National Association for Behavioral Healthcare

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Mental Health Parity Final Rule Promises Meaningful Implementation of Groundbreaking Law

NABH is very pleased that the U.S. Health and Human Services (HHS), Labor (DOL) and Treasury Departments' parity final rule released Sept. 9 takes major steps toward meaningful implementation of true parity between behavioral and physical healthcare coverage.

Additional sub-regulatory guidance on how to execute the complex rule is pending, and the rule's provisions will be implemented in a staged manner. Consequently, it will take some time before we can achieve actual parity nationwide and among countless health plans. Given this complexity, NABH, our members, and other partners will remain engaged with federal and state policymakers until the final rule provides meaningful parity protection.

The long-awaited rule lays the groundwork for more stringent compliance protocols and related definitions (noted below) to finally bring the *Mental Health Parity and Addiction Equity Act* to life 16 years after it was signed into law in October 2008. Responding to the 9,500 comments from stakeholders about the proposed parity rule released in July 2023, HHS, DOL and Treasury made some positive changes from their initial proposal in the final rule, which also reflects the concerns of health plans regarding the feasibility of some of the proposed rule's recommendations.

In addition, many of the changes allow for closer alignment with existing federal statute, seemingly to acknowledge the risk of legal challenges to the final rule to align with the recent U.S. Supreme Court decision in *Loper Bright Enterprises v. Raimondo*, in which the High Court overturned the 40-year-old Chevron deference doctrine.

The rule affects group health plans and group or individual health insurance coverage that cover both behavioral and physical healthcare services. In general, the main focus of the rule is to require health plans to prepare comparative analyses that assess parity compliance of their non-quantitative treatment limitations (NQTLs), including specifying the mandatory components of these analyses, and a process for publicly sharing these reports. Examples of important NQTLs include:

- "Medical management standards (such as prior authorization) limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative,
- Formulary design for prescription drugs,
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design,
- 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 services under the plan or coverage, and

- Plan or issuer methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates."

A Data-driven Approach for Demonstrating NQTL Parity Compliance

The rule requires health plans to implement a data analysis plan to assess how each NQTL impacts access to mental health (MH)/substance use disorder (SUD) care, including whether each NQTL causes "material differences" in access. In the final rule, health plans will be allowed to consider "the terms of the NQTL at issue, the quality or limitations of the data, causal explanations and analyses, evidence as to the recurring or non-recurring nature of the results, and the magnitude of any disparities." Using such analyses, NQTLs that are found to be parity non-compliant will not be implemented until they are compliant. The final rule also notes that NQTL oversight will be a collaborative process that includes working with health plans to find ways to address potential issues with compliance, rather than taking a strictly punitive approach.

Increased Compliance Transparency

Plans and issuers are required to provide all comparative analysis upon request to the three federal departments, states, and consumers experiencing treatment limitations. For self-insured employers, all beneficiaries are entitled to request the comparative analyses. These analyses must include:

- "a description of the NQTL,
- the identification and definition of the factors used to design or apply the NQTL,
- a description of how factors are used in the design or application of the NQTL,
- a demonstration of comparability and stringency, as written,
- a demonstration of comparability and stringency, in operation, and
- findings and conclusions."

More Stringent NQTL Compliance Measures

NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates. The rule addresses these NQTL issues by:

- Reinforcing that health plans and issuers cannot use NQTLs that are more restrictive than those predominantly applied to physical health benefits in the same classification.
- Disallowing implementation of new NQTLs that do not meet parity standards.
- Specifying how insurers are to measure and report on their network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.
- Concerning the design of NQTLs, prohibiting discriminatory information, evidence, sources, or standards that systematically disfavor access to behavioral healthcare benefits as compared with physical health benefits.

Mitigating the Impact of Bias in NQTL Design

The final rule prohibits the use of "discriminatory factors and evidentiary standards" in designing a NQTL. Specifically, factors are considered discriminatory if, "based on all the relevant facts and circumstances,

they systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits." For example, a seemingly neutral NQTL, but which is based on historical claims data not compliant with parity, would violate this provision of the final rule.

Generally Accepted Standards of Care (GASC)
Another important gain is the rule's requirement that health plans explain any medical necessity standards that diverge from GASC. While the parity law does not require that medical necessity guidelines align with GASC, this new requirement will bring meaningful transparency and accountability to the process of creating these extremely effective guidelines.

Standardized "Substantially All," "Treatment Limitations," and Other Elements
When determining the treatment limits of a MH or SUD benefit, the parity test to compare the coverage with relevant physical health benefits should be applied to substantially all medical/surgical benefits in that classification. HHS, DOL, and Treasury included this approach in the final rule, rather than the proposed mathematical test for "substantially all" to implement a less cumbersome option.

The rule further defines "treatment limitations" as well as "processes, strategies, evidentiary standards, and other factors." This provides greater clarity for compliance and eliminates potential loopholes. The rule also offers more specific examples of each, including specifying that the list of example non-quantitative treatment limitations (NQTLs) is meant to not be exhaustive. The final rule defines "treatment limitations" as: "Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (such as standards related to network composition), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage."

Mandates Use of Standard Clinical Identifiers
In defining MH and SUD, the rule uses the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), removing any non-clinical considerations from the definition. Importantly, this makes it clear that eating disorders and autism spectrum disorders fall within the definition of MH/SUD for parity compliance.

"Meaningful Benefits" Definition
To meet the mandatory "meaningful benefits" test, MH and SUD benefits will be compared with all benefits provided for physical health coverage in the same classification. This provision accommodates NABH's request for a final definition that can mitigate future coverage disagreements among stakeholders, including plans, providers, auditors, and the courts. A meaningful benefit includes "a core treatment," i.e., "a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice." This provides additional clarity about what is expected for coverage at every level of benefit under parity.

No "Network Adequacy" Guidance
The final rule does not include a special calculation for network adequacy, which the proposed rule suggested. In the discussion of the final rule, HHS, DOL and Treasury noted they responded to comments citing operational and legal concerns. The final rule also does not require a particular approach for analyzing data around network adequacy, such as reimbursement data.

Self-insured Employers
The final rule contains a number of considerations for self-insured employers in working with third-party administrators (TPAs) to help them achieve parity compliance with minimal additional burden. This

includes considerations about how to engage TPAs in getting required data, as well as sharing compliance reporting obligations and liability for non-compliance. The federal departments also signaled interest in continuing to work with employers to ease the burden of compliance and improve coordination with TPAs.

Opt-out Option Removed

The rule amends the sunset provision to prevent opting out of compliance with MHPAEA, as required by law, after Dec. 29, 2022, with a June 27, 2023 deadline for certain plans that are subject to collective bargaining.

Effective Dates

The deadline to implement "the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses" is Jan. 1, 2026.

For more details, please see the federal departments' joint fact sheet and news release.