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Agencies Release Long Awaited Mental Health Parity Guidance

On July 25, 2023, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (IRS), published multiple pieces of much-awaited mental health parity guidance. We will refer to the DOL, HHS, and IRS collectively as the "Agencies" in the remainder of this Alert. This guidance consists of the following:

- Proposed regulations on requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA or the "Act"), herein after referred to as the "Proposed Rule,"
- Technical Release 2023-01P (Technical Release) detailing proposed data requirements under a special rule for non-quantitative treatment limitations (NQTLs) related to network composition,
- 2023 MHPAEA Comparative Analysis Report to Congress (the "2023 Report"), and
- FY 2022 MHPAEA Enforcement Fact Sheet (Fact Sheet).

This Alert summarizes the guidance and provides insight on next steps for employers sponsoring self-insured medical/Rx plans covering mental health/substance use disorder (MH/SUD) benefits.

This Alert is also relevant for employers sponsoring fully insured plans in order to better understand why insurers may make certain plan design and administrative changes, or in situations where an employer may actually have some control over a fully insured plan's design.

Highlights

Mental health parity refresher

Medical/Rx plans providing mental health/substance use disorder (MH/SUD) benefits must satisfy certain parity requirements.

Insurers and plans must complete a comparative analysis for non-quantitative treatment limitations (NQTLs) imposed on MH/SUD benefits.

Major proposed changes*

- The rules will generally prevent a plan from excluding the key treatment for a covered MH/SUD condition.
- It will be harder for plans to require preauthorization and certain other gatekeeping requirements for MH/SUD benefits.
- The rules include new content requirements for the NQTL comparative analysis.

**The recently proposed rules are not final or enforceable*

Employer considerations

Employers should:

- Complete an NQTL comparative analysis;
- Review plan exclusions of any key treatments for covered conditions (i.e. ABA therapy for autism); and
- Pay attention to TPA opt-in/opt-out communications related to MH/SUD benefits and administration.

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Mental health parity rules at a glance

The MHPAEA has been around for many years.[1] From its enactment, there has been a flood of guidance from the Agencies addressing the Act's parity rules prohibiting plans from imposing greater restrictions on access to MH/SUD benefits than those applied to medical/surgical (M/S) benefits. The Consolidated Appropriations Act, 2021 (CAA) added additional requirements requiring certain documentation of parity between MH/SUD and M/S benefits.

General principles

The Act's parity rules apply to insurance carriers and group health plans covering MH/SUD benefits, including church plans and non-federal governmental plans, regardless of funding status.[2] MHPAEA generally provides that financial requirements and treatment limitations imposed on MH/SUD benefits cannot be more restrictive than those for M/S benefits. This includes both quantitative treatment limitations (QTLs) and NQTLs.

QTLs are numerical or financial limits, including a plan's cost sharing and visit limits for services. NQTLs involve behind-the-scenes plan administration practices, and include processes, strategies, evidentiary standards, and other factors used in determining whether a benefit should be covered (i.e. plan gatekeeping requirements, such as preauthorization/precertification, fail first protocols, and medically necessary standards).

MHPAEA's permitted classifications of benefits

We will refer to the MHPAEA's permitted classifications of benefits for parity purposes throughout this Alert. Plans must generally meet the QTL and NQTL requirements within each classification (as applicable). The permitted classifications are:

1. Inpatient, in-network (IN);
2. Inpatient, out-of-network (OON);
3. Outpatient, IN;
4. Outpatient, OON;
5. Emergency care; and
6. Prescription drugs.

The Act generally allows plans to treat outpatient office visits as a separate sub-category for both #3 and #4 separate and apart from other outpatient services.

CAA adds new requirements

Historically, QTL compliance has been high since QTLs are generally visible and their compliance requirements

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[1] MHPAEA was enacted on October 3, 2008, and amended the mental health parity provisions in ERISA §712 and parallel provisions in the Tax Code (IRC §9812) and Public Health Service Act (PHSA §2705 (now PHSA §2726)).

