FINAL MENTAL HEALTH PARITY RULES: A PLAN SPONSOR'S IMPLEMENTATION GUIDE

PART III: OVERVIEW OF NETWORK COMPOSITION GAPS, GHOST NETWORKS AND COMPLIANCE BEST PRACTICES

Editor's Note: This is the third installment in a three-part series. The first two installments were included as part of the March and April editions of the Self-Insurer.

Written By Alston & Bird, LLP Health Benefits Practice

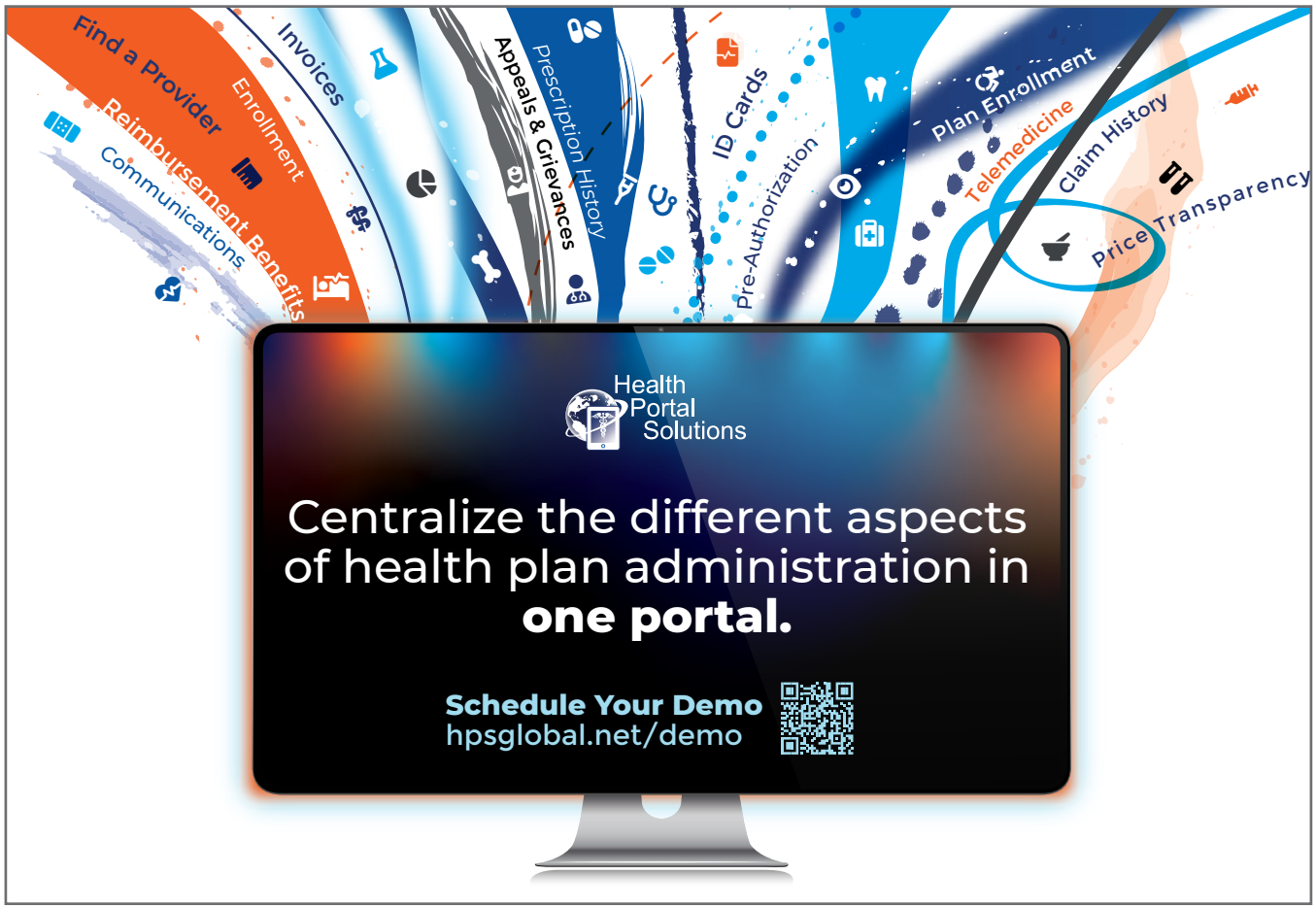
In September 2024, the U.S. Departments of Labor, Treasury, and Health and Human Services (the "Departments") issued a Final Rule under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Final Rule has a general effective date of the first day of the plan year beginning on or after January 1, 2025, though most of the requirements for completing the comparative analysis were first due as of February 10, 2021, under the Consolidated Appropriations Act, 2021 (CAA). Additional new requirements, including those related to network composition, are effective within the first plan year starting on or after January 1, 2026.

