Compliance Alert

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Employee Benefits Compliance

Final Mental Health Parity Compliance Rules and What They Mean for Group Health Plans

Executive Summary

On September 9, 2024, the Departments of Health and Human Services (HHS), Labor, and Treasury (collectively, the Departments) released final rules implementing the Mental Health Parity and Addiction Equity Act (MHPAEA). These rules apply to most fully insured and self-funded group health plans with exemptions for retiree-only plans, excepted benefits, and small self-funded plans (generally with 50 or fewer employees). The final rules amend certain provisions of the 2013 MHPAEA regulations and add new regulations which set content requirements and timeframes for responding to requests for nonquantitative treatment limitation (NQTL) comparative analyses required under MHPAEA, as amended by the Consolidated Appropriations Act, 2021 (CAA, 2021). (See Alert 2020-23, Year-End Appropriations Act Details New Requirements Under Mental Health Parity.) The final rules reflect and address thousands of comments received from the public during the comment period on the proposed rules that were published on August 3, 2023. (See Alert 2023-08, Agencies Issue Long Awaited Guidance on Mental Health Parity Compliance with New Requirement for Plan Sponsors.) Specifically, the final rules:

- Reinforce that health plans and issuers cannot use NQTLs that are more restrictive, as written or in operation, than the predominant NQTLs applied to substantially all medical/surgical (M/S) benefits in the same classification, but do not require the mathematical testing similar to the testing that applies when analyzing parity with respect to financial requirements or quantitative treatment limitations that was included in the proposed rules. (For a full background discussion of this requirement, including the classifications referenced here, see our Alliant Insight, Mental Health Parity, Its Time for a Check Up.)
- Require plans and issuers to collect and evaluate data and take reasonable action to address material differences in access to mental health (MH) or substance use disorder (SUD) benefits as compared to M/S benefits that result from application of NQTLs, where the relevant data suggest that the NQTL contributes to material differences in access.

- Prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to M/S benefits when designing NQTLs.
- Reiterate that if a plan provides any benefits for a MH condition or SUD in any benefits classification, it must provide meaningful benefits for that condition or disorder in every classification in which meaningful M/S benefits are provided and includes a definition of meaningful benefits.
- Amend existing examples and add new examples on the application of the rules for NQTLs.
- Set forth six content elements that must be included in the comparative analysis of the design and application of each NQTL imposed on MH/SUD benefits.
- Require ERISA plans to have a named fiduciary certify the fiduciary's engagement in the process of selecting qualified service providers to perform and document the comparative analysis, as well as satisfaction of the duty to monitor those service providers.
- Finalize regulatory amendments to implement the sunset provision for self-funded, non-Federal governmental plan elections to opt out of compliance with MHPAEA, as adopted in the Consolidated Appropriations Act, 2023 (CAA, 2023).

Along with these final rules, the Departments issued additional information, including a News Release, a Fact Sheet, and one page summaries of the what the final rules mean for plans and issuers, participants and beneficiaries, and providers.

Practical Perspective

These rules are detailed, complex, and voluminous at 550 pages. They make clear that it is absolutely essential for plan sponsors to engage third-party administrators (TPAs) and insurance carriers to conduct and prepare the required NQTL analysis on behalf of the plan, or at least undergo the required processes and provide all relevant data in a manner that facilitates the plan's compliance with this significant requirement. Insurance carriers will likely perform this analysis for fully insured plans, but self-funded plan TPAs may take varied approaches. Notably, the Departments make a number of references in these regulations signaling their expectation that TPAs and carriers actively engage in this process, including a note that the Departments are most interested in the type of large-scale compliance failures that generally trace back to TPA or carrier directed plan designs. The rules also specifically note the possibility of a TPA's co-fiduciary liability under ERISA section 405. So while the plan is ultimately responsible for compliance, the tone of the final rules should provide sufficient incentive for TPAs and carriers to provide the support their plan sponsor clients need on this requirement.

Background

Under longstanding Mental Health Parity rules, group health plans that cover MH/SUD benefits must ensure that any financial requirements (copays, deductibles, etc.), quantitative treatment limits (visit

limits), and non-quantitative treatment limits (NQTL) (medical management standards, network access, and formulary design) applicable to MH/SUD benefits are not more restrictive than the requirements or limitations for M/S benefits. The CAA, 2021 requires plans to complete an NQTL comparative analysis and, upon request, provide the analysis to the DOL (or appropriate Department) as well as relevant State authorities. The Departments later released FAQs Part 45 setting forth what the comparative analysis must include, what documents plans should be prepared to make available upon request, practices to avoid, and a timeline for corrective action. (See Alert 2021-08, DOL FAQs Address MH Parity Requirements under the Appropriations Act.) On July 25, 2023, the Departments issued proposed rules implementing and expanding the NQTL comparative analyses requirements under the MHPAEA, as amended by the CAA, 2021. These final rules generally codify the proposed rules with some modifications and are effective for plan years beginning on or after January 1, 2025, with the exception of certain key provisions that are effective for plan years beginning on or after January 1, 2026, as noted herein.

