Compliance Alert

March 9, 2021

Group Health Plan Transparency Rule and New Enhancements to Mental Health Parity and Addiction Equity Act

Transparency Rule:

The Transparency in Coverage final rule (the Transparency Rule) released by the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (the Departments) delivers on former President Trump's executive order on Improving Price and Quality Transparency in American Healthcare to Put Patients First. This final rule is a historic step toward putting health care price information in the hands of consumers and other stakeholders, advancing the Administration's goal to ensure consumers are empowered with the critical information they need to make informed health care decisions. The Administration previously issued requirements effective 1/1/2021 for hospitals to disclose their standard charges, including negotiated rates with third-party payers, in order to give patients access to hospital pricing information. The requirements in the Transparency Rule build upon the hospital requirements to provide consumers the tools needed to access pricing information through their health plans.

The requirements of the Transparency Rule for health benefit plans* are included below.

Public Disclosure

Plans will be required to make available to the public via a website, three separate machine-readable files that include detailed pricing information as follows:

1. Negotiated rates for all covered items and services for in-network providers.
2. Historical payments to, and billed charges from, out-of-network providers.
3. In-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level.

Plans must display these data files in a standardized format and provide monthly updates.
The files are required to be made public for plan years that begin on or after January 1, 2022.

Individual Disclosure

Plans will be required to make available to participants, beneficiaries and enrollees (or their authorized representative), through an internet-based self-service tool and in paper form upon request, personalized out-of-pocket cost information and the underlying negotiated rates for all covered health care items and services, including prescription drugs

For plan years that begin on or after January 1, 2023: An initial list of 500 shoppable services as determined by the Departments will be required to be available.

For plan years that begin on or after January 1, 2024: The remainder of all items and services will be required to be available.

* Rule applies to fully-insured and self-insured group health plans, HMOs and individual health insurance issuers subject to the ACA health insurance reforms. HRAs, FSAs, grandfathered plans, excepted benefits (such as vision and dental coverage, long-term care insurance), and stand-alone retiree health plans are exempt.

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Implementation

HPI is currently reviewing the requirements, assessing technical capabilities, and reaching out to our external vendor partners to determine our next steps in collecting and building the data needed to develop web-based tools to assist your plan in complying with both the public and individual disclosure requirements. We will update you as our progress on this initiative progresses. As with any type of major federal legislation, additional federal guidance on this issue will be released and HPI will also continue to update you as new or evolving guidance is issued.

Mental Health Parity and Addiction Equity Act:

The federal Consolidated Appropriations Act 2021 ("the Act") addresses new enhancements to the Mental Health Parity and Addiction Equity Act (MHPAEA) for group health plans that offer both medical and surgical benefits and mental health or substance use disorder (MH/SUD) benefits that impose non-quantitative treatment limitations (NQTLs) on MH/SUD benefits. The Act requires plans and issuers to perform and document comparative analyses of the design and application of NQTLs, upon request, to the secretaries of the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury (Treasury).

Examples of NQTLs on MH/SUD benefits include, but not limited to:

- Medical management standards
- Prior authorization or ongoing authorization requirements
- Concurrent review standards
- Formulary design for prescription drugs
- Step therapy protocols
- Standards for providing access to out-of-network providers
- Exclusions based on failure to complete a course of treatment
- Standards for provider admission to participate in a network, including reimbursement rates

The Act does not provide any guidance on how the comparative NQTL analysis should be conducted, or what information it must contain. The secretaries are required to issue guidance within 18 months of the date the Act was signed into law (by late June 2022). In the meantime, the DOL has issued a *Self-Compliance Tool* found at www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf which plans can use to conduct the analysis. The Tool not only covers the analysis of the NQTL's, but addresses all of the MHPAEA requirements (which the Act has not modified) including the Financial and Quantitative requirements. The agencies have issued the *Tool* for plans to use as a good faith effort to evaluate compliance with the entirety of the MHPAEA, correct any areas to bring the plan into compliance and document the results and actions taken.

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HPI currently reviews our client's plans for compliance with the MHPAEA and we make recommendations, as applicable, to generate results which comply with the intent of the MHPAEA to treat coverage of mental health and substance abuse services substantially the same as coverage of medical and surgical services. While the regulations include a complex actuarial analysis to confirm parity for mental and substance abuse Financial Requirements and Quantitative Treatment Limits, HPI's third party administrative services do not include actuarial services and HPI does not conduct the complex testing procedure suggested. It is our understanding that when coverage for mental health and substance abuse is set at the same levels as those that apply to substantially all other covered medical and surgical services (e.g., for the treatment of cancer, heart disease, influenza, etc.), the testing will not result in a contrary result. However, the *Self-Compliance Tool* does account for actuarial testing and would most likely be requested from the agencies if a client were asked to provide their analysis of their MH/SUD benefits under their Plan.

In order to assist our clients with their completion of the *Self-Compliance Tool*, HPI is reaching out to our external vendor partners and actuarial firms to determine the services such entities could provide upon request, as well as the cost for their services. We will update you as our discussions evolve. In the meantime, if you have any questions about the MH/SUD benefits under your Plan, please feel free to reach out to your HPI Account Services Team.

Please note that HPI is working diligently with our partners and other entities to find solutions for compliance with the Transparency Rule and Mental Health Parity requirements and we know how important these regulations are to our clients. In the interest of time, we are providing the information in this Alert to you now and we will follow up with an FAQ. If you have any questions, please feel free to reach out to your HPI Account Services Team.