enforcement of the violation by the departments. The preamble to the Proposed Rule states that the departments will not cite a plan for a violation if there is a shortage of MH/SUD providers in a geographic area and where, despite proper action, and through no fault of the plan itself, that shortage persists—provided that the plan is otherwise compliant with MHPAEA. The preamble goes on to state that plans should document the actions they have taken to resolve the disparity and demonstrate why any disparities are attributable to provider shortages in the geographic area and are due to factors other than NQTLs related to network composition. The departments request comments on this provision, including on whether and how to allow plans to account for external circumstances that impact material differences in access.

A possible safe harbor for the network composition NQTL

The TR raises the possibility of a future safe harbor for the network composition NQTL. If plans meet or exceed future specified standards on the four data elements, they would not be subject to an enforcement action by the departments for the network composition NQTL for a period that would be specified in future guidance. That safe harbor would include a "variety of metrics" on the four data elements. The safe harbor would cover all the following for network composition: 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.

The departments are proposing that the safe harbor will last two calendar years beginning with the time the comparative analysis is requested. To be able to rely on the proposed safe harbor, however, no changes could be made that would affect the network composition NQTL, and certain other NQTL modifications would be prohibited as well. The departments expect that the safe harbor would set a "high bar" but are considering a phased-in approach in which plans can demonstrate progress toward meeting or exceeding the standards over the course of multiple plan years.

Exceptions for Independent Professional Medical or Clinical Standards or Standards to Detect or Prevent Fraud, Waste, and Abuse

All three of the NQTL requirements have exceptions or provisions for independent professional medical or clinical standards or standards to detect fraud, waste, and abuse. For the application and design requirement, this comes in the way of stating that these standards are nondiscriminatory. For the other two NQTL requirements, it is a specific exception.

The Proposed Rule itself is terse on these important exceptions. To fall within the independent professional medical or clinical standards exception, a plan must "impartially apply generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to medical/surgical benefits and mental health or substance use disorder benefits, and may not deviate from those standards in any way, such as by imposing additional or different requirements."

To qualify for the fraud, waste, and abuse exception, an NQTL "must be reasonably designed to detect or prevent and prove fraud, waste, and abuse, based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data, and also be narrowly designed to minimize the negative impact on access to appropriate mental health and substance use disorder benefits."

The preamble provides slightly more explanation and emphasizes that these exceptions are not intended as a "loophole" and are "narrowly tailored." The departments do recognize that these exceptions improve health care and outcomes. But the departments warn that if they become aware of the creation of new standards for the purpose of imposing NQTLs that are more restrictive for MH/SUD benefits, they may provide additional guidance consistent with MHPAEA's fundamental purpose. Recognizing that these exceptions could be subject to various interpretations, the departments are soliciting comments on ways to better or more fully frame these exceptions.

> ***Practice Pointer:*** When an NQTL cannot satisfy the substantially all/predominant test or when an analysis of the data collection reveals "material differences," the exceptions or provisions for independent professional medical or clinical standards or standards to detect fraud, waste, and abuse will be critically important if the plan wants to maintain the NQTL.

The Meaningful Benefit Requirement

The final rule provided that if a plan provides MH/SUD benefits in one of the MHPAEA classifications it must provide benefits in all the classifications. The Proposed Rule expands this requirement to provide "meaningful benefits" when compared to Med/Surg benefits in that classification. Two examples in the Proposed Rule demonstrate this requirement. In one, a plan covers outpatient, out-of-network developmental evaluations for autism spectrum disorder (ASD) but excludes all other ASD services in that classification, including applied behavior analysis (ABA). For Med/Surg, the plan provides a "full range" of outpatient treatments for services in this classification. The departments conclude that since the plan only covers one type of benefit for ASD in the classification but provides a full range of Med/Surg benefits in the same classification, it has not met the meaningful benefit requirement.

In another example, a plan covers diagnosis and treatment for outpatient, in-network eating disorders but does not provide nutritional counseling for that disorder. The plan generally provides Med/Surg benefits for primary treatments in that classification. The departments conclude that since nutritional counseling is one of the primary treatments for eating disorders, the plan does not provide meaningful benefits for eating disorders compared to the services provided for Med/Surg benefits in that classification.