[2] For the most part, MHPAEA only affects medical/Rx coverage offering MH/SUD benefits and does not apply to excepted benefits or ancillary benefits (including most EAPs). However, an employer cannot avoid the parity rules by carving out the MH/SUD benefits offered under a medical plan into a separate plan. The rules will view them as a single benefits package.

are objective. By contrast, NQTL compliance has been much lower since plan administration is subjective and not clearly visible without a deep dive into a plan's administrative processes and procedures. As a result, NQTLs have been an increasing area of focus and priority for the Agencies over the years. While a comparative analysis of MH/SUD and M/S NQTLs has been a best practice over the years to ensure compliance, the CAA made documenting the comparative analysis a literal requirement.

The CAA amended MHPAEA by imposing a new administrative requirement on plans and insurance carriers subject to the parity rules. As of February 10, 2021, group health plans that impose NQTLs on MH/SUD benefits must:

- Complete a comparative analysis to identify and analyze all NQTLs placed on MH/SUD benefits; and
- Document compliance with MHPAEA by outlining how the NQTLs placed on MH/SUD benefits are no more restrictive than their M/S counterparts.

Insurance carriers and plan administrators must make this comparative analysis available to federal and state enforcement authorities upon request, and these enforcement authorities have been requesting comparative analyses since the requirement first went into effect. The 2023 Report provides a summary of recent Federal enforcement efforts.

The Proposed Rule

The Proposed Rule covers a broad range, from simply formalizing and reiterating prior Agency guidance to significantly changing the parity compliance landscape for group health plans. Please note that the Proposed Rule is not enforceable as is. The Agencies are seeking comments from stakeholders on multiple provisions. Based on those responses, it is possible the final rule will look different. When finalized, the new requirements will go into effect the first day of the first plan year beginning on or after January 1, 2025.

Below is a brief summary of the proposed provisions with the biggest potential impact on group health plans. We do not intend this Alert to address each and every provision in the Proposed Rule. A companion alert will follow with additional details once final rules appear.

Meaningful benefits

The Proposed Rule would require plans to provide "meaningful benefits" for the treatment of any MH/SUD condition covered under the plan in each classification. Whether a plan provides meaningful benefits for a particular MH/SUD condition will be determined by comparing MH/SUD coverage for that condition to benefits provided for M/S conditions in each classification.

Example

A medical plan covers Autism Spectrum Disorder (ASD) in the outpatient, out-of-network (OON) classification on a limited basis. The plan covers OON developmental evaluations for ASD but excludes coverage for all other outpatient OON treatments, including ABA therapy. At the same time, the plan covers a wide range of outpatient OON treatments for M/S conditions. This plan would fail to provide meaningful benefits for treatment of ASD in violation of MHPAEA under the Proposed Rule. Please note that this is an example of the Proposed Rule codifying the DOL's current interpretation of the parity rules.

The Proposed Rule does not define "meaningful benefits" and requests comments from stakeholders on whether it would be more practical to require plans to instead:

- Provide substantial coverage for covered MH/SUD conditions, or
- Require coverage of the primary or most frequent types of treatment used for a covered condition or disorder in each classification.

The latter option posed by the Agencies is more in line with the DOL's guidance in the 2022 Report to Congress.[3]

Separate treatment limitations

A separate treatment limitation that only applies to MH/SUD benefits and not to any M/S benefits has always been a violation of MHPAEA. While addressed in prior Agency guidance, it does not explicitly appear in the statute or existing regulations. The Proposed Rule formalizes this prohibition.

Example

A plan that requires preauthorization for ABA therapy – which is an outpatient treatment for ASD – but does not require preauthorization for any outpatient treatments for M/S conditions, would be a separate treatment limitation in violation of MHPAEA.

Sunset of MHPAEA opt-out for non-federal governmental plans

The Consolidated Appropriations Act, 2023[4] eliminated the ability of non-federal governmental plans to opt out of compliance with MHPAEA. The Proposed Rule formalizes this sunset of the opt-out and specifically provides:

- No new elections to opt out of compliance with MHPAEA can be made after December 29, 2022;
- Current opt-out elections expiring on or after June 27, 2023, may not be renewed; and
- Self-funded, non-federal governmental plans subject to multiple collective bargaining agreements with an opt-out election currently in effect and expiring on or after June 27, 2023, may be able to extend the election until the expiration of the last collective bargaining agreement.

