The ERISA Edit: Long-Awaited Rules on Mental Health Parity Announced

Employee Benefits Alert
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Tri-Agencies Propose Rules on Mental Health Parity, Issue Report to Congress

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) was intended to ensure that benefits coverage for mental health and substance use disorders is designed and provided to participants, beneficiaries and enrollees in covered health insurance and health plans in parity with coverage for medical and surgical conditions. When Congress amended MHPAEA in 2020, it required plans and issuers to perform and document certain non-quantitative treatment limitation (NQTL) comparative analyses. Since then, however, there has been confusion about what these NQTLs comparative analyses should contain and about the parity obligation more generally.

On July 25, 2023, the Departments of the Treasury, Labor, and Health and Human Services (the Tri-Agencies) made public Proposed Rules to amend the existing NQTL and other MHPAEA parity standards, as well as a related Technical Release. The Proposed Rules would, among other things:

- Require plans and issuers to collect and evaluate relevant data in a manner reasonably designed to assess the impact of NQTLs on access to mental health and substance use disorder benefits and medical/surgical benefits, and would set forth a special rule regarding network composition
- Amend existing examples and add new examples on the application of the rules for NQTLs to clarify and illustrate the protections of MHPAEA
- Set forth the content requirements for NQTL comparative analyses and specify how plans and issuers must make these comparative analyses available to the Tri-Agencies.

The Tri-Agencies also released their long-awaited MHPAEA Comparative Analysis Report to Congress. When Congress amended MHPAEA in 2020, it required plans and issuers to provide their NQTL analyses to the Tri-Agencies, which must then report to Congress annually on the results of their MHPAEA enforcement activities. Accompanying the Report are an Enforcement Fact Sheet and an Appendix to the Fact Sheet. A News Release covers both the regulations and the report. Comments to the Proposed Rules are due 60 days after they are published in the Federal Register, which has not yet occurred.

We are reviewing these materials and will certainly have more to say in upcoming editions of *The ERISA Edit*. Also stay tuned for details on a Miller & Chevalier webinar dedicated to these issues.

Health Plan Participants Lack Standing in Suit Challenging Rebate Allocations

Last week, the U.S. District Court for the District of New Jersey dismissed a putative ERISA class action filed by two participants in a health plan sponsored by MetLife Group, Inc. (MetLife). *Knudsen v. MetLife Group, Inc.*, No. 23-cv-426 (July 18, 2023, D.N.J.). The named plaintiffs claimed that the plan earned $65 million in prescription drug rebates between 2016 and 2021 and that MetLife allegedly wrongfully paid the rebates to itself for its own benefit. The plaintiffs asserted that, had MetLife not mismanaged the plan and had it instead allocated the rebates properly (*i.e.*, to the plan), MetLife "may have reduced co-pays and co-insurance for pharmaceutical benefits" and "may have distributed rebates to participants in proportion to their contributions to the Plan." The plaintiffs claimed that, instead, they were deprived of distributions or paid excessive amounts towards the cost of coverage, co-pays, and/or co-insurance.

Relying in part on the Supreme Court's decision in *Thole v. U.S. Bank N.A.*, 140 S.Ct. 1615, 1620 (2020), the District Court dismissed the four-count complaint, holding that the named plaintiffs lacked Article III standing because they failed to allege a concrete individual harm. The court concluded that the plan was analogous to a defined benefit plan like the one at issue in *Thole* and plaintiffs therefore had no claim to any particular asset that composes a part of the plan's general asset pool, including the rebates at issue. Moreover, the plaintiffs did not allege that they did not receive their promised benefits; instead, they "allege[d] that they paid excessive out-of-pocket costs, which in the context of this kind of defined-benefit [p]lan, is not an individual injury." Finally, the court found that even if plaintiffs were to succeed and the rebate-related funds were deposited back into the plan, "whether each participant's costs would be reduced or distributions would be paid out" was speculative and conclusory.

