The Mental Health Parity and Addiction Equity Act:
What You Need to Know – Part 3

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MHPAEA Overview: NQTL Rules

- Defining terms
- Core requirements of MHPAEA
- QTL Rules
- New NQTL two-part test
- Comparative analysis rules
- Practical advice

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The ABCs of Mental Health Parity

MHPA: Mental Health Parity (1996)
MHPAEA: Mental Health Parity and Addiction Equity Act (2008)
ACA: Affordable Care Act (2010)
CAA: Consolidated Appropriations Act
QTL: Quantitative Treatment Limit
NQTL: Nonquantitative Treatment Limit
MH/SUD: Mental Health/Substance Use Disorder
M/S: Medical/Surgical
DOL: Department of Labor
CMS: Centers for Medicare and Medicaid Services

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Overview

Mental Health Parity and Addiction Equity Act ("MHPAEA")

How did we get here?

- Congressional belief that health plans (fully-insured and self-funded) were not treating mental health ("MH") (and, later, substance use disorder ("SUD")) fairly
  - Mental Health Parity Act of 1996
    - ✓ Expanded in 2008 to MHPAEA
    - ✓ Expanded again by Consolidated Appropriations Act, 2021 ("CAA")
- When compared to medical/surgical ("M/S") benefits

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Plans Subject to Law

- Generally applies to "group health plans" (typically, major medical plans)
- Excepted benefits (such as most FSAs, dental, vision, etc.) generally excluded
- No exemption for church plans
- "Small" plans / retiree-only plans generally excluded
  - Definition of "small" can be a bit confusing
  - Generally, employer had at least 2 but not more than 50 employees on business days during preceding year
- Increased cost exception possible, but difficult

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MHPAEA Overview

MHPAEA establishes three main requirements

(1) Annual/lifetime limits: If plan has annual or lifetime dollar limits for M/S benefits, must apply those same (or higher) dollar limits for MH/SUD

- *E.g.*, it would have been problematic to include a $1,000,000 lifetime limit on M/S benefits but a $500,000 lifetime limit on MH/SUD
- Really not relevant any longer, though, because ACA eliminated dollar-based annual and lifetime limits for "essential health benefits"
- In other words, the problem was basically "resolved" by ACA

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MHPAEA Overview

(2) Financial requirements (such as coinsurance, copayments, deductibles) and quantitative treatment limitations (*e.g.*, visit limits) cannot be more restrictive against MH/SUD benefits compared to M/S benefits

- AND, no separate cost-sharing requirements only for MH/SUD benefits
  - *E.g.*, could not draft plan to say that there is a $1,000 deductible for M/S benefits and a $500 deductible for MH/ SUD benefits. Even though the deductible is "better", it violates MHPAEA because it is separate

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MHPAEA Overview: QTL Rules

- QTL test: Identify "classifications" such as inpatient, in-network and emergency care
- Check whether the financial requirement (such as copayment or coinsurance) applies to at least 2/3 of medical/surgical ("M/S") benefits in the classification
  - If "no", cannot apply to any mental health/substance use disorder ("MH / SUD") benefits in the classification

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MHPAEA Overview: QTL Rules

- If "yes", check if there is a single level that applies to more than ½ of M/S benefits
  - If "no", aggregate them until you get to 50.01%
  - If "yes", use that limit for MH / SUD benefits
- If plan has not run the QTL test previously, it should be run
- Will your TPA or other vendor run it for you?

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NQTL

A NQTL is a non-numeric limit on the scope or duration of benefits for treatment.

Examples include:

- Medical management standards limiting/excluding benefits based on medical necessity or appropriateness, or whether treatment is experimental or investigative
- Formulary design for prescription drugs
- Network tier design (*e.g.*, preferred and participating providers)

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NQTL

Additional types of NQTLs:

- Standards for provider admission to participate in a network (*e.g.*, insurance requirements)
- Methods for determining usual, customary, and reasonable
- Refusal to pay for higher cost therapies unless lower cost therapies are not effective (*e.g.*, step therapy protocols)
- Exclusions based on failure to complete a course of treatment
- September 2024: DOL declines to provide complete list of NQTLs (or even list of ones it has identified). Creates risk that may be difficult to identify all NQTLs (which should be done)

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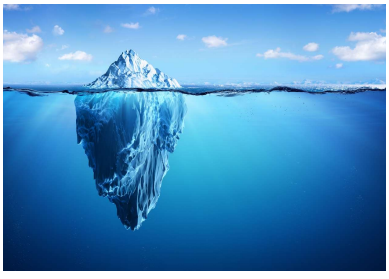
NQTL



- Risk of deficient SPD is small and fixed relatively easily
- Risk of deficient TPA / PBM / network / telehealth vendor practices is larger; more difficult to identify; more difficult to "fix"
- Employers likely will put pressure on TPAs, PBMs, other vendors to identify "below the water" issues