Content Requirements for an NQTL Comparative Analysis

The Proposed Rule would reshape the content of the NQTL comparative analysis by incorporating the data collection requirements and the substantially all/predominant test. Other organizational and substantive changes are made as well. There are six separate requirements with multiple subparts under each requirement. Under the Proposed Rule, including subparts, there would be approximately 40 requirements for a comparative analysis (some that might not apply to all plans).

The six broad requirements are:

- Description of the NQTLs: There are four subparts here, including the results of the substantially all/predominant NQTL testing and how the plan identified the variations of the NQTL for the predominant aspect of that testing.
- Identification and definition of the factors used to design or apply the NQTL: Here, with five different subparts, the plan will identify and give a detailed description of the factors relied on to design and apply the NQTL and the evidentiary standards supporting those factors.
- Description of how the factors are used in the design and application of the NQTL: This requirement (with 10 different subparts) codifies much of the prior 2021 FAQs on the content of an NQTL comparative analysis.
- Determination of comparability and stringency as written: There are 10 different subparts for this requirement.
- Determination of comparability and stringency in operation: The "as written" and "in operation" stringency requirements are similar in that they both require discussion of the results of the data collection and analysis. Stringency in operation is more detailed, requiring identification of the data collected, an evaluation of the outcomes of the data, a detailed description of any material differences found that are not attributable to differences in the comparability or stringency of the NQTL, and measures taken to mitigate any material differences.
- Findings and conclusions: There are five different subparts for this requirement.

> ***Practice Pointer:*** If the Proposed Rule is finalized, every NQTL comparative analysis will need to be updated and expanded.

The NQTL Comparative Analysis Process

The Proposed Rule would provide further clarity on the NQTL comparative analysis process. When a department requests an NQTL comparative analysis from an employer, it typically provides a very short timeframe for response. The departments emphasize that under the CAA 2021 that comparative analysis should have been prepared by February 10, 2021. Similarly, the departments typically provide short timeframes for employers to respond to follow-up requests. Under the Proposed Rule, each of those time periods would be codified as 10 business days.

If there is a final finding of noncompliance with the comparative analysis, the CAA 2021 required that the plan notify all participants and beneficiaries of that noncompliance within seven calendar days. The Proposed Rule now contains eight content requirements for that notice, including a statement "prominently displayed" and in no less than 14-point type that the applicable department "has determined that [the group health plan] is not in compliance with the Mental

Health Parity and Addiction Equity Act." The Proposed Rule specifies the delivery method for the notice and allows an internet posting if the participant or beneficiary is notified in paper form (such as a postcard) that the notice is posted on the internet.

Also, if there is a final determination that a group health plan is noncompliant with the comparative analysis requirement, the departments can direct the plan not to apply any NQTL where that analysis was noncompliant until the plan comes into compliance.

For ERISA-covered plans, the Proposed Rule would codify the DOL's position previously expressed in FAQs that the NQTL comparative analysis is an instrument under which the plan is established or operated for purposes of Section 104 of ERISA. Under the Proposed Rule, plan administrators must provide the comparative analysis to participants and beneficiaries within 30 days following a written request or potentially face a $110 per day penalty.

Also, for ERISA-covered plans there must be a certification by one or more named fiduciaries that they have reviewed the comparative analysis and found it to be in compliance with the Proposed Rule's content requirements.

THE 2023 REPORT TO CONGRESS

The 2023 report covered DOL actions between November 1, 2021 to July 31, 2022 and Centers for Medicare & Medicaid Services (CMS) actions between March 25, 2022 to June 6, 2022, although both departments give statistics from the 2022 report going back to February 2021. Both departments found the same deficiencies stated in the 2022 report.

The DOL has six current NQTL enforcement priorities. Four were previously announced and two are new:

- 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).
- New: Impermissible exclusions of key treatments for mental health conditions and substance use disorders.
- New: Adequacy standards for MH/SUD provider networks.

The DOL has placed an increased enforcement emphasis on network composition and participation standards, which also includes how plans set their reimbursement rates. The DOL reports that it is pursuing over 20 network admission standards investigations.