With the non-federal opt-out of MHPAEA compliance no longer available, some non-federal governmental plans will have to comply with MHPAEA for the first time.

ERISA required disclosure

The Proposed Rule clarifies that plans must provide the comparative analysis and any plan-related information used to complete the analysis to plan participants within 30 days upon request as an ERISA plan document.[5] An ERISA plan subject to MHPAEA that fails to perform a comparative analysis – which is a trend that continues to persist (see 2023 Report Findings) – not only risks a determination of non-compliance during federal/state enforcement efforts but also fails to fulfill its ERISA fiduciary obligations.

Insurers and TPAs also on the hook: The Agencies intend to also put the burden on insurers/third-party administrators (TPAs) to provide information necessary to complete the comparative analysis by clarifying that this information constitutes documents, records, and other information that is relevant to a claimant's claim for benefits and must be provided free of charge under ERISA. Failure to provide this information to the plan or its participants/beneficiaries can result in co-fiduciary risk for the TPA. We hope this provision will address the difficulties plans have faced in getting information necessary to complete the analysis.

[3] See the 2022 MHPAEA Report to Congress, published January 25, 2022. This report addressed the Agencies view that ABA therapy is a primary treatment for ASD. Unless there are exclusions for primary treatments of other M/S diagnoses, a complete exclusion of ABA therapy would be an impermissible NQTL.

[4] See Section 1321 of the Consolidation Appropriations Act, 2023.

[5] This requirement falls under ERISA Section 104(b), which requires plans to provide certain materials (including instruments under which the plan is established or operated) to plan participants and beneficiaries upon request. Failure to produce requested documentation within 30 days of the request results in an up to $110 per day penalty, in addition to penalties for failure to meet ERISA fiduciary obligations.

New three-part test for NQTLs

The most significant of the changes under the Proposed Rule prohibits plans from applying any NQTL to a MH/SUD benefit that is more restrictive than the predominant NQTL that applies to substantially all M/S benefits in the same classification. To determine whether the NQTL (as written and in operation) is compliant, plans must apply a three-part test prior to its implementation. This requirement on its own will likely impact a plan's ability to impose certain NQTLs on MH/SUD benefits in certain classifications, as outlined in the Employer impact section.

Exceptions

NQTLs that meet certain exceptions do not have to pass the no more restrictive requirement and design and application tests described below. They are, however, still subject to the data collection and evaluation requirement. These exceptions are narrowly defined and only apply to NQTLs that:

- Impartially apply generally recognized independent professional medical or clinical standards, consistent with generally acceptable standards of care, to both MH/SUD and M/S benefits, or
- Are reasonably designed to detect, prevent, or prove fraud, waste, and abuse using objective and unbiased data.

#1 No more restrictive requirement

First, the plan would have to show that the NQTL is no more restrictive when applied to MH/SUD benefits than to M/S benefits. This requires a four-step process, which expands on the QTL and financial requirement tests and would apply them to NQTLs for the first time.

1) The plan must determine what portion of plan payments for M/S benefits is subject to an NQTL in each classification. The plan may use any reasonable method to determine expected payment amounts. Generally, this will require consideration of claims data.

2) The plan must determine whether the NQTL applies to "substantially all" M/S benefits in each classification by looking at the portion of plan payments for M/S benefits subject to the NQTL versus total payments for M/S benefits in the classification. An NQTL is determined to apply to "substantially all" M/S benefits in a classification if it applies to at least two-thirds of M/S benefits in that classification.

   If an NQTL imposed on a MH/SUD benefit does not apply to substantially all M/S benefits in a classification, the plan cannot apply it to any MH/SUD benefit in that classification.

3) If an NQTL applies to substantially all M/S benefits in a classification, the plan must next determine the "predominant" (most common or frequent) variation of the NQTL applicable to the highest proportion of M/S benefits in that classification.

4) The plan must then determine whether the "predominant" NQTL imposed on any MH/SUD benefit in that same classification is more restrictive. An NQTL would be more restrictive if it imposes conditions, terms, or requirements that limit access to MH/SUD benefits more than compared to M/S benefits in the same classification.

