

**TECHNICAL RELEASE 2023-01P****DATE: JULY 25, 2023****SUBJECT: REQUEST FOR COMMENT ON PROPOSED RELEVANT DATA REQUIREMENTS FOR NONQUANTITATIVE TREATMENT LIMITATIONS (NQTLS) RELATED TO NETWORK COMPOSITION AND ENFORCEMENT SAFE HARBOR FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS SUBJECT TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT****I. INTRODUCTION**

This Technical Release sets out principles regarding the relevant data that group health plans and health insurance issuers would be required to collect and evaluate for NQTLS related to network composition to demonstrate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) and seeks public comments to inform guidance under the notice of proposed rulemaking (NPRM) released by the Departments of the Treasury (Treasury Department), Labor (DOL), and Health and Human Services (HHS) (collectively, the Departments), entitled *Requirements Related to the Mental Health Parity and Addiction Equity Act*. The NPRM proposes amendments to the Federal regulations implementing MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021),¹ for group health plans and health insurance issuers offering group or individual health insurance coverage. The proposed rules would, if finalized, establish new requirements for group health plans and health insurance issuers offering group or individual health insurance coverage to collect and evaluate relevant data in a manner reasonably designed to assess the impact of a nonquantitative treatment limitation (NQTL) on access to mental health and substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits, and consider the impact as part of the plan's or issuer's analysis of whether the NQTL, in operation, complies with the relevant provisions of the proposed rules.² The proposed rules provide that the Departments may specify in guidance the type, form, and manner of collection and evaluation for the relevant data.

¹ In the NPRM, HHS also proposes regulatory amendments to implement the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA, adopted in the Consolidated Appropriations Act, 2023.

² Under the proposed rules, plans and issuers generally may not impose any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL applied to substantially all M/S benefits in the same classification (under proposed 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), and 45 CFR 146.136(c)(4)(i)). Additionally, plans and issuers may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to M/S benefits in the

The Departments are particularly concerned about how NQTLs related to network composition affect access to MH/SUD benefits, as these inherently impact a participant's, beneficiary's, or enrollee's access to MH/SUD providers. There is a growing disparity in reimbursement rates (as a percentage of Medicare-allowed amounts) between in-network MH/SUD providers and M/S providers.³ Additionally, participants, beneficiaries, and enrollees must utilize out-of-network providers for MH/SUD benefits significantly more often than when accessing M/S benefits.^{4,5} Given that NQTLs related to network composition impact a participant's, beneficiary's, or enrollee's access to MH/SUD benefits, the Departments are issuing this request for comments to inform future guidance related to the type, form, and manner of data required to be collected and evaluated under the proposed rules, if finalized, and operational instructions on what constitutes relevant data for such NQTLs related to network composition.⁶ This future guidance would be intended to help streamline the Departments', as well as States', review of NQTL comparative analyses and to reduce burdens for plans and issuers by setting forth a specific data-driven approach for assessing whether the NQTLs related to network composition that a plan or issuer imposes with respect to MH/SUD benefits comply with applicable requirements. To inform such guidance, this Technical Release requests comments on the application of the proposed data collection and evaluation requirements to NQTLs related to network composition. The Departments will consider whether additional guidance is necessary with respect to the application of the proposed data collection and evaluation requirements to NQTLs related to network composition.

The Departments envision that future guidance on the data collection and evaluation requirements for NQTLs related to network composition would have two components. First, the Departments intend to address the type, form, and manner of the data that plans and issuers would be required to collect and evaluate, along with other relevant data as appropriate, as part of their comparative analyses for NQTLs related to network composition if proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A) are finalized. Second, the guidance would define standards for the data elements specified by the Departments and set forth a potential enforcement safe harbor for plans and issuers that include data in their comparative analyses that demonstrate they meet or exceed all the standards with respect to NQTLs related to network composition, for a specified period of time.

classification (under proposed 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), and 45 CFR 146.136(c)(4)(ii)). The proposed rules, if finalized, would also provide an exception to the requirement for plans and issuers to collect and evaluate relevant outcomes data for NQTLs that impartially apply certain independent professional medical or clinical standards at proposed 26 CFR 54.9812-1(c)(4)(iv)(D), 29 CFR 2590.712(c)(4)(iv)(D), and 45 CFR 146.136(c)(4)(iv)(D).

³ Melek, S., Davenport, S., Gray, T. J. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement (p. 6). Milliman.

https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

⁴ *Id.*

⁵ For purposes of this document, the term "providers" should be understood to refer to both providers and facilities.

⁶ While the Departments intend to focus initially on providing more detail on relevant data for NQTLs related to network composition, the Departments may also issue additional guidance on the type, form, and manner for the data required to be collected and evaluated for other NQTLs. Until such guidance is issued or finalized, plans and issuers would still be required to comply with proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A) with respect to all NQTLs.

The potential enforcement safe harbor would, if satisfied, provide sufficient evidence to demonstrate to the Departments that participants, beneficiaries, and enrollees in the plan or coverage would have comparable access to in-network MH/SUD and M/S providers. The Departments note that they would retain authority, under their authority to investigate plans and issuers,⁷ to request additional data (not specified in the guidance), including data sufficient to analyze assertions made in a plan's or issuer's comparative analysis, or additional data if the Departments conclude that a plan or issuer has not submitted sufficient information as part of its comparative analysis.

The Departments will continue to work together to develop regulations and other interpretive guidance to assist the regulated community and other interested parties with the implementation of and compliance with MHPAEA. This Technical Release was developed in collaboration with HHS and the Treasury Department and is being issued by DOL on behalf of the Departments. The Departments invite public comment on all aspects of this Technical Release, including the specific questions included throughout the document.⁸ Please send comments via email to mhpaea.rfc.ebsa@dol.gov. To be assured consideration, comments must be received no later than October 2, 2023. All comments submitted to DOL will be shared with HHS and the Treasury Department and posted on DOL's Employee Benefits Security Administration's (EBSA) website.

II. **BACKGROUND**⁹

MHPAEA was enacted on October 3, 2008, as sections 511 and 512 of the Tax Extenders and Alternative Minimum Tax Relief Act of 2008.¹⁰ MHPAEA amended Internal Revenue Code (Code) section 9812, Employee Retirement Income Security Act (ERISA) section 712, and Public Health Service (PHS) Act section 2705 to add new requirements, including provisions to apply the MH parity requirements to SUD benefits and make further amendments to the existing parity provisions for aggregate annual and lifetime dollar limits established under the Mental Health Parity Act of 1996.¹¹ The Patient Protection and Affordable Care Act (Affordable Care

⁷ See Code section 9812(a)(8)(B)(ii); ERISA sections 504 and 712(a)(8)(B)(ii), and PHS Act sections 2723 and 2726(a)(8)(B)(ii).