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NQTLs: 2024 Regulations

- Added new 2-part test AND expanded on what "comparative analysis" must include
- 2-Part NQTL Test: Plan cannot impose NQTL with respect to MH / SUD benefits in any classification that is more restrictive, as written or in operation, than the "predominant" NQTL that applies to "substantially all" M/S benefits in same classification, if plan fails to meet:
  - "Design and application" rules or
  - "Required use of outcomes data" rules

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NQTLs: 2-Part Test

- Design and Application Rule: Any processes, strategies, evidentiary standards or other factors ("Processes") used in applying the NQTL to MH/SUD benefits within a classification must be comparable to, and applied not more stringently than, the processes used in applying the NQTL to M/S benefits in the same classification
  - New definitions for various terms (e.g., "processes", "strategies", "evidentiary standards", "factors")
  - Definition of what is a "MH" or "SUD" benefit must follow current ICD / DSM guidance
  - Plan may not rely upon any discriminatory factors or evidentiary standards (1/1/2026 effective date)

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NQTLs: 2-Part Test

- Standard will be "discriminatory" if it is "biased or not objective" against MH / SUD benefits
- Facts and circumstances include: reliability of information; independence of information; methodologies used to select information and consistency of application
  - Not "biased" if plan has taken steps to address it
- Historical information "from a time when the plan was … not in compliance" with MHPAEA is "biased" if it "systematically disfavor[s] access" to MH / SUD benefits
  - If almost all plans are not in compliance today, does that mean that no one can use any historical information?
- "Safe harbor" for independent fraud, waste and abuse standards

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NQTLs: 2-Part Test

- Required Use of Data Outcomes Rule (1/1/2026)
  - Plans must collect and evaluate "relevant data" in manner reasonably designed to assess impact of the NQTL on relevant outcomes related to access to MH / SUD benefits
  - And "carefully consider" the impact
  - May not disregard relevant outcomes data that it knows or reasonably should know suggest NQTL is associated with material differences in access to MH / SUD benefits compared to M / S benefits
    - Note the "squishy" terms: "associated with", "access"

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NQTLs: 2-Part Test

- What is "relevant data"? Will receive further guidance
- But regulations state it "could include, as appropriate", but is "not limited to":
  - Number and percentage of claims denials
  - Other data relevant to NQTLs required by state law or private accreditation standards
    - Must ERISA plans consider state laws? If so, which ones?
  - At a minimum, employers should review these and see what, e.g., private accreditation standards require

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NQTLs: 2-Part Test

- For network composition, "relevant data" "could" include, but not be limited to:
  - 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 (for comparable services and as benchmarked to a reference standard)

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NQTLs: 2-Part Test

- What if data is unavailable?
- If it's a new NQTL and data is "temporarily unavailable", must provide in comparative analysis "detailed explanation of the lack of relevant data", basis for plan's conclusion, when and how data will become available
- If data can never exist, provide "reasoned justification" explaining it; identify data considered and rejected; document "additional safeguards" used to ensure compliance

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NQTLs: 2-Part Test

- What if data exists; plan / TPA / PBM runs the data; but data suggests that NQTL leads to "worse" (my word) outcomes for MH / SUD benefits?
- If data "suggests" that NQTLs "contribute[]" to "material differences in access" to MH / SUD benefits, "strong indicator" that plan violates rules
- Plan "must take reasonable action" to "address the material differences to ensure compliance"
- Plan "must document the actions that have been or are being taken by the plan to address" those differences
- Bar seems pretty low: If data "suggests" that NQTL "is likely to have a negative impact on access" to MH / SUD benefits, must act
  - Squishy terms continue. Will "negative impact" be a 50% difference? 0.01% difference? Regardless, employers will ask TPAs, PBMs to "crunch the numbers"

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NQTLs: 2-Part Test

- Special rules related to network composition
- Plan must "collect and evaluate relevant data" in manner reasonably designed to assess aggregate impact of all such NQTLs on access to MH / SUD and M / S benefits
- What to do if plan identifies issues? Guidance provides examples
- Strengthen efforts to recruit and encourage broad range of MH / SUD providers and facilities to join the network
  - Can include increasing their compensation
    - How much more will this cost employers?
  - Streamline credentialing process
  - Contact out-of-network providers and (again?) ask them to join

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NQTLs: 2-Part Test

- Special rules related to network composition, continued
- Expand telehealth
- Help enrollees find in-network providers
  - Adopt more-robust assistance? Ask TPAs or other vendors if they provide this type of assistance?
- Ensure that provider directories are accurate and reliable
  - "Ghost" provider concerns
  - Likely should already be doing this (from an ERISA / CAA perspective)