If an NQTL does not pass all four steps, the Proposed Rules consider it more restrictive as applied to MH/SUD benefits and prohibited under MHPAEA. If an NQTL passes all four steps, it will still need to satisfy both the design and application and data collection and evaluation tests described later in this section to comply with MHPAEA.

Example 1

A medical plan requires preauthorization for all outpatient MH/SUD provider office visits but does not require preauthorization for outpatient M/S physician office visits. The plan cannot satisfy the substantially all/predominant

test for this NQTL requirement and must drop the preauthorization requirement for MH/SUD provider office visits (or also impose the preauthorization requirement on most outpatient M/S physician office visits).

Example 2

A medical plan requires that all inpatient, in-network M/S and MH/SUD facilities must have 24-hour onsite nursing services available. In order for the plan to be able to impose this requirement on MH/SUD facilities, it must determine if the NQTL is more restrictive as applied to MH/SUD benefits.

The NQTL applies to all M/S benefits in the inpatient, in-network classification, so it automatically satisfies the 2/3 benchmark and applies to "substantially all" M/S benefits. Since there is only one variation of this NQTL, the 24-hour onsite nursing service requirement is also the "predominant" NQTL.

This medical management NQTL satisfies the *no more restrictive* requirement, since all participants would go through the same steps to access treatment at any M/S or MH/SUD facility.

#2 Design and application

The medical plan must satisfy certain design and application requirements. Under this test, the plan must demonstrate that the NQTL, both as written and in actual operation, is comparable to and not applied more stringently than for M/S benefits in the same classification.

The plan must be able to demonstrate that it did not rely on any discriminatory information in designing and/or applying the NQTL. Whatever information the plan does rely upon should take into account all relevant facts and circumstances and apply the information in an unbiased manner. The Proposed Rule mentions that relying upon historical plan data may be discriminatory if it results in less favorable treatment of MH/SUD benefits (without expanding upon that).

#3 Data collection and evaluation

The plan must collect, evaluate, and consider the impact of certain data to determine if there are any "material differences" in access to MH/SUD benefits versus M/S benefits. The Agencies do not provide a definition of "material differences" and request comments on how to define this term. If the data reveals there are material differences with respect to access to MH/SUD benefits, this is a red flag that the NQTL is not compliant with MHPAEA. This will not automatically result in a finding that the plan is out of compliance, but the Agencies may require further action to demonstrate compliance.[6]

The Proposed Rule outlines specific outcomes data that must be collected and analyzed, including:

- Number and percentage of relevant claim denials;
- Any other data relevant to the NQTLs as required by state law or private accreditation standards; and
- Additional relevant data for NQTLs related to network composition (see section below).

Special rule for network composition NQTLs

In the preamble to the Proposed Rule, the Agencies discuss their particular concerns with MH/SUD network composition issues. These include disparity between IN rates, network composition standards, and moving

[6] The plan would need to document the analysis, and all actions taken to mitigate material differences and explain why the material difference in access does not result in a violation of MHPAEA.

participants to OON providers for MH/SUD benefits because of a lack of IN providers. As a result, there is a special data collection and evaluation rule for network composition NQTLs as outlined in the Technical Release.[7]

If a plan meets or exceeds specific data-based standards providing sufficient evidence to demonstrate comparable access to IN MH/SUD providers compared to M/S providers, an enforcement safe harbor would be available. Under this safe harbor, no enforcement action would be taken against the plan for two calendar years from the date an Agency requests the analysis.[8]

Formalization of the NQTL comparative analysis requirement

The Proposed Rule incorporates the CAA comparative analysis requirements directly into MHPAEA, including formalizing the basic obligation for plans to complete a comparative analysis, the various stages of the federal/state enforcement process, and plan obligations upon findings of non-compliance. It also contains content requirements for the comparative analysis. While most of this information isn't new, there are a few notable additions.

Agency enforcement process

The most notable change in the Proposed Rule surrounds plan obligations upon final determinations of non-compliance. As outlined under the CAA, plans must disclose the Agency's determination of non-compliance to all plan participants and beneficiaries.[9] The plan must provide this notice within 7 days after receipt of the Agency's determination. The plan can deliver this electronically (the DOL'S electronic safe harbor disclosure rules apply), but it must provide a paper copy upon request.