⁸ To the extent that this Technical Release merely summarizes policies or proposals proposed in the NPRM, interested parties should comment on those underlying policies and proposals through the ongoing rulemaking process by submitting comments in accordance with the instructions provided in the NPRM (electronically at <https://www.regulations.gov> or via mail). In this Technical Release, the Departments are not soliciting comments on the substance of the underlying policies in the NPRM but rather only on the issues raised with respect to relevant data for NQTLs related to network composition and a potential future enforcement safe harbor related to that data.

⁹ Additional background information is included in the preamble to the proposed rules released contemporaneously with this Technical Release.

¹⁰ Division C, Pub. L. 110-343, 122 Stat. 3765 (Oct. 3, 2008).

¹¹ Under section 1251 of the Affordable Care Act and its implementing regulations at 26 CFR 54.9815-1251, 29 CFR 2590.715-1251, and 45 CFR 147.140, the requirements of MHPAEA generally apply to both grandfathered and non-grandfathered group health plans and health insurance coverage in the group and individual markets, with an exemption for small employers under Code section 9812(c), ERISA section 712(c), and PHS Act section 2726(c). Issuers of non-grandfathered individual and small group health insurance coverage are also required to comply with MHPAEA as applied through the Federal essential health benefits (EHB) requirements under 45 CFR 147.150 and

Act)¹² extended MHPAEA to apply to individual health insurance coverage and redesignated MHPAEA in the PHS Act as section 2726.¹³

The Departments share responsibility for interpretations under MHPAEA, including regulations and other guidance, which are generally developed and issued jointly to ensure consistency.¹⁴ DOL and the Treasury Department have enforcement jurisdiction over private employment-based group health plans. States have primary enforcement responsibility with respect to health insurance issuers.¹⁵ HHS enforces MHPAEA with respect to health insurance issuers offering group or individual health insurance coverage in States that elect not to enforce or fail to substantially enforce MHPAEA.¹⁶ HHS also has direct enforcement authority over non-Federal governmental plans in all States.¹⁷

The Departments published final regulations implementing MHPAEA on November 13, 2013 (2013 final regulations).¹⁸ The 2013 final regulations established six classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs. If a plan or health insurance coverage provides MH or SUD benefits in any classification of benefits, MH or SUD benefits must be provided in every classification in which M/S benefits are provided.¹⁹

The 2013 final regulations specify that the parity requirements apply to financial requirements, such as deductibles, copayments, and coinsurance; quantitative treatment limitations that are expressed numerically, such as day or visit limits; and NQTLs, which are generally non-numerical requirements that limit the scope or duration of benefits, such as prior authorization requirements, step therapy, and standards for provider admission to participate in a network, including reimbursement rates.²⁰ The 2013 final regulations provide that plans and issuers may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD

156.115(a)(3). However, because the Federal EHB requirements apply only to non-grandfathered health insurance coverage and there is an exemption in the MHPAEA statute for small employers, the requirements of MHPAEA (including as applied through the Federal EHB requirements) do not apply to grandfathered health plans offered in the small group market.

¹² Pub. L. 111-148, 124 Stat. 119 (Mar. 23, 2010).

¹³ While the Federal EHB requirements do not apply to grandfathered individual health insurance coverage, the requirements of MHPAEA apply to both grandfathered and non-grandfathered individual health insurance coverage. See PHS Act section 2726 and Affordable Care Act section 1251. See also *supra* note 11.

¹⁴ 64 FR 70164 (Dec. 15, 1999).

¹⁵ See PHS Act 2723(a)(1).

¹⁶ See PHS Act 2723(a)(2) and (b)(1)(A). Currently, HHS is responsible for enforcement of MHPAEA with respect to issuers in Texas and Wyoming. In addition, HHS has collaborative enforcement agreements with Alabama, Florida, Louisiana, Montana, and Wisconsin. These States with collaborative enforcement agreements with HHS perform State regulatory and oversight functions with respect to some or all the applicable provisions of title XXVII of the PHS Act, including MHPAEA. However, if the State finds a potential violation and is unable to obtain compliance by an issuer, the State will refer the matter to HHS for possible enforcement action.

¹⁷ See PHS Act 2723(b)(1)(B). See also the definition of non-Federal governmental plan at 45 CFR 144.103.

¹⁸ 78 FR 68240 (Nov. 13, 2013).

¹⁹ 26 CFR 54.9812-1(c)(2)(ii); 29 CFR 2590.712(c)(2)(ii); and 45 CFR 146.136(c)(2)(ii).

²⁰ 26 CFR 54.9812-1(c)(2); 29 CFR 2590.712(c)(2); and 45 CFR 146.136(c)(2).

benefits in the classification are comparable to, and are applied no more stringently than those used in applying the NQTL to M/S benefits in the same classification.²¹

On December 27, 2020, Congress enacted the CAA, 2021.²² Section 203 of Title II of Division BB of the CAA, 2021 amended MHPAEA, in part, to expressly require group health plans and health insurance issuers offering group or individual health insurance coverage that offer both M/S benefits and MH/SUD benefits and impose NQTLs on MH/SUD benefits to perform and document comparative analyses of the design and application of their NQTLs.²³ Further, plans and issuers are required to make their comparative analyses available to the Departments or applicable State authorities, upon request.²⁴ The comparative analysis requirements became effective on February 10, 2021, 45 days after the date of enactment of the CAA, 2021.

Concurrent with the release of this Technical Release, the Departments released an NPRM proposing to amend the Federal regulations implementing MHPAEA, as amended by the CAA, 2021.²⁵ The proposed rules would, if finalized, strengthen the existing MHPAEA protections and establish new requirements for plans and issuers, including with respect to the NQTL comparative analysis requirements under the new provisions added by the CAA, 2021. Proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A) would require plans and issuers, when designing and applying an NQTL, to collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to MH/SUD benefits and M/S benefits, and consider the impact as part of the plan's or issuer's analysis of whether the NQTL, in operation, complies with proposed 26 CFR 54.9812-1(c)(4)(i) and (c)(4)(ii), 29 CFR 2590.712(c)(4)(i) and (c)(4)(ii), and 45 CFR 146.136(c)(4)(i) and (c)(4)(ii).²⁶ The proposed rules further provide that the Departments may specify in guidance the type, form, and manner of collection and evaluation for the data required under the proposed rules. Specifically, under the proposed rules at 26 CFR 54.9812-1(c)(4)(iv), 29 CFR 2590.712(c)(4)(iv), and 45 CFR 146.136(c)(4)(iv):

- For all NQTLs, relevant data that a plan or issuer would be required to collect and evaluate would include, but would not be limited to, the number and percentage of relevant claims denials and any other data relevant to the NQTL required by State law or private accreditation standards.
- In addition, for NQTLs related to network composition standards, a plan or issuer would be required to collect and evaluate relevant data that would include, but would 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 (including as compared to billed charges).

²¹ 26 CFR 54.9812-1(c)(4); 29 CFR 2590.712(c)(4); and 45 CFR 146.136(c)(4).

²² Pub. L. 116-260, 134 Stat 1182 (Dec. 27, 2020).