This article is the third in a three-part series designed to inform plan sponsors of self-insured plans about the key components of the Final Rule and compliance steps for satisfying regulatory requirements. In Part I, we provided a high-level overview of the essential elements of the Final Rule, focusing on the two-part test for nonquantitative treatment limitations (NQTLs). In Part II, we provided an overview of compliance action steps, timeframes, and requirements for the Final Rule in further detail and highlighted the Department of Labor's (DOL) 2024 Report to Congress, released in January 2025. In this Part III, we will home in on the network composition of NQTL and provide a high-level overview of "ghost networks," insurance directories listing inactive or nonexistent mental health providers that create the illusion of accessible care, which violates MHPAEA by creating coverage gaps within networks.

We will close by providing compliance best practices for agreements with administrative service organizations (ASOs) and third-party administrators (TPAs), as the Departments have not issued new compliance tools to date. For purposes of this article, "mental health/substance use disorder" is referred to as "MH/SUD," and "medical/surgical" is referred to as "Med/Surg."

ADDRESSING MATERIAL DIFFERENCES IN NETWORK COMPOSITION UNDER MHPAEA

One of the most challenging aspects of this Final Rule is the Departments' expectation that plans collect data on their networks and address gaps between MH/SUD and Med/Surg providers and facilities. Ideally, the Departments would like participants to be able to access a network MH/SUD provider or facility just as easily as they can access a Med/Surg provider or facility. Plans are left trying to figure out how



to "quantify" this "nonquantitative" treatment limitation based on relevant data that plans are required to collect and analyze, yet the Final Rule itself provides only a few brief data elements for this purpose (which we covered in Part I of this series). The Departments had promised additional guidance with "adequate" time for plans to prepare, but so far, no guidance has been issued, and no updates have been made to the Employee Benefits Security Administration's ("EBSA") online Self-Compliance Tool.

In addition to the data elements listed in the Final Rule itself, the Departments stated in the preamble that they would "expect" that a plan might collect and analyze data on:

- For in-network and out-of-network utilization, compare the ratio of inpatient, in-network and outpatient, in-network MH/SUD and Med/Surg claims to inpatient, out-of-network and outpatient, out-of-network MH/SUD and Med/Surg claims.
- The number of providers (or facilities) within specified MH/SUD and Med/Surg provider categories (or categories of facilities) per 1,000 participants and beneficiaries who have actively submitted claims within the past 6 months.
- Comparing MH/SUD and Med/Surg turnaround time for applications to be approved for a provider to join the plan's network as well as approval and denial rates for applications to join the network;
- Percentage of participants and beneficiaries who have access, within a specified time and distance by one (or more) in-network providers who are available to accept new patients comparing MH/SUD providers and Med/Surg providers;
- Median in-network MH/SUD and Med/Surg reimbursement rates for services with the same CPT codes;
- Median in-network reimbursement rates for inpatient MH/SUD and Med/Surg benefits, as compared to Medicare rates;

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Once a plan has collected and analyzed this data, the plan will need to address any "material differences" between MH/SUD and Med/Surg benefits by taking affirmative steps to close network gaps. In Example 10 of the Final Rule, the Departments outline the following "reasonable actions" that a plan can take, "as necessary," if the relevant data suggest that the NQTLs related to network composition, in the aggregate, contribute to material differences that are likely to have a negative impact on access to MH/SUD benefits as compared to Med/Surg benefits:

- Strengthen efforts to recruit and encourage a broad range of available providers and facilities to join the plan's network of providers, including by taking actions to
    - increase compensation and other inducements,
    - streamline credentialing processes,
    - contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network and
    - develop a process to monitor the effects of such efforts;
- Expand the availability of telehealth arrangements to mitigate overall provider shortages in certain geographic areas;
- Provide additional outreach and assistance to participants and beneficiaries enrolled in the plan to assist them in finding available in-network providers and facilities and
- Ensure that the plan's provider directories are accurate and reliable.

The plan also needs to document these efforts and include the documentation as part of its comparative analysis submission.

Even beyond the hypothetical example in the Final Rule, EBSA, in the 2024 Report to Congress, approvingly highlighted similar efforts that a plan had taken, stating that the plan was "committed to taking significant steps toward actively monitoring its network composition and filling gaps" by:

- Providing live support for participants who have difficulty finding available in-network providers.
- Providing arrangements for the plan to pay for out-of-network care when in-network providers are not available.
- Identifying network gaps through ongoing review of network composition and utilization data, including appointment wait times and out-of-network provider use.
- Taking affirmative steps to close network gaps, such as targeted provider recruitment.
- Measuring progress to close network gaps using the same data-based measures used to identify them.
- Expanding telehealth services.
- Expanding a supplemental network of substance use disorder treatment facilities.
- Soliciting proposals through the RFP process to evaluate the suitability of other networks and network administrators outside of the plan's then-current network administrator.

EBSA stated that it "applauds the plan's commitment to parity and its efforts to ensure its participants and beneficiaries have meaningful access" to MH/SUD benefits as compared to Med/Surg benefits. EBSA

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found the plan's response to be "constructive because it focused on processes, strategies, evidentiary standards, and other factors (including resources) it could control to address access disparities, rather than simply pointing to provider shortages, general arguments about market forces, or how its network administrator controlled many aspects of network composition."