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NQTLs: 2-Part Test

- Cannot have separate NQTLs that are applicable only with respect to MH/SUD benefits
  - But not required to have same NQTLs for MH/SUD and M/S benefits
- Each NQTL for MH/SUD benefits within a classification must comply with the plan as written and in operation

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Comparative Analysis Under April 2021 FAQs

- CAA did not require a change in coverage, but did add to documentation requirements of the plan
- Plans must be able to provide a comparative analysis of NQTLs if requested by the DOL or plan participants (or state regulator / CMS for non-ERISA plans)
- A specific, detailed and well-reasoned written explanation of the basis for a plan's conclusion that NQTLs comply with parity law
  - General statements without support or documentation is not enough
  - Six-step process required in 2021 – and in 2024. But the phrasing / details of the process has changed

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High-Level Comparison: 2021 v. 2024

- 2021 FAQs / MHPAEA Self-Compliance Tool

2021 Guidance	2024 Regulations	Comments
1. "Identify the NQTL"	1. Description of NQTL (a) Specific terms of plan (b) Identify all MH / SUD and M / S benefits to which NQTL applies (c) Which benefits are in which classification	Similar broad goal. But many more specific requirements under 2024 regulation
2. "Identify the factors considered in the design of the NQTL"	2. Identify and define factors and evidentiary standards used to design and apply NQTL (a) Every factor considered or relied upon (b) Define each factor (c) Steps plan taken to correct any "biased" factor (2026)	Adds "evidentiary standards". Specific requirement to "define" each factor is new

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
3. "Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL"	3. Describe how factors are used in design and application of NQTL (a) Detailed explanation of how each factor is used to determine if NQTL applies to the benefit (b) If application of factor depends on specific decision "made in the administration of benefits", nature of decisions, timing of same, professional designations and qualifications of decision maker (c) Special rules if "more than one factor" (d) Identify any "deviations or variations from a factor" or its applicability	Very different guidance. Much of it is new, or at least phrased differently. For example, concept of "variation" is mentioned in Self-Compliance Tool, but "deviation" not similarly emphasized

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
4. Are processes comparable to and no more stringently applied to MH / SUD benefits, both as written and in operation?	4. Demonstration of comparability and stringency as written (a) Document each factor used, including "quantitative data, calculations, or other analyses showing whether [NQTL] ... met or did not meet any applicable threshold identified" (b) Records maintained by plan documenting consideration and application of all factors and "results of their application" (c) For each classification, compare how NQTL is designed and applied, including "specific provisions of any forms, checklists, procedure manuals or other documentation"	

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
4. [Continued] Are processes comparable to and no more stringently applied to MH / SUD benefits, both as written and in operation?	4. [Continued] Demonstration of comparability and stringency as written (d) Documentation describing how factors are comparably applied, to determine which benefits are subject to NQTL (e) Explain reasons for any deviations or variations in application of factor, including in definition of factors, design of factors or in application of factors	Much more detail in 2024. Employers should verify if their existing MHPAEA template documents contain this level of detail. Note that all of #4 is applicable for plan years starting 1/1/2025

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
5. Comparability in operation. Although slightly unclear, appears that plan was to specifically describe whether NQTLs comparably applied "in operation"	5. Demonstrate comparability and stringency in operation (a) "Comprehensive explanation" of how plan evaluates whether, in operation, processes used for MH / SUD are comparable to, and applied no more stringently than, processes for M / S (b) Explain "any methodology or any underlying data used to demonstrate" this (c) Sample period, inputs used in any calculations, definitions of terms used, any criteria used	

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
5. [Continued] Comparability in operation. Although slightly unclear, appears that plan was to specifically describe whether NQTLs comparably applied "in operation"	5. [Continued] Demonstrate comparability and stringency in operation (d) If "relevant data" is temporarily unavailable, explain lack of data and plan's conclusions about why it is not available (2026) (e) For NQTL for which no data can reasonably assess "relevant impact" of NQTL, "reasoned justification" on why data can never exist; explain what data was considered and rejected; document additional safeguards used (2026) (f) Identify relevant data collected and evaluated (2026) (g) Document outcomes that resulted from application of NQTLs, including evaluation of relevant data and "reasoned justification" that "any differences in relevant data do not suggest … material differences in access" to MH / SUD care (2026)	

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
5. [Continued] Comparability in operation. Although slightly unclear, appears that plan was to specifically describe whether NQTLs comparably applied "in operation"	5. [Continued] Demonstrate comparability and stringency in operation (h) Detailed explanation of any material differences in access, including "reasoned explanation of any material differences in access" that are not attributable to differences in comparability or relative stringency of NQTL; if differences due to generally recognized independent professional medical or clinical standards to detect or prevent fraud and abuse, explain same (2026) (i) Discuss actions taken to address material differences, in operation; includes "reasoned explanation" of same; includes, for network composition, actions taken to address differences (2026)	Much more detail. Previously, DOL did not require any specific data analysis (e.g., percentage of time prior authorization approved for MH / SUD v. M / S benefits). Will data be calculated at "employer level"? Or "TPA level"? What if data set is limited? On network composition, preamble suggests that plans should pay MH / SUD providers more