²³ Code section 9812(a)(8)(A), ERISA section 712(a)(8)(A), and PHS Act section 2726(a)(8)(A).

²⁴ *Id.*

²⁵ See *supra* note 1.

²⁶ See *supra* note 2.

- For all NQTLs, to the extent the relevant data evaluated pursuant to proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A) show material differences in access to MH/SUD benefits as compared to M/S benefits:
 - The differences would be considered a strong indicator that the plan or issuer violates proposed 26 CFR 54.9812-1(c)(4)(i) or (c)(4)(ii), 29 CFR 2590.712(c)(4)(i) or (c)(4)(ii), and 45 CFR 146.136(c)(4)(i) or (c)(4)(ii).
 - Further, under the proposed rules, if finalized, the plan or issuer would be required to:
 - Take reasonable action to address the material differences in access as necessary to ensure compliance, in operation, with proposed 26 CFR 54.9812-1(c)(4)(i) and (ii), 29 CFR 2590.712(c)(4)(i) and (ii), and 45 CFR 146.136(c)(4)(i) and (ii); and
 - Document the action that has been or is being taken by the plan or issuer to mitigate any material differences in access to MH/SUD benefits as compared to M/S benefits, as required under proposed 26 CFR 54.9812-2(c)(5)(iv), 29 CFR 2590.712-1(c)(5)(iv), and 45 CFR 146.137(c)(5)(iv).
- Furthermore, a special rule for NQTLs related to network composition in proposed 26 CFR 54.9812-1(c)(4)(iv)(C), 29 CFR 2590.712(c)(4)(iv)(C), and 45 CFR 146.136(c)(4)(iv)(C) would provide that, when designing and applying one or more NQTLs related to network composition standards, a plan or issuer fails to meet the requirements of proposed 26 CFR 54.9812-1(c)(4)(i) and (c)(4)(ii), 29 CFR 2590.712(c)(4)(i) and (c)(4)(ii), and 45 CFR 146.136(c)(4)(i) and (c)(4)(ii), in operation, if the relevant data show material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits in a classification.
- For all NQTLs, a plan's or issuer's comparative analysis for an NQTL imposed with respect to MH/SUD benefits and M/S benefits would be required to:
 - Identify the relevant data collected and evaluated to comply with proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A);
 - Evaluate the outcomes that resulted from the application of the NQTL to MH/SUD benefits and M/S benefits, including the relevant data under proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A);
 - Provide a detailed explanation of material differences in those outcomes that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH/SUD benefits and M/S benefits and the bases for such a conclusion; and
 - Discuss any measures that have been or are being implemented by the plan or issuer to mitigate any material differences in access to MH/SUD benefits as

compared to M/S benefits, including the actions the plan or issuer is taking to address material differences in access to ensure compliance with MHPAEA.²⁷

III. DISCUSSION

MHPAEA's fundamental purpose is to ensure that participants, beneficiaries, and enrollees in group health plans or group or individual health insurance coverage who seek treatment for covered MH conditions or SUDs do not face greater barriers to accessing benefits for such conditions or disorders than they would face when seeking coverage for the treatment of a medical condition or surgical procedure. The Departments are committed to realizing this purpose and in furtherance of this goal, the Departments have made compliance with MHPAEA a top enforcement priority.

NQTLs related to network composition are an area of particular focus for the Departments. As stated earlier, to support and help implement the proposed rules, if finalized, and the Departments' oversight efforts, the Departments are outlining principles in this Technical Release and soliciting comments to inform:

- Future guidance on the type, form, and manner of the data that plans and issuers would be required to collect and evaluate, along with other relevant data as appropriate, as part of their comparative analyses for NQTLs related to network composition if proposed 26 CFR 54.9812-1(c)(4)(iv)(A), 29 CFR 2590.712(c)(4)(iv)(A), and 45 CFR 146.136(c)(4)(iv)(A) are finalized; and
- Standards for the relevant data specified by the Departments and a potential enforcement safe harbor for plans and issuers that include data in their comparative analyses that demonstrate they meet or exceed all of the standards with respect to NQTLs related to network composition, for a specified period of time.

Any future guidance would specify a prospective date by which comparative analyses would be required to include the specified data elements. This prospective applicability date would allow a sufficient period for plans and issuers to collect and evaluate the data required by the future guidance and to include an evaluation of the data in their comparative analyses for NQTLs related to network composition.²⁸

²⁷ Proposed 26 CFR 54.9812-2 (c)(5)(ii)-(v), 29 CFR 2590.712-1(c)(5)(ii)-(v), and 45 CFR 146.137(c)(5)(ii)-(v).

²⁸ As noted in the preamble to the NPRM, the requirement to perform and document comparative analyses is an independent statutory obligation that is not dependent upon a request by the Departments or an applicable State authority but is generally required for plans and issuers that cover both MH/SUD benefits and M/S benefits and impose NQTLs on MH/SUD benefits. Therefore, plans and issuers must ensure that they have performed and documented comparative analyses for their NQTLs as required by MHPAEA, including collecting and evaluating data as required under the proposed rules (if finalized) and the final future guidance, regardless of the timing of any request by the Departments. Plans and issuers must also ensure that the comparative analyses are reflective of the current terms of the plan or coverage, which may require them to update their comparative analyses, or perform and document new comparative analyses when there is a change in plan benefit design or administration, or utilization that is not reflected in the current version of comparative analyses.

Some States have adopted reporting and other requirements to enable them to evaluate how the application of certain NQTLs affects outcomes and some interested parties have also published model tools to collect this type of data.²⁹ Consistent with the purpose of MHPAEA, adopting a similar data-driven approach would help the Departments evaluate certain NQTLs to determine whether they are more restrictive with respect to MH/SUD benefits than M/S benefits. Specifically, the collection and evaluation of relevant data as part of plans' and issuers' comparative analyses would allow the Departments to better understand how plans and issuers design and apply NQTLs related to network composition and whether they comply with MHPAEA's requirements. This is particularly important to assess participants', beneficiaries', and enrollees' access to MH/SUD benefits relative to M/S benefits and to achieve the statutory goals of MHPAEA.

Accordingly, the Departments seek to identify key metrics that, if satisfied, would demonstrate that a plan's or issuer's NQTLs related to network composition do not place greater restrictions on access to MH/SUD benefits than on M/S benefits. Such an approach would permit the Departments to focus their enforcement resources in other areas where potential violations result in greater restrictions being imposed on MH/SUD benefits under the plan or coverage as compared to M/S benefits. The Departments note that whether or not a plan or issuer satisfies or attempts to satisfy the terms of the enforcement safe harbor for any NQTL related to network composition does not relieve the plan or issuer of its obligations under MHPAEA to perform and document comparative analyses of the design and application of each NQTL imposed on MH/SUD benefits, to demonstrate compliance with MHPAEA and its implementing regulations, and to provide its comparative analyses to the Departments or an applicable State authority upon request.³⁰ In addition, although States could take a similar approach to enforcement, the adoption of a Federal enforcement safe harbor would not diminish the authority of States to fully enforce MHPAEA with respect to issuers.

