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Provider networks in an era of mental health parity enforcement

by Tricia A. Beckmann, Zach Snyder, and Kacey B. Dugan

As most compliance professionals can attest, compliance with federal or state mental health parity laws is one of the most challenging, multidisciplinary efforts. As regulators step up enforcement, provider network issues—including so-called "ghost" or "phantom" networks—are brought to the forefront. It is important for compliance professionals to understand how these enforcement areas relate to one another and be prepared to devote more attention to provider directory verification and mental health and substance use disorder treatment access.

Brief overview of MHPAEA

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage. The financial requirements and quantitative treatment limits that apply to mental health or substance use disorder (MH/SUD) benefits must be no more restrictive than the predominant financial requirements applied to substantially all medical/surgical (physical health) benefits covered by the plan.[1]

In addition, nonquantitative treatment limitations (NQTLs) affect the scope or duration of benefits under the plan and are not expressed numerically. Specifically, any processes, strategies, evidentiary standards or other factors used in applying an NQTL to MH/SUD benefits must be comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical (M/S) benefits.[2] Approximately 270 unique NQTLs were identified since February2021 by the U.S. Department of Labor (DOL), according to its 2023 MHPAEA Report to Congress.[3] Importantly, provider network NQTLs are well-recognized and comprise two of six areas of focus for DOL's NQTL enforcement priorities; specifically, standards for provider admission to participate in a network, including reimbursement rates, and adequacy standards for MH/SUD provider networks.[4]

How network issues affect parity

Given the complex nature of the analysis needed to apply the MHPAEA requirements, NQTLs have posed the biggest challenge. For example, DOL has stated that a network with far fewer MH/SUD providers is a "red flag" that could signal an impermissible NQTL.[5] Yet, a disparity in numbers alone is not determinative of compliance under current regulations. Rather, what matters is how plans develop admission standards and maintain providers in its network—both on paper and in operation—that is, the *process, strategy, evidentiary standards, or other factors* for building and maintaining the network. Similarly, a difference in provider reimbursement rates is not determinative of compliance. Instead, what matters is *how* the health plan determines rates and, particularly, the incentives used to increase network participation.

To understand how network issues can trigger MHPAEA investigations, the following excerpt from the 2022 MHPAEA Report to Congress illustrates this point:

> [DOL's] Boston Regional Office received a complaint from a group health plan participant who was having difficulty finding an in-network mental health provider. The participant stated that the list of participating providers offered by the insurer was inaccurate; when she called the providers on the list, she discovered that many of them were no longer participating providers or they had moved out of the area. The benefits advisor referred the complaint for investigation.[6]

How parity issues impact networks

Conversely, the sheer breadth and interconnectedness of a typical audit or market conduct exam involving MHPAEA inevitably expose a plan's network to additional scrutiny of both provider directory accuracy and network adequacy, which, as described below, are increasingly regulated in their own rights. Under the federal MHPAEA law, the primary enforcement remedy to date is the re-adjudication of relevant claims and a corrective action plan to prevent improper conduct in the future. Yet, below the surface, this remedy can impact a health plan's networking strategy writ large. When a parity violation exists across many plans or TPA businesses, providers may change their networking strategies across the board, positively or negatively for a plan. For example, if a provider receives increased reimbursement from one payer, it might close its panel or refuse to contract with another payer with lower rates. On the other hand, a plan might lower its barriers to credentialing (e.g., remove an experience level or training criterion), thereby making it easier for a provider to join or continue to participate in the network.

To give another real-world example of how parity issues impact provider networks, the Rhode Island insurance department conducted a market conduct exam in 2022 for a health insurer's fully insured individual and group insurance markets.[7] The state found the insurer failed to provide oversight, training, or auditing over its behavioral health delegated vendor regarding directory updates, nor did it maintain sufficient network data oversight to identify inadequacies as required. The examiner found 31 demographic changes during the examination period, and 141 address and tax identification number changes during the examination period were completed *after* the seven-business-day period required by state law.[8] Moreover, without citing a specific black letter law violation, the state expressed "concern" that the insurer's time and distance standards for MH/SUD benefits were less favorable than for primary care, OB/GYN and specialty providers. The state also cited the insurer for a violation of the state's access standards for MH/SUD urgent care and emergency services that were less favorable than for M/S urgent care and emergency services, in violation of state law.[9]