Regulatory Purpose and New Definitions

The final rules add a purpose section to emphasize the overall intent of the statute that plans not design or apply financial requirements and treatment limitations that impose greater burden on access to MH/SUD benefits than they impose on access to M/S benefits in the same classification, and that the regulations should be interpreted in a manner consistent with that purpose.

In terms of how a plan defines a condition, disorder, or procedure—either as MH/SUD or M/S—that definition must be consistent with generally recognized independent standards of current medical practice. For this purpose, a plan's definition of whether a condition or disorder is a MH condition or SUD must follow the most current version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM). If generally recognized independent standards of current medical practice do not address how to treat a condition, disorder, or procedure, plans and issuers may define it in accordance with applicable Federal and State law.

The final rules also add new key definitions for the following terms:

- "Evidentiary standards" are any evidence, sources, or standards that a plan or issuer considered or relied upon in designing or applying a factor with respect to an NQTL.
- "Factors" are all information, including processes and strategies (but not evidentiary standards), that a plan or issuer considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan or coverage.
- "Processes" are actions, steps, or procedures that a plan or issuer uses to apply an NQTL.

- "Strategies" are practices, methods, or internal metrics that a plan or issuer considers, reviews, or uses to design an NQTL.

NQTL Requirements

Under the final rules, plans are prohibited from imposing any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all M/S benefits in the same classification. However, the final rules do not adopt the mathematical tests to determine "substantially all" and "predominant" that were in the proposed rules. To impose an NQTL, a plan must satisfy the following two sets of requirements:

Part 1: Design and Application Requirements

Plans must not design or apply financial requirements and treatment limitations that impose a greater burden on access to MH/SUD benefits than what is imposed on access to M/S benefits in the same classification of benefits. This necessitates an examination of the processes, strategies, evidentiary standards, and other factors used in designing and applying an NQTL to MH/SUD benefits in the classification to ensure they are comparable to, and are applied no more stringently than, those used in designing and applying the limitation with respect to M/S benefits in the same classification. As part of this process, a plan may not use discriminatory factors and evidentiary standards to design an NQTL imposed on MH/SUD benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which it is based are biased or not objective in a manner that discriminates against MH/SUD benefits as compared to M/S benefits, which is generally determined based on the specific facts and circumstances. The regulations provide the following example of the design and application requirements:

***Example**: For MH/SUD benefits and M/S benefits, a plan's reimbursement rate for physicians and non-physician practitioners for the same CPT code are based on a combination of factors, such as the nature of the service, duration of the service, intensity and specialization of training, provider licensure and type, number of providers qualified to provide the service in a given geographic area, and market need (demand). In operation, the plan utilizes an additional strategy to further reduce reimbursement rates for MH/SUD non-physician providers from those paid to MH/SUD physicians by the same percentage for every CPT code but does not apply the same reductions for non-physician M/S providers. In this example, the plan is in violation of the Mental Health Parity rules because, in operation, the factors used in designing and applying its reimbursement rate for MH/SUD benefits is not comparable and is more stringent than the reimbursement rate for M/S benefits.*

Part 2: Relevant Data Evaluation Requirements

To ensure that an NQTL applicable to MH/SUD benefits in a classification is no more restrictive in operation than the predominant NQTL applied to substantially all M/S benefits in the same classification, plans and issuers must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on relevant outcomes related to access to MH/SUD benefits and M/S benefits. This includes NQTLs related to network composition standards.

The final rules provide flexibility to determine what should be collected and evaluated, and include examples of relevant data for all NQTLs (the number and percentage of claims denials and any other data relevant to the NQTL as required by State law or private accreditation standards) and additional relevant data for NQTLs related to network composition standards (in-network and out-of-network utilization rates, network adequacy metrics, and provider reimbursement rates).

A relevant data evaluation that indicates a material difference in access to MH/SUD benefits is a strong indicator of a non-compliant plan design. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits.