The Departments will carefully consider feedback received before establishing the type, form, and manner of the data collection and evaluation that would be required under the proposed rules, if finalized, and any specific standards for the potential enforcement safe harbor in future guidance.

IV. RELEVANT DATA TO BE COLLECTED AND EVALUATED WITH COMPARATIVE ANALYSES FOR NQTLs RELATED TO NETWORK COMPOSITION

In this section of the Technical Release, the Departments outline four specific types of data that they are considering requiring plans and issuers to collect and evaluate as part of their comparative analyses for NQTLs related to network composition. The Departments believe these types of data would generally be relevant for evaluating the impact of all NQTLs related to network composition on access to in-network providers of MH/SUD services in comparison to in-network providers of M/S services. The four types of data are: out-of-network utilization;

²⁹ The Appendix to this Technical Release lists several examples of these State law and interested party data tools.

³⁰ Code section 9812(a)(8)(i), ERISA section 712(a)(8)(i) and PHS Act section 2726(a)(8)(i).

percentage of in-network providers actively submitting claims; time and distance standards; and reimbursement rates. For all four specific types of relevant data, the Departments envision future guidance specifying the data would need to be collected and evaluated in the aggregate for all plans or policies using the same network of providers or schedule of reimbursement rates, as discussed further below. The Departments request detailed feedback on all aspects of these types of data (as well as the form and manner in which the data should be included in plans' and issuers' comparative analyses), to inform future guidance.

A. Out-of-Network Utilization

Plans and issuers have asserted that, in some geographic areas, the scarcity of in-network MH/SUD providers is frequently attributable to an overall shortage of MH/SUD providers that are able and willing to participate in provider networks. In some cases, this may be due to a shortage of MH/SUD providers in a geographic area. However, disproportionately high use of out-of-network MH/SUD providers by participants, beneficiaries, and enrollees, as compared to out-of-network M/S providers, is evidence that MH/SUD providers may be available in those geographic areas but joining provider networks is not sufficiently appealing to them. In such circumstances, plans and issuers may not be establishing NQTLs related to network composition for MH/SUD benefits in a manner that is comparable to, and applied no more stringently than, the manner in which standards related to network composition are established for M/S benefits.

As a result, the Departments believe that plans and issuers that impose NQTLs related to network composition should be required to collect and evaluate relevant data on the percentage of covered and submitted out-of-network claims for MH/SUD benefits as compared to M/S benefits. Specifically, if the proposed rules are finalized, the Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include data on the out-of-network utilization for M/S, MH, and SUD benefits for the following types of items and services:

- Inpatient, hospital-based services;
- Inpatient, non-hospital-based services, including inpatient rehabilitation facilities and skilled nursing facilities for M/S items and services, and non-hospital-based inpatient facilities and residential treatment facilities for MH/SUD items and services;
- Outpatient facility-based items and services, including physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, and pathology, services for M/S care provided in an outpatient facility setting; and intensive outpatient and partial hospitalization services for MH conditions or SUDs in an outpatient facility setting;
- Outpatient office visits; and
- Other outpatient items and services.

To provide enough relevant data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits as compared to M/S

benefits, the Departments are considering requiring plans and issuers to collect and evaluate relevant out-of-network utilization data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the comparative analysis was conducted. For example, for a comparative analysis conducted during a plan or policy year beginning January 1, 2026, the plan or issuer would be required to collect and evaluate data from calendar years 2023 and 2024.

The Departments are of the view these data would help with assessment of a plan's or issuer's operational compliance with respect to any NQTLs related to network composition, in part by identifying the extent to which there are material differences in out-of-network utilization for MH/SUD benefits as compared to M/S benefits (and therefore, whether participants, beneficiaries, and enrollees are able to comparably access in-network MH/SUD benefits, as compared to M/S benefits). Under the special rule in the NPRM, if finalized, material differences in access would indicate that one or more of a plan's or issuer's NQTLs related to network composition fails to comply with MHPAEA.³¹

The Departments request comments on the following issues:

- How can the Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?
- Should the Departments require plans and issuers to collect and evaluate relevant out-of-network data on specific items and services as outlined above, or should the Departments also require data on certain subsets of items and services? Should the Departments require plans and issuers to collect and evaluate relevant out-of-network utilization data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the request for a comparative analysis was made? Should the Departments consider a different look-back period for this data collection?
- Should different categories of items and services be used instead of the categories described above?
- Should out-of-network utilization data be provided in terms of the percentage of claims, number of claims, total dollar amounts of all claims, and/or something else? Why? If the data is collected in terms of number of claims, what should count as a "claim" in cases where multiple items and services are listed in one claim?
- How should the Departments control for treatment received from MH/SUD providers where no claim for benefits was made (i.e., because the participant, beneficiary, or enrollee did not submit a claim for services furnished by an out-of-network provider)? How should the Departments control for claims that are otherwise not covered or for duplicate submissions or incomplete claims?

³¹ Proposed 26 CFR 54.9812-1(c)(4)(iv)(C), 29 CFR 2590.712(c)(4)(iv)(C), and 45 CFR 146.136(c)(4)(iv)(C).

- How should the evaluation of out-of-network utilization data take geographic area into account? How should the Departments define geographic areas? Should the Departments do so in a manner that is consistent with other data elements described in this document?
- What data, if any, would be analogous to out-of-network utilization for plans or issuers that generally do not provide out-of-network benefits for non-emergency care (such as health maintenance organizations, exclusive provider organizations, and closed network plans)? If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?
- What data, if any, would be analogous to out-of-network utilization for plans or issuers that do not utilize a traditional network of providers (such as reference-based pricing plans)? If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?
- Are there other plan or benefit designs that may need additional guidance or alternatives for the relevant data on out-of-network utilization that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?
- Are there ways in which out-of-network utilization data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?
- What terminology is important for the Departments to define precisely to facilitate the collection and evaluation of out-of-network utilization data?
- Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Departments consider when specifying the out-of-network utilization data that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?

B. Percentage of In-Network Providers Actively Submitting Claims

Often a plan's or issuer's published or printed provider network directory includes providers that are not actively furnishing services to participants, beneficiaries, and enrollees in the plan or

coverage (i.e., “ghost networks”).³² While it is important for plans and issuers to disclose their full network of providers, a plan’s or issuer’s purported network may not align with the active network, or the subset of providers that are available to provide services to participants, beneficiaries, and enrollees. In cases where a plan’s or issuer’s purported network of MH/SUD providers is narrower than the active network, especially when compared to the purported and active network of medical and surgical providers, such data would help determine whether plans and issuers are establishing NQTLs related to network composition for MH/SUD benefits in a manner that is comparable to, and applied no more stringently than, the manner in which standards related to network composition are established for M/S benefits.