The Proposed Rule lists the specific information the notice must include:

- The following statement prominently displayed on the first page, in no less than 14-point font:

  > *"Attention! The [Department of Labor/Department of Health and Human Services/Department of the Treasury] has determined that [insert the name of group health plan or health insurance issuer] is not in compliance with the Mental Health Parity and Addiction Equity Act."*

- Summary of the Agency's final determination of non-compliance, including any provisions or practices identified as out of compliance, any corrective actions, and information on how participants and beneficiaries can obtain a copy of the final determination of non-compliance from the plan;
- Summary of changes the plan has made as part of its corrective action plan, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits reprocessed; and
- Contact information for questions and complaints, with a statement explaining how participants and beneficiaries can obtain more information about the notice, including a phone number, email or web portal address for the plan or issuer, and contact information for the relevant enforcement agency.

Content requirements

The Proposed Rule also lists the minimum information the comparative analysis must include for each NQTL:

1) Description of the NQTL, including information related to the substantially all/predominant tests;

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[7] This data includes, but is not limited to: a) IN and OON utilization rates (including data related to provider claim submissions); b) Network adequacy metrics (including time and distance data, data on providers accepting new patients), and c) Provider reimbursement rates (including as compared to billed charges). Departments are considering aggregate collection and evaluation by TPAs for all plans and policies using the same network of providers or reimbursement rates.

[8] If there are any material changes made to network composition NQTLs during the two year-period, the enforcement safe harbor no longer applies as of the date of the change, and the plan could be subject to agency enforcement action.

[9] The plan must also provide a copy of the notice to the Secretary of Labor (or designee), any service provider involved in the claims process, and any fiduciary responsible for deciding benefit claims within the same timeframe.

2) Identification and definition of factors used to design or apply the NQTL, including a detailed description of each factor and each evidentiary standard;

3) Description of how factors are used in the design and application of the NQTL;

4) Demonstration of the comparability and stringency of the NQTL, *as written*;

5) Demonstration of the comparability and stringency of the NQTL, *in operation* (including utilization review, denial and appeal rates); and

6) Findings and conclusions – including a new requirement for ERISA plans requiring certification from at least one named fiduciary that they reviewed and understand the comparative analysis, its findings and conclusions.

With the exception of the new certification requirement for ERISA plans, the majority of the above listed content requirements are consistent with prior guidance. Ultimately, this new certification requirement for ERISA plans adds another layer of fiduciary risk for failure to comply with the comparative analysis requirement.

2023 MHPAEA Report to Congress

The 2023 Report summarizes both DOL and HHS enforcement activity. The DOL has primary enforcement authority over MHPAEA for insurers and group health plans sponsored by private employers. The Centers for Medicare & Medicaid Services (CMS), a division of HHS, has primary authority over MHPAEA enforcement for group health plans sponsored by non-federal governmental employers, and insurers in Texas, Missouri, Oklahoma, and Wyoming.

Enforcement activity

The Biden administration and DOL have repeatedly commented that MH/SUD parity is a top enforcement priority. If the Proposed Rule was not evidence enough of the Agencies' commitment to MH/SUD parity, the 2023 Report to Congress further emphasizes their commitment to this area of enforcement.

In the report, the DOL noted that it is dedicating 25% of its employee benefits enforcement resources to NQTL enforcement activity, including expansion of training and personnel in this area. The report provided a detailed description of past enforcement activity, but this Alert focuses on the Agencies' investigations and findings.

Enforcement priorities

In addition to continuing to focus their NQTL investigations on prior authorization and concurrent care review[10] requirements, provider admission standards, and reimbursement rates, the Agencies also added two new enforcement priorities for the coming year:

- Impermissible exclusions of key treatments for MH/SUD diagnoses; and
- Adequacy standards for MH/SUD provider networks.

[10] Concurrent care review requirements involve a review of ongoing care in real-time, while the participant is receiving treatment, to determine whether it is appropriate and should be covered.