In sum, the plaintiffs lacked a "concrete stake in the outcome of [the] lawsuit." Because each of their claims for equitable and monetary relief had the same factual predicate and alleged injury, all their claims failed for lack of standing. *Knudsen* is one of a growing number of cases where courts have relied upon *Thole* when ruling that participants lacked standing to pursue their ERISA claims against health plans. *See Winsor v. Sequoia Benefits & Ins.*, No. 21-16992 (9th Cir. Mar. 8, 2023) and *Smith v. UnitedHealth Group, Inc.*, No. 22-cv-1658 (May 5, 2023, D. Minn.). *Thole* may continue to be an obstacle to plan participants seeking to challenge high or hidden service provider fees when benefits are paid in accordance with plan terms.

Feds Ask Employers and Issuers to Extend Health Plan Special Enrollment Periods

In a July 20, 2023 letter, the Centers for Medicare and Medicaid Services (CMS), along with the Departments of Treasury and Labor, asked employers, plan sponsors, and issuers to voluntarily extend their health plans' special enrollment period beyond the minimum 60-day period required by statute for individuals who have lost or will lose health benefits coverage through Medicaid and the Children's Health Insurance Program (CHIP) anytime between March 31, 2023 and July 31, 2024. During the COVID-19 public health emergency, most Medicaid and CHIP coverage terminations were paused under the Families First Coronavirus Response Act (FFCRA) but resumed on March 31, 2023. As a result, states have started to review eligibility under regular program enrollment standards and to terminate coverage for individuals, including children, who are found no longer eligible.

Recent press reports indicate that between 8 million and 24 million people will lose Medicaid coverage now that terminations are no longer paused, and it is anticipated that large numbers of those coverage losses will result from enrollees' failure to receive state notices sent to old addresses or their untimely or incomplete submission of renewal applications. A recent government study projects that approximately 3.8 million individuals who lose Medicaid coverage will be eligible for employment-based coverage.

Earlier this year, CMS announced a temporary Marketplace special enrollment period to enable qualified individuals and their families who lose Medicaid or CHIP coverage post-FFCRA to enroll in Marketplace health insurance coverage outside of the annual open enrollment period. According to the agency, exceptional circumstances surrounding the resumption of Medicaid and CHIP renewals for the first time in three years warrant the extended enrollment periods. For example, CMS states that individuals may not realize that they lost Medicaid or CHIP coverage until they try to access care, having missed notices from their state agencies.

The July 20 letter also encourages employers and their human resources personnel to offer information and assistance to employees transitioning to employment-based coverage.

FTC Cautions Against Reliance on Its Prior PBM Advocacy

On July 20, 2023, the Federal Trade Commission (FTC) voted unanimously to issue a statement that cautions against reliance on its prior advocacy and reports relating to the pharmacy benefit manager (PBM) market. The 11 advocacy letters and reports at issue, which are listed in the statement, were issued between 2004 and 2014 and reflect the FTC's thinking at the time that state and federal proposals to increase PBM transparency could undermine competition. According to the FTC's June 20 statement, the PBM industry has changed significantly with increased vertical integration and horizontal concentration, increases in rebates, list prices, and Medicare fees, and the expiration of certain consent orders involving pharmaceutical companies. The FTC states that it

has been tracking these developments and is currently engaged in a "major study of the PBM industry." Until that study is completed, reliance on the previously issued letters and reports "may be misplaced." According to the statement, "advocates continue to cite prior [FTC] work in opposition to efforts by lawmakers, enforcers, and regulators to mandate PBM transparency requirements," but "these older statements, studies, and reports may no longer reflect current market realities."

Upcoming Speaking Engagements and Events

Joanne Roskey and Anthony Shelley will present, "Discussion with EBSA: Enforcement & Regulatory Priorities Impacting Health Plans," at the BCBS 2023 Law, Audit, Compliance & Ethics Conference on August 9, 2023.