As a result, the Departments believe that plans and issuers that impose NQTLs related to network composition should be required to collect and evaluate relevant data on the frequency with which different types of in-network MH/SUD providers and M/S providers submitted claims for unique participants, beneficiaries, and enrollees. Specifically, if the proposed rules are finalized, the Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include both the percentage of in-network providers who submitted no in-network claims and the percentage of in-network providers who submitted claims for fewer than five unique participants, beneficiaries, and enrollees during a period. For this data element, the Departments contemplate requiring plans and issuers to collect and evaluate data for different types of providers (and make comparisons between a type of MH/SUD provider and an analogous type of M/S provider). The potential types of providers that the Departments are considering include:

- MH/SUD providers including child psychiatrists and psychologists; other psychiatrists and psychologists; psychiatric nurse practitioners; master’s level MH counselors, marriage and family therapists, independent clinical social workers, and advanced social workers; non-master’s level MH counselors; board certified SUD addiction medicine physicians; and other non-physician SUD professionals; and
- M/S providers including cardiologists; neurologists; orthopedists; pediatricians; other specialty physicians; physician primary care providers (other than pediatricians); non-physician primary care providers; and non-physician specialty providers.

To provide enough relevant data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits and M/S benefits, the Departments are considering requiring plans and issuers to collect and evaluate relevant data on the percentage of in-network providers actively submitting claims from the six full calendar months that ended 90 days prior to the month in which the comparative analysis was conducted.

³² See Ellison, K. (Feb. 19, 2022). *73 doctors and none available: How ghost networks hamper mental health care.* The Washington Post. <https://www.washingtonpost.com/health/2022/02/19/mental-health-ghost-network/> and Senate Committee on Finance. (May 3, 2023). *Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks.* <https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf>.

For example, for a comparative analysis conducted on February 1, 2026, the plan or issuer would be required to collect and evaluate data from May 1 – October 31, 2025.

The Departments are of the view that these data would help assess a plan's or issuer's operational compliance with respect to any NQTLs related to network composition, in part by identifying the extent to which there are material differences in the percentage of in-network providers actively submitting MH/SUD claims for participants, beneficiaries, and enrollees as compared to M/S claims (and therefore, whether participants, beneficiaries, and enrollees are able to comparably access in-network MH/SUD benefits, as compared to M/S benefits). Under the special rule in the NPRM, if finalized, material differences in access would indicate that one or more of a plan's or issuer's NQTLs related to network composition fails to comply with MHPAEA.³³

The Departments request comments on the following issues:

- How can the Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?
- Should the Departments require plans and issuers to collect and evaluate relevant data on the groups of MH/SUD providers or M/S providers as outlined above, or should the groups of providers be categorized differently? How should the Departments approach the required comparisons between MH/SUD providers and M/S providers for purposes of ensuring the NQTLs related to network composition comply with MHPAEA?
- Which NQTLs impact the percentage of in-network providers actively submitting claims and how should the Departments analyze these data to understand whether a plan or issuer complies with MHPAEA?
- Should the Departments also require plans and issuers to collect and evaluate data on the total number of active in-network providers per participant, beneficiary, or enrollee, in order to determine not only the percentage, but also the number of providers actively submitting claims? If so, how will this aid in evaluating compliance of NQTLs related to network composition?
- How should the evaluation of the percentage of in-network providers actively submitting claims take into account the place of service or availability of telemedicine benefits? How should the Departments define the settings in which care is provided?
- How should the evaluation of the percentage of in-network providers actively submitting claims take geographic areas into account? How should the Departments define geographic areas? Should the Departments do so in a manner that is consistent with other relevant data described in this document?

³³ Proposed 26 CFR 54.9812-1(c)(4)(iv)(C), 29 CFR 2590.712(c)(4)(iv)(C), and 45 CFR 146.136(c)(4)(iv)(C).

- Should the Departments also require plans and issuers to collect and evaluate data as part of their comparative analysis for NQTLs related to network composition on the percentage of in-network providers actively submitting claims who are accepting new patients?
- What data, if any, would be analogous to the percentage of in-network providers actively submitting claims for plans or issuers that generally do not utilize a traditional network of providers (such as reference-based pricing plans)? If there is no analogous data, would the other relevant data described in this document meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?
- Are there other plan or benefit designs that may need additional guidance or alternatives for the relevant data on the percentage of in-network providers actively submitting claims that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?
- Are there ways in which data on the percentage of in-network providers actively submitting claims is susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits, when that is not the case?
- What terminology is important for the Departments to define precisely to facilitate the collection and evaluation of data on the percentage of in-network providers actively submitting claims?
- Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Departments consider when specifying the data on the percentage of in-network providers actively submitting claims that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?

C. Time and Distance Standards

Network adequacy standards regarding the time and distance that participants, beneficiaries, and enrollees must travel to access in-network providers have traditionally been used to ensure that plans and issuers contract with a sufficient number of providers delivering a range of services to covered individuals, and that those providers are practically available based on their geographic distribution. Time and distance standards are currently used by the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage (MA) plans and qualified health plans

(QHPs) on the Federally-facilitated Exchanges (FFE), as well as by several States for Medicaid managed care plans and by some States for health insurance issuers.³⁴

The Departments are of the view that plans and issuers that impose NQTLs related to network composition should be required to collect and evaluate relevant data on the percentage of participants, beneficiaries, and enrollees that would be able to access one or more providers of specified types within a certain time and distance. Specifically, if the proposed rules are finalized, the Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include data on the percentage of participants, beneficiaries, and enrollees who can access, within a specified time and distance by county-type designation, one (or more) in-network providers within MH/SUD provider categories (including psychiatry, inpatient care, residential treatment, mobile crisis units, opioid treatment providers, child and adolescent providers, geriatric providers, eating disorder providers, and Autism spectrum disorder providers) and one (or more) in-network providers within certain M/S provider categories. The Departments envision using the same county-type designations used for MA plans and QHPs on the FFEs, including large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations.

To provide enough relevant data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits as compared to M/S benefits, the Departments are considering requiring plans and issuers to collect and evaluate relevant time and distance data for a specified period of time that ended at least 90 days prior to the date a comparative analysis is conducted. As explained below, the Departments request comment on the period of time for which plans and issuers should collect and evaluate this data.

The Departments are of the view that these data would help with the assessment of a plan's or issuer's operational compliance with respect to any NQTLs related to network composition, in part by identifying whether there are material differences in the percentage of participants, beneficiaries, and enrollees who can access one or more in-network MH/SUD providers within a specified time and distance as compared to in-network M/S providers. Under the special rule in the NPRM, if finalized, material differences in access would indicate that one or more of a plan's or issuer's NQTLs related to network composition fails to comply with MHPAEA.³⁵

The Departments request comments on the following issues:

- How can the Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers? Are there other measures, such as wait times, that should be used to determine whether NQTLs related to network composition are designed and applied in compliance with MHPAEA?

³⁴ See Assistant Secretary of Health and Human Services for Planning and Evaluation (2021). "Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing." Available at <https://aspe.hhs.gov/reports/network-adequacy-behavioral-health>.