GHOST NETWORKS

The Departments also expressed concern about "ghost" or phantom networks where a plan may list MH/SUD providers as being in network when they actually are not, or are unreachable by participants based on the information in a provider directory, or are not accepting new patients. The preamble includes some examples of "secret shoppers" calling MH/SUD providers listed in provider directories to see if the information was correct or whether the secret shopper could get an appointment. EBSA's survey results, as described in the DOL's 2024 MHPAEA Report to Congress, closely mirrored the findings of the Senate survey results examining the availability of MH/SUD listed providers.

Ghost networks can cause other compliance failures for ERISA employer group health plans. ERISA Section 720 requires plans to maintain an updated provider directory. If a plan participant receives otherwise covered services from a provider or facility in the directory that is not part of the network, the plan cannot impose cost-sharing greater than cost-sharing for an in-network provider or facility and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum. Plans also must establish a process to update and verify provider director accuracy at least once every 90 days and establish a protocol for responding to telephone and electronic requests about a provider's network status (and to retain communication in such individual's file for at least 2 years). The list of providers must be up-to-date, accurate, and complete (using reasonable efforts) and must be distributed

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RECENT LITIGATION

Regulators aren't the only ones enforcing compliance with network composition and provider directory requirements. Lawsuits highlighting network inadequacies and provider directories are on the rise. One recent complaint, filed on October 22, 2024, as a class action in federal court, also details the use of "secret shoppers" who purportedly discovered deficiencies in a plan's provider directory on access to MH/SUD providers (for autism and ADHD, specifically).

The complaint focuses on ghost networks and alleges that the provider directories are grossly inaccurate (secret shoppers succeeding in scheduling only seven appointments out of calls to 100 providers), leading to significant barriers to accessing mental healthcare. Plaintiffs' claims include breach of contract, deceptive acts, false advertising, violation of New York Insurance Law, fraudulent misrepresentation, and unjust enrichment. Among other things, the plaintiffs ask the court to declare the defendant's actions violate federal law, including the No Surprises Act, the Public Health Services Act, ERISA (including section 720), and the Code See Doe v. Anthem, S.D.N.Y., No. 1:24-cv-08012.

COMPLIANCE BEST PRACTICES FOR PLAN SPONSORS – ASO AND TPA AGREEMENTS

As mentioned in past installments, the Final Rule provides even more impetus to have conducted an updated, compliant comparative analysis, given that plans were required to complete a comparative analysis as of February 10, 2021. Remember, there are very short turnaround times if a department, a participant, or a beneficiary asks for this comparative analysis. Comparative analyses will need to be updated to cover these requirements, effective January 1, 2026, for calendar year plans, including requirements imposed

because of:

- The meaningful benefits standard.
- The prohibition on discriminatory information used in the design and application requirements.
- The relevant data evaluation requirements.

Agreements with service providers need to be reviewed—in particular, ASO and TPA agreements—to make sure that they are clear on the allocation of responsibilities for preparing a comparative analysis.

Plan fiduciaries should be made aware of the certification requirement and the need to engage in "a prudent process to select one or more qualified service providers to perform and document a comparative analysis."

This is also a good time to make sure that ASO/TPA agreements spell out who is responsible for quantitative treatment limitations (QTL) testing/analysis (e.g., might a qualified service provider other than the ASO/TPA prepare the analysis) and that the plan sponsor retains a copy of that testing. QTL testing does not have to be done every year but needs to be performed if there is a change in plan benefit design, cost-sharing structure, or utilization that would affect a QTL within a classification (or subclassification).

Work with your ASO or TPA to identify any areas where there may be a plan design issue with the meaningful benefits/core treatment standard, and be prepared to address those for plan years beginning in 2026. For the design and application requirements, seek verification from the TPA/ASO that they are not using any biased or discriminatory information in designing the NQTL, including historical data.

Data collection will be the most challenging aspect of the Final Rule. There are still many unknowns about the type of data that must be collected. The Final Rule is limited in the list of these requirements, but at the very least, plans should start collecting the data identified in the Final Rule as well as other relevant data suggested in the preamble and examples—especially related to the network composition NQTLs, as discussed above.

Discuss with the TPA/ASO their ability to collect and analyze the data, including whether they have the technology required for data collection. Include in the RFP proposals to evaluate the suitability of the network composition for MHPAEA. Be prepared to review and revise TPA/ASO agreements for the NQTL comparative analysis. These service provider agreements should go beyond that to address responsibilities for the meaningful benefit requirement, data collection, and whether the TPA/ASO is using any discriminatory data.

CONCLUSION

As we conclude this three-part series, we will continue to keep an eye out for the promised further clarifications and guidance from the departments on the NQTL data to be collected and analyzed and watch for developments in the courts and challenges to the Final Rule under Loper Bright or otherwise—particularly challenges to the relevant data evaluation and meaningful benefits requirements. ■

Attorneys John Hickman, Ashley Gillihan, Steven Mindy, Amy Heppner, Laurie Kirkwood, and Bria Smith provide the answers in this column. John is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley and Steven are partners in the practice; Amy and Laurie are senior members in the Health Benefits Practice; Bria Smith is an associate in the Employee Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to John at john.hickman@alston.com