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Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group
Denver, Colorado
November 18, 2024

The MHPAEA (B) Working Group of the Regulatory Framework (B) Task Force met in Denver, CO, Nov. 18, 2024. The following Working Group members participated: Jane Beyer, Chair (WA); Chrystal Bartuska, Vice Chair (ND); Crystal Phelps (AR); Stesha Hodges (CA); Cara Cheevers and Debra Judy (CO); Paul Lombardo (CT); Howard Liebers (DC); Elizabeth Nunes (GA); Andria Seip (IA); Joanna Coll (IL); Julie Holmes (KS); Mary Kwei (MD); T.J. Patton (MN); Amy Hoyt and Teresa Kroll (MO); Charles Whitehead (NC); Michelle Heaton (NH); Kyla Dembowski (OH); Landon Hubbart (OK); Lindsi Swartz (PA); Jill Kruger (SD); Daniel McAdams (TX); Julie Blauvelt (VA); Darcy Paskey (WI); Joylynn Fix (WV), and Tana Howard (WY).

1. Heard Presentations on the Final Federal Rule on Mental Health Parity

   A. Federal DOL

Beth Baum (U.S. Department of Labor—DOL) discussed the final rule, particularly the content requirements for comparative analyses. She said a recorded webinar with more information is available on the DOL's website. Baum said the final rule includes six steps for comparative analyses, with each building on the previous one. She said plans are expected to paint a detailed picture of how they comply with parity requirements and must provide, upon request, a list of all non-quantitative treatment limits (NQTLs) they apply. The first step is to describe the NQTL, but there is no need to include the entire policy. Plans must also identify all benefits the NQTL applies to and which classification they fit into. The next step is to identify and define the factors and evidentiary standards used to develop the NQTL, including sources. Plans can also use this step to describe how they cured previous discrimination in factors considered. The third step is to describe how the factors are used in the application of the NQTL, including how decisions on the NQTL are made and who makes them. Next, plans must demonstrate compliance with parity laws as written. She said this includes quantitative data or calculations used in designing and applying the NQTL, as well as forms and procedure manuals. She said the bulk of the material will be in the fifth step, a review of compliance with parity in operation. This is meant to be a comprehensive analysis, including data, documentation of outcomes, explanations of material differences in access, and discussion of reasonable steps taken in response to material differences. Baum said plans may describe a lack of data, but DOL expects this to be used only in narrow circumstances. The final step is to find and draw conclusions on whether the plan is compliant with parity laws. For Employee Retirement Income Security Act (ERISA) plans, a fiduciary must certify that they selected a provider to perform the analysis and monitor its completion.

Bartuska asked for confirmation on requirements applicable to qualified health plans (QHPs). Baum said the federal Centers for Medicare & Medicaid Services (CMS) could speak more directly to QHP certification requirements, but her understanding is that the rule applies the same standards to individual market plans as group plans. Bartuska asked about the certifications required for ERISA plans and whether states would receive copies of the certifications in cases when an ERISA plan is fully insured and thus subject to state regulation. Baum said the certification does not need to be included for non-ERISA plans, and they only need to provide copies of the comparative analysis to beneficiaries when they have an adverse benefit determination. She said sending copies to states would depend on how the comparative analysis is requested.

Seip asked whether the DOL would update its compliance guide or other resources to help state insurance regulators apply the new rules. Baum said the DOL would update its self-compliance tool as well as its next Report to Congress and is considering guidance on what data must be collected under the final rule.

B. BCBSA

Jennifer Jones (Blue Cross Blue Shield Association—BCBSA) presented concerns health plans have with the final rule. She said BCBSA shares the goal of improving access to mental health services for all Americans. She said BCBSA's plans have made investments to support this goal, including offering robust benefits and high-quality networks.