³⁵ Proposed 26 CFR 54.9812-1(c)(4)(iv)(C), 29 CFR 2590.712(c)(4)(iv)(C), and 45 CFR 146.136(c)(4)(iv)(C).

- Should the Departments require plans and issuers to collect and evaluate the ratio of providers to participants, beneficiaries, and enrollees (also known as provider-to-enrollee ratios)? Are there models, either from Federal network adequacy or state network adequacy requirements, that could inform such a measure?³⁶
- Should the Departments incorporate as additional relevant data elements on providers accepting new patients in these time and distance standards? Do plans and issuers have the necessary information to collect and evaluate such information as part of their comparative analyses for NQTLs related to network composition?
- How should a plan or issuer determine from where a participant, beneficiary, or enrollee is traveling? How should these data account for availability and/or use of public transportation or other alternate forms of transportation?
- How can the Departments account for any difficulties that underserved and minority groups face that may not be accounted for in traditional time and distance measures?
- Should the time and distance metrics be adjusted to account for access to providers who offer telehealth services only or providers who offer telehealth in addition to in-person services in plans' and issuers' networks? If so, how?
- How should the Departments develop specific categories of MH/SUD and M/S providers for purposes of requiring plans and issuers to collect and evaluate these data as on time and distance as part of their comparative analysis for NQTLs related to network composition? Should the Departments use the categories specified in the National Uniform Claim Committee (NUCC) taxonomy to group provider and facility types as the relevant comparison groups for MH/SUD providers and M/S providers?³⁷ If so, are any variations from this taxonomy necessary for group health plans or health insurance issuers? Is there an alternate method that could be used to categorize MH/SUD providers and M/S providers?
- How should provider groups with multiple providers on staff, or where multiple providers bill under a group National Provider Identifier (NPI), be counted? Are there other unique aspects of certain provider or facility structures that the data should account for?
- Should the Departments require plans and issuers to collect and evaluate data separately for different county type designations, similar to existing CMS standards,³⁸ or some other method of accounting for different geographic areas?
- What data, if any, would be analogous to time and distance data for plans that generally do not utilize a traditional network of providers (such as reference-based pricing plans)?

³⁶ See 42 CFR 422.116; Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services (highlighting that thirteen states have adopted provider/enrollee ratios or a minimum number of providers).

³⁷ The NUCC provider taxonomy is a code set used to specify provider type for claim transactions. Further, issuers seeking QHP certification in the FFEs are required to use the NUCC provider taxonomy to categorize provider data for determining compliance with FFE network adequacy standards. For more information about the NUCC and the provider taxonomy, see <https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40>.

³⁸ For more information, see <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>.

If there is no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully represent whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?

- Are there other plan designs that may need additional guidance or alternatives for the relevant data on time and distance that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?
- Are there ways in which time and distance data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?
- What terminology is important for the Departments to define precisely to facilitate the collection and evaluation of time and distance data?
- Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Departments consider when specifying which categories of MH/SUD and M/S providers should be used for a comparative approach to examining access in terms of time and distance to MH/SUD providers that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of these methodologies?

D. Reimbursement Rates

Reimbursement rates for in-network behavioral health professionals are generally lower than for in-network M/S providers providing comparable services.³⁹ Lower reimbursement rates and high demand for services from MH/SUD providers, among other factors, contribute to the difficulty participants, beneficiaries, and enrollees have finding in-network MH/SUD providers as compared to in-network M/S providers. Where reimbursement rates are not sufficient, a plan or issuer might be unable to attract a comparable network of MH/SUD providers relative to M/S providers to ensure compliance with MHPAEA. The Departments are interested in whether such differences may signal that methodologies for determining reimbursement rates are not comparable for MH/SUD and M/S providers.

As a result, the Departments believe that plans and issuers that impose NQTLs related to network composition should be required to collect and evaluate relevant data comparing in-network

³⁹ Melek, Stephen P., Davenport, Stoddard, and Gray, T. J. (2019). "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement." Milliman. Available at <https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx..>

payments and billed charges for MH/SUD benefits and M/S benefits in the inpatient, in-network and outpatient, in-network classifications (for office visits and all other benefits), as well as the allowed amounts for specific Current Procedural Terminology (CPT) codes that are reimbursed to specific types of MH/SUD providers and M/S providers, comparing them to each other, as well as to Medicare rates (which are commonly used as a benchmark for developing in-network rates), or a similar benchmark. Specifically, if the proposed rules are finalized, the Departments are considering specifying the relevant data that plans and issuers would be required to collect and evaluate for NQTLs related to network composition which would include the following data:

- In-network payments and billed charges for inpatient MH/SUD and M/S benefits, outpatient office visit MH/SUD and M/S benefits, and all other outpatient MH/SUD and M/S benefits; and
- Allowed amounts for CPT codes 99213 and 99214 as well as CPT codes 90834 and 90837 for specific types of MH/SUD and M/S providers.

To provide enough relevant data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits as compared to M/S benefits, the Departments are considering requiring plans and issuers to collect and evaluate relevant reimbursement rate data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the comparative analysis was conducted. For example, for a comparative analysis conducted during a plan or policy year beginning January 1, 2026, the plan or issuer would be required to collect and evaluate data from calendar years 2023 and 2024.

The Departments are of the view that these data would help with the assessment of a plan's or issuer's operational compliance with respect to any NQTLs related to network composition, in part by identifying the extent to which there are material differences between in-network payments (as compared to billed charges) for MH/SUD benefits and M/S benefits and between allowed amounts, as compared to each other and to Medicare rates, for MH/SUD benefits and M/S benefits (and therefore, whether participants, beneficiaries, and enrollees are able to comparably access in-network MH/SUD benefits, as compared to M/S benefits). Under the special rule in the NPRM, if finalized, material differences in access would indicate that one or more of a plan's or issuer's NQTLs related to network composition fails to comply with MHPAEA.⁴⁰

The Departments request comments on the following issues:

- How can the Departments ensure that the data would provide a meaningful representation of whether a plan or coverage is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?

⁴⁰ Proposed 26 CFR 54.9812-1(c)(4)(iv)(C), 29 CFR 2590.712(c)(4)(iv)(C), and 45 CFR 146.136(c)(4)(iv)(C).