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High-Level Comparison: 2021 v. 2024

2021 Guidance	2024 Regulations	Comments
6. Conclusion. Although slightly unclear, appeared that plan was to draw a conclusion about whether it complied with NQTL rules	6. Findings and conclusions. Comparative analysis must address findings and conclusions as to comparability of processes and their stringency. Must include: (a) Findings or conclusions that plan is or is not (or might or might not be) in compliance, along with actions plan will or has taken to address noncompliance (b) Reasoned and detailed discussion (c) Citations to any other information not included that supports findings (d) Date analysis completed (e) Title and credentials of relevant persons who participated in analysis (f) If consultant was used who is an "expert", assessment of their qualifications and extent to which plan relied upon expert's evaluation	Again, more detailed. Most comparative analyses have much of this, but some details (like "credentials") are arguably new

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Meaningful Benefits (1/1/2026)

- Regulations state that if a plan provides any benefits for MH/SUD in any classification, plan must provide "meaningful benefits" for treatment for that condition or disorder in each classification
- Would prevent a plan from providing a range of M/S benefits, but "only one limited benefit" for MH/SUD
  - E.g., will be difficult to only cover diagnosis of autism spectrum disorder, without covering treatment of same
- Who will "comb through" all MH / SUD benefits and verify that they are "meaningful"?
- What if employer does not WANT to cover some services (like full treatment for gender dysphoria)?

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Fiduciary Certification (1/1/2025)

- For plans which are subject to ERISA, a plan fiduciary would be required to certify in writing that they believe a "prudent process" was used and that they selected a "qualified service provider" to perform and document the comparative analysis
  - Fiduciary must "review" the comparative analysis; "ask questions about the analysis"; "discuss it" with service provider; "understand the findings and conclusions"; ensure that service provider "provides assurance that, to the best of its ability, the NQTL and comparative analysis complies with the requirements of MHPAEA"
- In recent webinar, DOL attorney said that there is flexibility on who "qualified service provider" would include (no specific definition)
- Puts lot of personal pressure on plan fiduciaries to ensure that everything is legally correct
- Unclear how employers with fully-insured plans will address this

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DOL Enforcement

- If DOL finds that parity has been violated (or comparative analysis is not provided or incomplete), the Plan has 45 days to take corrective action
- After 45 days, if the DOL finds that the Plan is still in violation, the Plan must notify enrolled participants of the noncompliance within seven business days
  - Standard language, 14-point font: "Attention!" HHS "has determined that plan is not in compliance" with MHPAEA. Inviting private lawsuits?
  - Plan participants can ask for a copy of comparative analysis; covered by ERISA; will attorney-client privilege help shield "unfavorable" findings?
- DOL must provide an annual report naming plans in violation
- In addition, the DOL may refer violators to the IRS, which can assess civil penalties of up to $100 per day
- DOL could bring lawsuit and prohibit use of an NQTL

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Practical Considerations

- TPAs, PBMs, employers that do not have any comparative analysis likely will need to "scramble" and put one together
  - 1/1/2025 deadline is looming
  - Could new Trump administration repeal regulations? Could Congress intervene?
- Employers should ask vendors for updated comparative analyses
- What if TPAs, PBMs, etc. won't have them finalized by first plan year that starts 1/1/2025?

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Practical Considerations

- Tough for anyone to know what data will be required, at this point
  - Will TPA be able to "crunch the numbers" for clients? Will TPAs charge for that?
  - When will DOL tell us what data is needed? ABC / Coalition letter to DOL on 10/24/2024 says guidance needed by 12/31/2024 good-faith relief will be needed
  - Letter argues that TPAs, PBMs will need at least a year to develop required data reports
- Note that no good-faith relief available yet
  - ABC / Coalition letter requests at least one year relief period

Practical Considerations

- Cost to do this work? DOL estimates an employer's cost at $50,000 - $150,000 per plan. Put it into 2025 budget?
  - TPA's cost to develop procedures: estimated $200,000 - $300,000
- Attorneys (including our law firm) do this work. When employers use same TPA or PBM we can split the cost of reviewing that vendor's comparative analysis
  - E.g., suppose 5 clients ask us to review several of ABC TPA's NQTLs and cost is $30,000. We would divide $30,000 cost by 5, so each employer would pay $6,000
  - Some pieces cannot be divided – e.g., review of employer's unique SPD
  - Contact John Barlament at 414.298.8218 or jbarlament@reinhartlaw.com for more information