Jones said BCBSA is concerned that the latest parity rule will make it harder for patients to access care. She said the language on "no more restrictive" benefits could reduce medical management and access to higher acuity providers and remove guardrails that encourage providers to use evidence-based medicine. She said provider standards are problematic because some providers already have full panels, so bringing them in-network will not open appointments. She said the rule does not clarify what defines an NQTL, so some care management and other decision support could be treated as NQTLs. Jones identified some technical challenges with the rule. She said the timing is tight for implementation, with some going into effect in January 2025 and others in 2026. She said the departments should work to resolve ambiguity and differences in interpretation.

Jones asked for collaboration in addressing underlying barriers to mental health care, including expanding the use of non-clinical personnel, telehealth, and the pipeline of mental health providers.

C. LAC

Deborah Steinberg (Legal Action Center—LAC) spoke on behalf of NAIC consumer representatives. She provided examples of consumer barriers to care and offered suggestions to state insurance regulators for supporting consumers of mental health and substance use services and reducing the burden on them.

Steinberg said updated definitions in the rule will help include parity protections for benefits for those with autism, eating disorders, and gender dysphoria. She recommended states align their definitions because some state laws define these services as medical. She said the requirement for meaningful benefits would help ensure coverage for autism spectrum disorders (ASDs) and opioid use disorder. Steinberg said plans may look to different sources for standards of medical care than do providers or consumers. Consumer representatives recommend that states require plans to use non-profit professional societies' standards of care criteria, as five states do already. She said the updated non-exhaustive list of NQTLs and the requirement for evaluating outcomes data are very important for consumers.

Steinberg said the data show that mental health and substance use service providers are paid less than comparably trained medical/surgical professionals. She said consumers go out of network for mental health care at a much higher rate than for medical/surgical services. She said this data must be collected on a plan level. Steinberg said states should define the data elements to be collected rather than let plans decide. She encouraged states to adopt network adequacy standards, citing Maryland's standards as a good model because of their specificity. She said prohibiting discriminatory factors in developing NQTLs is an important element of the rule. She provided an example of a plan using out-of-network payment rates from 1983 to show that plans continue to use practices from before the passage of MHPAEA. She said it is critical for states to require the submission of comparative analyses on an annual basis because plan practices change each year. She said this will allow states to proactively address discriminatory plan elements. Steinberg said states should train front-line consumer assistance staff on parity red flags and allow them to forward complaints to investigators. She said consumers are

not equipped to file parity complaints themselves. She requested that the Working Group develop standardized guidance and templates incorporating the new rules.

Cheevers asked Jones about consumers who cannot find in-network providers and what incentives BCBSA plans use to attract providers to join networks. Jones said plans have quality expectations for any provider joining their network. Jones said patient volume is the primary leverage plans have to encourage providers to join. Plans can also offer providers data on their patient population. For mental health, she said plans have found ways to streamline the credentialing process and better support sole practitioners and other providers with less infrastructure. She said plans have supported integrating behavioral health into primary care to relieve burdens on behavioral health providers when patients are interested in having their conditions managed by primary care doctors.

Coll asked Jones whether plans are considering increasing payment amounts to behavioral health providers or revising requirements for payment through a third-party vendor. Jones said there are examples where plans have made substantial increases in payment to encourage providers to come in-network, but these plans have not seen significant gains in providers coming in-network. She said some plans believe there are providers who have full panels and would not choose to come in-network at any payment level.

Heaton asked Jones for an example of how the definition of NQTLs may limit the care management benefits that plans offer. Jones said that when care or case management is labeled as an NQTL, there is an expectation that it is delivered the same for behavioral health as medical and surgical services. She said this constrains the design and expansion of these programs, and care management does not function the same for medical and mental health needs.

Coll asked about plans that increased payment and did not see significant network growth. Jones said she would have to check with the plan to find more details. Beyer said that a Washington analysis using the state's all-payer claims database found that behavioral health providers were paid less than Medicare rates, on average, while primary and specialist medical providers were paid more than Medicare rates.

Having no further business, the MHPAEA (B) Working Group adjourned into regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.

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