- Are there different or additional CPT codes than those outlined above (99213, 99214, 90834 and 90837) that would help plans and issuers evaluate their reimbursement rate structures?
- Which specific types of MH/SUD and M/S providers should be considered for purposes of the comparative analysis data collection and evaluation requirement on reimbursement rates for NQTLs related to network composition? Which types of M/S providers are the appropriate comparators to which particular types of MH/SUD providers for this purpose?
- In determining average in-network payments, average billed charges, and average allowed amounts, should the average be calculated as a mean, a median, or a mode?
- How should these data points account for non-fee-for-service payments, quality incentives, facility fees, or other similar payments that are not accounted for in reimbursement rates?
- Is the National Medicare Fee Schedule helpful to compare reimbursement rates, and if not, why not?
- How should the evaluation of reimbursement rate data requirements take geographic area into account? How should the Departments define geographic areas? Should the Departments do so in a manner that is consistent with other data elements described in this document?
- Should the Departments require plans and issuers to collect and evaluate relevant reimbursement rate data from the two most recent and complete calendar years that ended at least 90 days prior to the start of the plan or policy year during which the request for a comparative analysis was made? Should the Departments consider a different look-back period?
- What data, if any, would be analogous to reimbursement rate data for plans that do not utilize a set schedule of reimbursement rates? If there are no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?
- Are there other plan designs that may need additional guidance or alternatives for the relevant data comparing reimbursement rates that a plan or issuer would be required to collect, evaluate, and include as part of its comparative analyses for NQTLs related to network composition?
- Are there ways in which reimbursement rate data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?
- What terminology is important for the Departments to define precisely to facilitate the collection and evaluation of out-of-network utilization data?

- Which existing models or methodologies (including, but not limited to, those in the Appendix) should the Departments consider when specifying the reimbursement rate data that plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition? If there are existing methodologies, what are the advantages and disadvantages of those methodologies?

E. Aggregate Data Collection

For all four specific types of relevant data, the Departments are considering requiring relevant data to be collected and evaluated by a third-party administrator (TPA) or other service provider in the aggregate for all plans or policies, as applicable, that use the same network of providers or reimbursement rates because, in many instances, plan-level or product-level data may not reflect sufficient claims experience to provide enough data for plans and issuers to evaluate and consider the impact of an NQTL related to network composition on access to MH/SUD benefits as compared to M/S benefits. There may also be economies of scale that can be realized under an aggregate data approach for TPAs and other service providers, by limiting the number of individualized data sets that they would have to produce for the plans and issuers with which they contract. Therefore, the Departments are considering a framework for the collection and evaluation of relevant data, under which:

- Self-insured plans would work with their TPAs and other service providers, and fully insured plans and issuers would work with their service providers, if any, to obtain these data to include in their comparative analyses (in the same manner as the Departments expect them to be working currently with those entities to perform and document their comparative analyses).
- Where different plans, policies, or benefit package options use different networks of providers, plans and issuers would provide data for the network of providers they use for each plan, policy, or option.

The Departments request comments on this aspect of data collection for all four categories of data.

V. FUTURE POTENTIAL FEDERAL ENFORCEMENT SAFE HARBOR FOR NQTLs RELATED TO NETWORK COMPOSITION

If the proposed rules are finalized, the Departments would use the four types of data described above to assist with their respective reviews and evaluations of whether a plan's or issuer's NQTLs related to network composition comply with MHPAEA. More specifically, in addition to requiring the relevant data be collected and evaluated as part of a plan's or issuer's comparative analysis, the Departments intend to create an enforcement safe harbor with respect to NQTLs related to network composition for plans and issuers that meet or exceed specific data-based standards identified in future guidance. Plans and issuers that satisfy the terms of the safe harbor would not be subject to an enforcement action by the Departments under MHPAEA with respect

to NQTLs related to network composition for a period of time, that would be specified in the guidance. The safe harbor could include a variety of metrics, based on data such as 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), reimbursement rates (including as compared to billed charges), and others. The Departments expect to assess the effectiveness and operation of the potential enforcement safe harbor on an ongoing basis and would retain the ability to update or modify its terms, including the type, form, and manner of data required to qualify for the safe harbor. States would be permitted, but not required, to adopt a similar enforcement safe harbor with respect to health insurance issuers when the state is the primary regulator of MHPAEA. The Departments request detailed feedback on the principles set forth in this section of the Technical Release that would inform future guidance outlining a potential Federal enforcement safe harbor.

A. Goal of Potential Enforcement Safe Harbor

The goal of the future potential enforcement safe harbor would be to promote equal access for participants, beneficiaries, and enrollees to in-network MH/SUD benefits as compared to in-network M/S benefits. The potential enforcement safe harbor would allow plans and issuers flexibility in developing their provider networks (i.e., not requiring exactly the same number of MH/SUD and M/S providers) while ensuring access to MH/SUD benefits is comparable to access to M/S benefits. Plan and issuer practices that evade or subvert the goal of the future potential enforcement safe harbor would not satisfy the safe harbor.

B. Scope of Potential Enforcement Safe Harbor

Under the future potential enforcement safe harbor, the Departments would not take Federal enforcement action under MHPAEA for a set time period against a plan or issuer, if all of the standards established in future guidance are satisfied. The NQTLs related to network composition covered by the safe harbor would include 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 covered services under the plan or coverage.

A plan or issuer that satisfies some, but not all, the standards specified in future guidance would not be eligible for relief under this potential enforcement safe harbor. The Departments also note that this potential enforcement safe harbor would be limited to NQTLs related to network composition and would not extend to other NQTLs.

C. Applicability Period

If all of the standards set forth in a future guidance establishing the enforcement safe harbor are satisfied, the Departments would not take enforcement action against a plan or issuer with

respect to the specific NQTLs related to network composition covered by the safe harbor for a period of two calendar years from the date the comparative analysis is requested or such other time identified in future guidance. Such enforcement relief would only be available if, during the two-year or other identified period, the plan or issuer has not made a change⁴¹ in benefit design or to the processes, strategies, evidentiary standards, and other factors used to design or apply the plan's or issuer's NQTLs related to network composition to MH/SUD benefits that would additionally limit the scope or duration of those benefits (or that would increase the scope or duration of M/S benefits without comparably increasing the scope or duration of MH/SUD benefits) or substantially affect the probative value of the data submitted in the comparative analysis. If such a change was made by a plan or issuer, the enforcement safe harbor would no longer apply as of the date such a change was effective.

D. Standards for Potential Enforcement Safe Harbor

Based on comments received in response to the solicitations in this Technical Release, the Departments intend to set standards that a plan or issuer would need to meet or exceed to qualify for the potential enforcement safe harbor for NQTLs related to network composition. Consistent with the goal for this potential enforcement safe harbor, the Departments expect that these standards would set a high bar to ensure that enforcement relief is provided only to plans or issuers that clearly demonstrate, through the data provided as part of their comparative analysis, that participants, beneficiaries, and enrollees have equal access to in-network MH/SUD benefits as compared to in-network M/S benefits such that there is strong indication that a plan's or coverage's NQTLs related to network composition comply with MHPAEA. The Departments are also considering whether a phased-in approach for this enforcement safe harbor, in which plans and issuers demonstrate progress toward meeting or exceeding the standards over the course of multiple plan years, would be appropriate to establish a long-term standard for plans and issuers to achieve if they do not meet the standards, while providing them with a pathway to meet or exceed those standards from their current baselines.