These new enforcement priorities align with the concerns highlighted by the Agencies in the Proposed Rule surrounding network configuration NQTLs and the "meaningful benefit" requirement.

Deja vu? If the priority for impermissible exclusions of key treatments sounds familiar, it is because the DOL took the position that an exclusion for a key treatment for an otherwise covered MH/SUD condition is an NQTL violation if there is no comparable exclusion for M/S conditions in the Agencies' 2022 Report to Congress. The DOL had been applying that interpretation for about a year before officially writing it down in the 2022 report.

2023 Report findings

In the 2023 Report, the Agencies express their considerable frustration with continued deficiencies and claimed victory for corrective actions obtained for identified NQTL violations.

Common deficiencies

The 2023 Report highlights the ongoing general lack of preparedness by plans and insurers when the Agencies requested the comparative analysis. The Agencies did not find a single comparative analysis provided by an insurer or a plan to be sufficient. In many instances, the insurer/plan did not even start the analysis before an Agency request. In all other cases, the analysis provided was incomplete and missing key information needed for the Agency to make a determination of NQTL compliance with MHPAEA.[11]

The Agencies' frustration with insurers and plans continuing to ignore the comparative analysis requirement is clear, both in the 2023 Report and in the preamble to the Proposed Rule. The Agencies take the view that the comparative analysis requirement is no longer new, and their sympathy for unprepared plans is gone. The Agencies were clear in the 2023 Report that they intend to be quicker to issue non-compliance letters in the future rather than allowing time for unprepared plans to catch up. The enforcement statistics may look very different in the 2024 annual report.

Most common prohibited NQTLs

The Agencies uncovered dozens of prohibited NQTLs in the course of their investigations, and the most common fell into nine general categories.

Most Common NQTLs	
1. Preauthorization and precertification requirements	2. Exclusion of ABA therapy, cognitive, intensive behavioral, habilitative, or rehabilitative interventions to treat MH/SUD diagnoses
3. Concurrent care review	4. Provider billing restrictions
5. Exclusion of medication-assisted treatment or medications for opioid use disorder	6. Exclusion of nutritional counsel for MH conditions
7. Provider experience requirement beyond licensure	8. Exclusion of residential care or partial hospitalization for MH/SUD conditions
9. Prescription drug exclusions of specific treatment for certain conditions	

[11] Examples included: (i) failures to explain any differences in access to MH/SUD vs. M/S benefits; (ii) insufficient or missing data, such as claim approval and denial rates showing how the NQTL was applied in operation; and (iii) failures to provide sufficient detail on the processes used in applying the NQTL or evaluating the differences between application to MH/SUD and M/S benefits.

According to the 2023 Report, the top two categories of NQTLs were significantly more common than the remaining 7 categories.

Corrective Action

The Agencies did not get to the final non-compliance determination stage in many cases, because the insurer or plan agreed to corrective action at an earlier state of the review process. The following are examples of corrective action taken:

- Prior Authorization Requirement on Certain MH/SUD Benefits: TPA included prior authorization requirement for intensive outpatient MH/SUD benefits for its self-insured plans but no similar requirement for M/S benefits. The plan will reprocess improperly denied claims.
- ABA Therapy Exclusions: Two different plans covering ASD completely excluded ABA therapy as a covered treatment. Both plans removed the prohibited NQTL (as well as new NQTL put in place by one plan requiring review of provider notes before covering ABA therapy). The plan will reprocess improperly denied claims.

Corrective action for most NQTLs usually includes the removal or reduction in scope of the NQTL, corresponding plan amendments, a disclosure of the change to participants and beneficiaries, and reprocessing affected claims.

Employer impact

The Proposed Rule is not enforceable, but both it and the 2023 Report give an indication of the Agencies' enforcement priorities, their expectations for comparative analysis reviews, and the anticipated changes to mental health parity compliance. There are some key takeaways for employers as they look at plan design and NQTL comparative analysis compliance. Please remember that portions of the Proposed Rules are not new and merely codify the DOL's existing interpretation of the Act, such as the DOL's position that an exclusion of the key treatment for a covered MH/SUD condition is already an NQTL violation under the law.