In that situation, the plan or issuer is required to take reasonable action as necessary to address any material differences in access shown in the data. The final rules provide the following example of reasonable action to address a material difference:

***Example**: A plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient, in-network M/S benefits and for all inpatient, in-network MH/SUD benefits. While inpatient, in-network benefits for M/S conditions are approved for periods of one, three, and seven days after which a treatment plan must be submitted by the patient's attending provider and approved by the plan, the approvals for seven days are most common under this plan. For inpatient, in-network MH/SUD benefits, routine approval is most commonly given only for one day, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. In this example, the difference in the duration of approvals is not the result of independent professional medical or clinical standards or standards to detect or prevent and prove fraud, waste, and abuse, but rather reflects the application of a heightened standard to the provision of the mental health and substance use disorder benefits in the relevant classification. Therefore, the plan is in violation of the Mental Health Parity rules because the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits.*

Meaningful Benefits

Under the final rules, if a plan provides any benefits for a MH condition or SUD in any benefits classification, it must provide meaningful benefits for that condition or disorder in every classification in which meaningful M/S benefits are provided. Whether the benefits provided are meaningful is determined in comparison to the benefits provided for M/S conditions in the same classification. Specifically, for a plan to provide meaningful benefits, it must provide benefits for a core treatment for that condition or disorder in each classification in which the plan provides benefits for a core treatment for one or more M/S conditions or procedures. A core treatment for a condition or disorder is defined by the final rules as a standard treatment or course of treatment, therapy, service, or intervention as indicated by generally recognized independent standards of current medical practice. The Departments also recognize that a core treatment for a particular condition or disorder may not necessarily refer to a single item or service but may encompass a suite of items and services that together constitute a core treatment. In this case, plans and issuers should be prepared to cover all components of the core treatment.

Example: A plan covers treatment for Autism Spectrum Disorder (ASD). For purposes of MHPAEA, ASD is a mental health condition under generally recognized independent standards of current medical practice. Specifically, the plan covers outpatient, out-of-network developmental screenings for ASD, but excludes all other benefits for outpatient treatment for ASD, including ABA therapy, when provided on an out-of-network basis. The plan generally covers the full range of outpatient treatments (including core treatments) and treatment settings for M/S conditions and procedures when provided on an out-of-network basis. Under the generally recognized independent standards of current medical practice consulted by the plan, developmental screenings alone that are covered for diagnostic purposes, without any coverage for a therapeutic intervention, do not constitute a core treatment for ASD. Although the plan covers benefits for ASD, in the outpatient, out-of-network classification, it only covers developmental screenings. Therefore, it does not cover a core treatment for ASD in the classification. Since the plan generally covers the full range of M/S benefits including a core treatment for one or more M/S conditions or procedures in the classification, it fails to provide meaningful benefits for treatment of ASD in the classification, as required under the final rules.

Comparative Analysis Requirements

The Six Elements

The final rules generally adopt the same content requirements listed in the proposed rules for the comparative analysis with several important modifications. A comparative analysis must include, at a minimum, with respect to each NQTL imposed under a plan or coverage option, six specific elements,

each of which contain detailed requirements. A full review of those detailed requirements exceed the scope of this Alert, but we summarize the key components below:

- **A description of the NQTL, including identification of benefits subject to the NQTL.** Plans must prepare a written list of all NQTLs imposed under the plan or coverage that includes a general description of any information considered or relied upon by the plan or issuer in preparing the comparative analysis for each NQTL.
- **The identification and definition of the factors and evidentiary standards used to design or apply the NQTL.** Plans must identify and define all factors and evidentiary standards considered or relied upon to design or apply the NQTL, as well as the evidentiary standards or sources (if any) from which each evidentiary standard was derived. Plans should be prepared to provide copies of the actual evidence or source used, as well as the date and relevant citation. Plans should also describe any steps taken to correct, cure, or supplement any information, evidence, sources, or standards that are the basis for a factor or evidentiary standard that would otherwise have been considered biased or not objective in the absence of such steps.
- **A description of how factors are used in the design and application of the NQTL.** A detailed explanation of how each identified factor is used to determine which benefits are subject to the NQTL and an explanation of the evidentiary standards or other information (if any) considered or relied upon in designing or applying factors, or the NQTL, including whether and how benefits are subject to the NQTL.
- **A demonstration of comparability and stringency, as written.** Evaluation of whether, in any classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits in a 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.
- **A demonstration of comparability and stringency, in operation.** Evaluation of whether, in any classification, in operation of the plan, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits in a 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. The plan's relevant data evaluation in assessing NQTLs will be important to incorporate here.

- **Findings and conclusions.** The comparative analysis must address any findings or conclusions indicating that the plan or coverage is not (or might not be) in compliance, including any actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance.