E. Potential Enforcement Safe Harbor Comment Solicitation

The Departments solicit comment on whether plans and issuers would seek to utilize the future potential enforcement safe harbor in light of the continued potential for State enforcement or, for plans covered by ERISA, the private right of action for participants and beneficiaries, as well as whether States that are the primary enforcers of MHPAEA with respect to issuers would provide relief in a manner similar to a future potential Federal enforcement safe harbor based on the principles outlined by the Departments. The Departments also solicit comments on all aspects of this potential enforcement safe harbor approach, including on the following issues:

- What are appropriate specific standards, consistent with the goals of the potential enforcement safe harbor, for each of the data elements described in this document (or any

⁴¹ Any change that enhances access to covered MH/SUD services and/or providers would not affect eligibility for continued enforcement relief up to the two-year or other identified period.

other types of data suggested to demonstrate that a plan's or issuer's NQTLs related to network composition are compliant with MHPAEA and provide comparable access to MH/SUD providers as compared to M/S providers)? Are there specific standards for each of the data elements described above that other interested parties are utilizing?

- To the extent a plan or issuer falls short of satisfying all of the standards for the safe harbor, under what circumstances, if any at all, would it be appropriate to nonetheless grant relief under a future safe harbor based on demonstrated improvements in meeting those standards over a period of time? What are appropriate measures of improvement and appropriate time periods for these purposes? To what extent should plans and issuers be able to show that they have made reasonable, good faith efforts to meet the applicable standards to qualify for the potential enforcement safe harbor?
- What safeguards should the Departments consider if the potential enforcement safe harbor is extended to plans and issuers that show improvement to ensure a comparable network of MH/SUD providers relative to its network of M/S providers if the otherwise applicable standards are not met?
- What other requirements, if any, should the Departments adopt as part of the safe harbor to further protect participants, beneficiaries, and enrollees from loopholes that subvert compliance with MHPAEA, and to help ensure parity in access to MH/SUD benefits as compared to M/S benefits?

VI. COMMENT SOLICITATION

In addition to the comment solicitations above, the Departments also request comments with respect to the following topics:

- What challenges would plans and issuers face in providing the data elements the Departments are considering requiring? Are there ways to mitigate those challenges? How can the Departments best assist plans and issuers with obtaining the necessary data from TPAs and other service providers?
- Do any of the data elements potentially require information technology system changes or builds? If so, what would be the estimated cost, and what would be a reasonable timeline by which those changes or builds could be modified or created?
- What would be a sufficient period of time to allow plans and issuers to establish data collection systems and collect the data outlined above to meet the requirements of any future guidance?
- In addition to aggregate data described above, should the Departments also require plan-level data or product-level data for any of the data elements described above (including reimbursement rates)? If so, for insured plans, should the data for this data collection be provided at the plan or product level (as the terms product and plan are defined in 45 CFR 144.103)?

- What additional or different data elements should the Departments consider including in the comparative analysis data collection and evaluation requirements that are relevant when analyzing NQTLs related to network composition for operational compliance? What additional or different data elements should the Departments include to ensure that a plan has a comparable network of MH/SUD providers relative to M/S providers? Specifically:
 - Are plans and issuers currently collecting data in each of the categories described in this Technical Release? If not, are plans and issuers presently collecting other data that provide insight into the issues described in this Technical Release that could be used in lieu of or in addition to the data elements that are not already collected?
 - Do plans and issuers have access to data showing the percentage of providers in relevant service areas and categories that participate in the plan's or coverage's network of providers? Do plans and issuers make representations as to the percentage of providers in their respective market who participate in their networks?
 - Do plans and issuers that contract with facilities currently have reasonable methods to determine the number of MH/SUD and M/S providers that participants, beneficiaries, and enrollees can access through those contracted facilities?
 - Do plans and issuers currently calculate provider-to-member ratio data?
 - What types of providers and geographic areas do plans and issuers use to calculate and report the categories of data mentioned in this guidance?
- What data currently collected by States (including, but not limited to, those in the Appendix) is particularly useful to demonstrate parity in how plans and issuers establish provider networks and show that NQTLs related to network composition applied to MH/SUD benefits are comparable to, and are applied no more stringently than, such NQTLs applied to M/S benefits, or demonstrate the comparability of plans' and issuers' MH/SUD networks as compared to their M/S networks?
- How should the Departments control for differences in specialties and subspecialties that exist between M/S providers and MH/SUD providers with respect to the data elements above? What level of specificity should the Departments provide with respect to the data elements and standards?
- How should the Departments define "in-network" and "out-of-network" in the context of these data requirements?
- Would the use of the data standards for the potential enforcement safe harbor create perverse incentives that could hinder, rather than promote, MHPAEA's objectives?

- How should the Departments account for MH/SUD or M/S professional or facility shortage areas or other external factors when designing the type, form, and manner of these data elements and the standards to qualify for the enforcement safe harbor?
- How should the Departments account for regions or specialties where the care is typically provided by one dominant health care system, as compared to small practices and solo practitioners, for any or all of the data elements and standards?
- How can the Departments better specify the data, or the required statistical analysis, on these data elements plans and issuers would be required to collect and evaluate as part of their comparative analyses for NQTLs related to network composition?
- Should the Departments require plans and issuers to utilize any particular format in including these data elements and standards? Are there particular templates that plans and issuers currently use and could rely on?

APPENDIX

The Departments are aware that several private organizations and States have already taken steps to develop reporting requirements capturing specific data that reflect how the application of certain NQTLs affect outcomes.⁴² The Departments acknowledge the important work that is underway in this space and welcome opportunities to help inform future guidance through the consideration of the related work of these organizations and States, and the lessons learned from their frameworks and tools. Therefore, the Departments solicit comment on how existing models or methodologies could inform future guidance specifying the data that plans and issuers would be required to collect and evaluate as part of their comparative analyses, including but not limited to, the following:

1. Bowman Family Foundation, Mental Health Treatment and Research Institute, LLC: Model Data Request Form (MDRF) – https://mhtari.org/Model_Data_Request_Form.docx
2. The Kennedy Forum: The “Six Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements – https://s3.amazonaws.com/pjk-wp-uploads/www.paritytrack.org/uploads/2017/09/six_step_issue_brief.pdf
3. Maryland: Md. Code, Ins. § 15-144 – reporting documents available at: <https://insurance.maryland.gov/Consumer/Pages/workgroups.aspx>
(Click on Mental Health Parity Workgroup link)
4. New Mexico: Senate Bill 273 (effective January 1, 2024) – reporting documents available at: <https://www.osi.state.nm.us/pages/bureaus/mcb/resources/mental-health-parity>
5. Pennsylvania: 40 Pennsylvania Consolidated Statutes §§ 908-14b and 4301-4304 – reporting documents available at: <https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/MentalHealthParityGuidance.pdf>
6. Texas: 28 TAC Chapter 21, Subchapter P, Division 2, §§ 21.2421-21.2427 – reporting documents available at: <https://www.tdi.texas.gov/health/hb10.html#:~:text=Division%20of%20TDI's%20parity,gov%20by%20July%201%2C%202023>
7. Washington: Second Market Scan

⁴² The Departments are providing links to these resources for reference only; linking to a non-United States Government website does not constitute an endorsement by the Departments or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.