Who needs to worry about this? Compliance with the mental health parity rules, including the NQTL comparative analysis requirement and new requirements under the Proposed Rule, falls on insurance carriers for fully insured plans and plan sponsors for self-insured plans (although compliance liability shifts to TPAs for issues solely within the TPA's control). The plan sponsor is usually the employer for most employer-sponsored coverage and the board of trustees or other governing body for multiple employer plans.

Proposed Rule considerations

Should the Proposed Rule be finalized as written, the biggest change is the new three-part NQTL test, specifically the application of the "substantially all" and "predominant" tests to NQTLs. This will have noticeable effects on a plan's ability to place certain restriction on MH/SUD benefits. For example (and as currently written), these tests would significantly affect the ability to impose preauthorization requirements on outpatient MH/SUD benefits since many plans do not broadly apply preauthorization requirements to M/S benefits.

The Proposed Rule also gives additional insight into what the Agencies are looking for when conducting comparative analysis reviews. Although the content requirements are not final, employers can use this list when completing comparative analyses in the meantime.

2023 Report considerations

It is clear that the Agencies are ramping up their enforcement efforts and intend to target plans and service providers

of all sizes. They continue to use investigative leads[12] to open investigations on plans with suspected MHPAEA violations. The DOL has also released multiple public facing communications highlighting individual rights under MHPAEA and encouraging Agency outreach to report potential violations.[13] The listed enforcement priorities and reported findings are a good indicator of the types of NQTLs the Agencies are looking for, and employers should be on the lookout for these NQTLs in their own plans to assess MHPAEA risk.

Next steps

In light of the Proposed Rule, the 2023 Report, and ongoing DOL enforcement activity, employers sponsoring self-insured plans covering MH/SUD benefits should consider taking the following steps in the near future.

1. Comparative analysis – Complete a comparative analysis for all NQTLs imposed on MH/SUD benefits under the plan (or plan options) consistent with the guidance from the Proposed Rule. The comparative analysis remains current unless and until there is a material change to NQTLs applied to MH/SUD benefits.

   Most plans will need to engage a third-party vendor to complete the analysis and coordinate with the TPA to get necessary information.

2. Review key treatment exclusions – Review the plan to determine whether there are any exclusions of the generally recognized key treatment for an otherwise covered MH/SUD condition, such as exclusions for:

   a) ABA therapy when the plan provides autism benefits,

   b) Methadone when the plan provides coverage for substance use disorders,

   c) Nutritional counseling when the plan provides benefits for eating disorders, and

   d) Residential treatment for treatment and recovery from MH/SUD conditions when the plan provides short-term inpatient benefits at secondary facilities for recovery from M/S conditions (such as rehabilitation facilities).

   The Agencies interpret these exclusions to violate the MHPAEA's NQTL rules. Plans may want to reconsider these exclusions under current plan design and consult legal counsel if they wish to keep them.

3. Look before leaping – We recommend exercising greater care and scrutiny when considering changes to MH/SUD benefits that will impose new restrictions for or reduce MH/SUD benefits. Although the Proposed Rules are not enforceable as is, it makes little sense to make plan design and/or administration changes that are inconsistent with them since the plan may have to undo those changes if the conflict remains in the final rules.

4. TPA communications – Please pay attention to TPA opt-in/opt-out communications about MH/SUD plan design and administration changes or recommendations. Correspondence from TPAs asking plans whether they want to remove or keep certain MH/SUD NQTLs is likely the result of Agency enforcement action against the TPA as an insurer for its fully insured book of business, another of the TPA's self-insured clients, or a pattern of similar enforcement activity against another insurer/TPA.

   A failure to respond or opting to keep the NQTL in question could result in future enforcement action and/or participant claims against the plan while relieving the TPA of any liability.

[12] See page 27 of the 2023 Report for a full list of where the Agencies get their investigative leads.

[13] See the DOL's blog post on their website from August 7, 2023 titled "A Proposed Rule to Make Mental Health Parity a Reality"; and EBSA's Guide to Understanding your Mental Health and Substance Use Disorder Benefits.

About the author

Kristen Gray, J.D. is an Employee Health & Benefits Senior Compliance Consultant, Manager for Marsh McLennan Agency's Compliance Center of Excellence.

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