The DOL notes that it is currently devoting 25% of the Employee Benefits Security Administration enforcement program to focus on NQTLs. This is a dramatic shift from years ago when DOL investigations almost always centered on retirement plans and investigations of health and welfare plans were a relative rarity. Also, the DOL states that during the reporting period that it "continued to expand staffing dedicated to MHPAEA enforcement, including an increase of over 30 investigators and technical experts."

The DOL is prioritizing potential violations stemming from actions of service providers since those potential violations may affect hundreds or thousands of plans. During the reporting period, the DOL indicates that it worked with 20 service providers to obtain corrections.

During the reporting period, the DOL took the following actions:

- 25 initial letters requesting comparative analyses for 69 NQTLs.
  - Prior authorization, exclusion of ABA and other therapies, network admission (including reimbursement rates), and concurrent care review were the top four NQTLs for which a comparative analysis was requested.
- 52 insufficiency letters covering over 100 NQTLs.
- 22 initial determination letters finding that plans and issuers had violated MHPAEA's requirements for 26 NQTLs.
- 3 final determination letters finding MHPAEA violations for 3 NQTLs.

The DOL notes that the majority of corrections it obtained were without the need to issue notices of noncompliance.

During the reporting period, the DOL found that none of the comparative analyses initially submitted were sufficient to demonstrate compliance. The DOL also mentions a lack of data to support the comparative analyses that were ultimately submitted. Also, because of NQTL operational compliance issues identified by the DOL, it is "increasingly conducting full investigations" into MHPAEA compliance.

> ***Practice Pointer:*** An insufficient NQTL comparative analysis can lead to a full DOL MHPAEA investigation, which can often span several years and involve numerous data requests, subpoenas, interviews, and depositions.

CMS's reporting was largely similar to the DOL's but was limited to 21 comparative analyses for six state and local governmental plans and five health insurers. CMS's focus was on preauthorization and concurrent review NQTLs.

NEXT STEPS

There is no set timetable for the Proposed Rule to be finalized. Comments on the Proposed Rule and the TR must be submitted to the departments by October 2, 2023, and it is unknown what, if any, aspects of the Proposed Rule may be modified. In the interim employers should:

- Work with their TPAs/ASOs to make sure there is a compliant NQTL comparative analysis under the CAA 2021 and existing guidance. The 2022 and 2023 Reports to Congress, April 2021 FAQs, and the existing MHPAEA Self-Compliance Tool provide guidance on completing that NQTL comparative analysis.
- Document that a plan fiduciary has actually reviewed the NQTL comparative analysis with the TPA/ASO or other service provider.
- While all NQTLs should be in the analysis, focus on the six NQTLs that the DOL has identified as enforcement priorities.
- Of those six NQTLs, note that network composition including network provider reimbursement rates is an area of increasing scrutiny. Appendix II of the MHPAEA Self-Compliance Tool, "Provider Rate Reimbursement Rate Warning Signs," provides a data framework for analyzing reimbursement rates. We do, however, expect a new version of the MHPAEA Self-Compliance Tool sometime this year.
- In addition to the Appendix II framework, together with your TPAs/ASOs, perform additional data stringency analyses on various NQTLs. For example, a comparison of denial/approval rates on requests for preauthorization for Med/Surg and MH/SUD claims in each MHPAEA classification.
- Begin working with your TPA/ASO on how they will comply with the data collection and analyses requirements contained in the Proposed Rule and the TR even though exact parameters of those requirements are not known.
- As part of the NQTL comparative analysis, isolate "variations" of any NQTL in anticipation of performing the substantially all/predominant testing.

- Confirm with your TPA/ASO that they will revise (or work with you in revising) any NQTL comparative analysis to conform with the Proposed Rule once finalized.
- Review any service provider agreement with the TPA/ASO to have clear provisions on the TPA/ASO's responsibility to provide the comparative analysis or information to complete that analysis if another service provider is going to perform this function. Specify any additional fees for this service and indemnification/remedies for failure to comply.

We will discuss the new Proposed Rules and mental health parity in depth at our Health & Welfare Benefits Monthly Update webinar on September 7 at 12:30 pm ET. Please click here to RSVP.

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