The Departments do not intend to provide an example of a comparative analysis that complies with the final rules, but will consider what additional resources and guidance are necessary to assist plans in complying with the final rules and have indicated that they intend to update the MHPAEA Self-Compliance Tool.

Named Fiduciary Certification

For plans subject to ERISA, these rules finalize the fiduciary certification requirements, but modify the proposed rules by instead requiring that the fiduciary certify that they engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis in accordance with MHPAEA, rather than certify NQTL compliance. As part of this process, however, the fiduciary must also demonstrate that they satisfied the duty to monitor those service providers. The DOL expects a plan fiduciary making such a certification, at a minimum, to review the comparative analysis prepared by or on behalf of the plan, ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings; and ensure that a service provider responsible for performing and documenting a comparative analysis provide assurances that, to the best of its ability, the NQTL and associated comparative analysis complies with the MHPAEA and its implementing regulations.

The Comparative Analysis Process, Timelines, and Required Disclosures

The final rules reiterate that plans and issuers should not wait for a request from the DOL or applicable State authority to perform and document their comparative analyses. This may impact the approach certain plan sponsors have taken with respect to performing their NQTL analysis, many of whom may have been waiting until these final regulations were issued. With respect to the process for a comparative analysis request from the DOL or state authority, the final rules provide as follows:

- After an initial request for a comparative analysis, the plan or issuer must submit it to the DOL within 10 business days (or an additional period of time specified by the DOL).
- If the comparative analysis is deemed insufficient, the DOL will specify the additional information necessary, which must be provided by the plan or issuer within 10 business days (or an additional period of time specified by the DOL).

- If the DOL makes an initial determination of noncompliance, the plan or issuer has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses.
- If the Secretary makes a final determination of noncompliance, the plan or issuer must notify all participants, beneficiaries, and enrollees enrolled in the plan or coverage not later than 7 business days after the Secretary's determination.
- The final rules set forth specific content for this notice and require that a copy of the notice be provided to the Secretary and relevant service providers and fiduciaries.

In addition to providing the analysis to the Department, plans and issuers must make a copy of the comparative analysis available when requested by a participant or beneficiary (or a provider or other person acting as a participant's or beneficiary's authorized representative) who has received an adverse benefit determination related to MH/SUD benefits, and for ERISA covered plans, participants and beneficiaries generally, who may request the comparative analysis at any time under ERISA section 104.

Sunset of MHPAEA Opt-Out for Self-Funded Non-Federal Governmental Plans

Historically, self-funded, non-Federal governmental plans were permitted to opt out of compliance with MHPAEA under certain circumstances. The Consolidate Appropriations Act (CAA), 2023, enacted on December 29, 2022, contained a sunset provision and removed the ability of those plans to opt out of MHPAEA compliance. The proposed regulations codified this sunset provision and the final regulations retained that requirement without change. By now, most self-funded, non-Federal governmental plans should have addressed this issue. The CAA, 2023 did, however, allow extended deadlines for certain collectively bargained plans with an opt-out election in effect at the time the law was passed. Collectively bargained plans that previously opted out of MHPAEA should review their plans and bargaining agreements to ensure compliance with those deadlines, and that their plans are in compliance with MHPAEA, as applicable.

Effective Dates

The final rules are generally effective for plan years beginning on or after January 1, 2025, with the exception of the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses, which apply on the first day of the plan year beginning on or after January 1, 2026. Note, however, that the comparative analysis statutory requirement was effective as of February 10, 2021, and the applicability date for these final rules does not alter current

obligations under the statute. The final regulations note that plans can rely on previously issued guidance to comply with their comparative analysis until the final regulations become fully effective.

Takeaways and Action Items

MHPAEA compliance has been and remains an enforcement priority of the Departments which is clear not only in the final rules, but also in the numerous companion pieces the Departments released. These final rules provide long-awaited details on the requirements for NQTLs and the content for the comparative analysis, but do not simplify the process for plan sponsors. On the contrary, these rules only confirm that much of the compliance, for all practical purposes, must be performed by TPAs, carriers, or other plan service providers. As a result, the importance of working with partners that are committed to providing plans with key compliance support is more important than ever.

Note, however, that plan sponsors should be readily familiar with the concepts and the basic components of this rule. Even in the event of an audit that identifies an issue, the final rules permit a number of opportunities to address those issues. As a result, most knowledgeable plan sponsors, in conjunction with the right partners, should be able to avoid a final determination of noncompliance. Plan sponsors that have not already completed a comparative analysis should closely review this guidance and prioritize this issue with their insurance carriers, TPAs, as well as any vendor partners supporting carved out benefits (e.g., Pharmacy Benefit Managers) to determine how they will help comply with these rules.

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