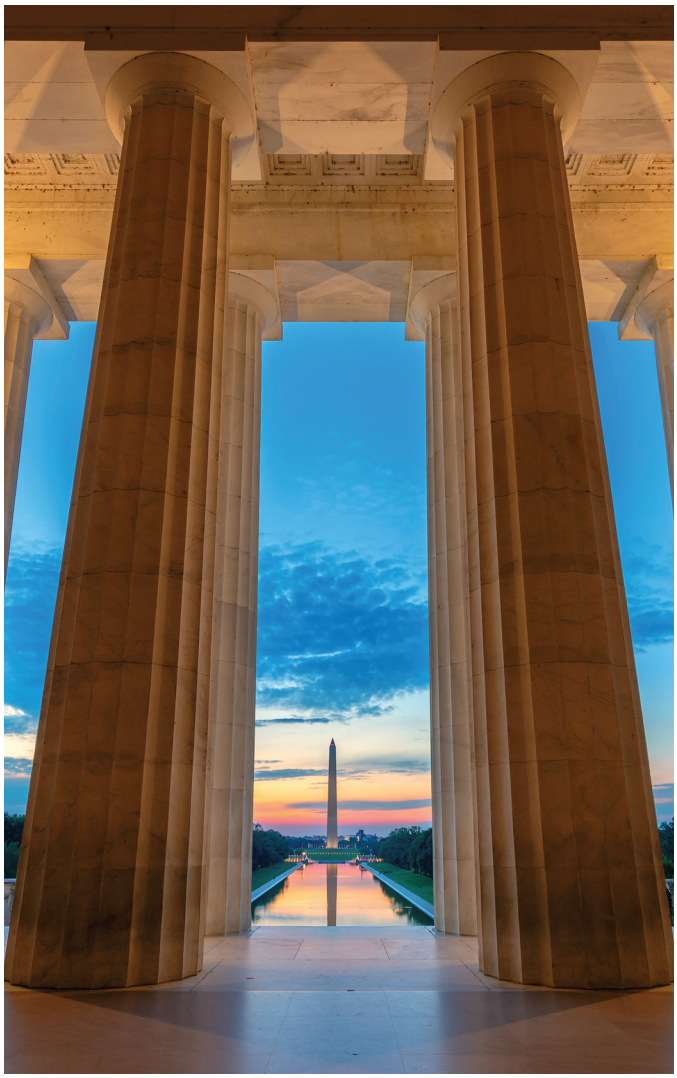
Brown & Brown

EMPLOYEE BENEFITS

DOL, Treasury and HHS Release Final Rules on Requirements Related to the Mental Health Parity and Addiction Equity Act

October 2024

On September 23, 2024, the Department of Labor, Department of Treasury and Department of Health and Human Services (hereinafter referred to as "the Departments") published final rules titled "Requirements Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)." These final rules follow and adopt modified versions of the MHPAEA proposed rules that were released on July 25, 2023[1], which introduced new requirements and comparative analysis rules surrounding Non-Quantitative Treatment Limitations (NQTLs) as established under the Consolidated Appropriations Act, 2021 (CAA, 2021). Through these final rules, the Departments seek to provide more clearly defined standards to ensure that health plan sponsors, insurance carriers and other stakeholders do not apply more stringent limits on access to mental health (MH) and substance use disorder (SUD) benefits as compared to medical/surgical (M/S) benefits within a health plan or policy. More information regarding these final rules is contained below.



[1] 2023-15945.pdf (govinfo.gov)

History of MHPAEA

On October 3, 2008, as part of the Emergency Economic Stabilization Act of 2008, MHPAEA became law. This law was intended to create parity/equality between MH/SUD benefits and M/S benefits. Later, final rules were issued on November 13, 2013, implementing MHPAEA[2]. These 2013 final rules created six classifications of benefits when comparing parity between MH/SUD benefits and M/S benefits:

1. Inpatient, in-network
2. Inpatient, out-of-network
3. Outpatient, in-network
4. Outpatient, out-of-network
5. Emergency care
6. Prescription drugs

The 2013 final rules also provided that the parity in benefits requirements apply not only to the financial requirements (e.g., copayments, deductibles) and the numerically expressed quantitative treatment limitations (QTLs) (e.g., maximum number of visits to a doctor) but also to the non-quantitative treatment limitations (NQTLs) (e.g., non-numerical requirements of a health plan such as prior authorization requirements, step therapy and provider admission requirements) within a health plan. On December 27, 2020, the CAA 2021 amended MHPAEA, expressly requiring group health plans and insurers to document and perform a comparative analysis of NQTLs under the plan to determine whether a plan's design and application of NQTLs are more stringent on MH/SUD benefits as compared to M/S benefits. The Departments have released multiple sets of Frequently Asked Questions (FAQs), fact sheets, compliance assistance tools, templates, reports and publications since the inception of MHPAEA. Proposed rules, with the same title as these final rules (i.e., Requirements Related to the Mental Health Parity and Addiction Equity Act), were released by the Departments on July 25, 2023, and reference to those proposed rules is made throughout this article.

Purpose and Definition of Terms

Originally, the Departments proposed to adopt a preamble to the MHPAEA statute that acts as a "fundamental purpose" statement to provide an overarching set of "guiding principles" for health plans and issuers to follow under the law. The final rules adopted this concept but slightly modified this section to remove the words "generally comparable" from the proposed rule's language.[3] The intent in removing these words in the final rules was to preserve the intent under the law to compare the financial requirements, QTLs and NQTLs imposed on MH/SUD benefits and M/S benefits in only six benefit classifications, rather than a "generally comparable" standard.[4]

[2] 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136

[3] § 2590.712 Parity in mental health and substance use disorder benefits

[4] The six benefit classifications include inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care and prescription drugs.

Adoption of Certain Definitions Related to the Terms Medical/Surgical Benefits, Mental Health Benefits and Substance Use Disorder Benefits

Independent Medical Standards

Regarding the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits," the final rules mostly adopted the proposed rules. The final rules state that the plan/coverage must define the conditions/procedures related to these terms in a manner that is consistent with the "generally recognized independent standards of current medical practice" (e.g., the most current version of the International Classification of Diseases (ICD) or APA Diagnostic and Statistical Manual of Mental Disorders (DSM)). In situations in which these conditions/procedures are not addressed within these generally recognized independent standards, the final rules state that a plan/issuer may define such condition/procedure under applicable Federal or State[5] law, but only to the extent that those rules align with generally recognized independent medical standards (to ensure that when state/Federal law conflicts with independent medical standards, the medical standards related to such condition/procedure would govern whether such condition/procedure falls into the proper category of comparison).

Must Include All Disorders regarding Substance Use Disorders

The final rules also state that a plan's definition of SUD benefits must include all disorders that are included within any of the diagnostic categories listed as a mental or behavioral health disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD[6] or that are listed in the most current version of the DSM[7]."

When a Specific Item or Service may apply to both Medical/Surgical and Mental Health/Substance Use Disorder Benefits

The final rules do not adopt a bright line rule regarding specific items or services that may contain both M/S benefits and MH/SUD benefits. The final rules only state that a plan must correctly characterize items and services in these three categories in a way that is consistent based on the condition/disorder being treated and in a manner that is consistent with the general purpose of MHPAEA, which requires parity between the MH/SUD benefits and the M/S benefits under a health plan.

The preamble to the final rules states that if a plan/coverage "defines a condition or disorder as a mental health condition or substance use disorder, plans and issuers…must treat all benefits for the condition or disorder as mental health benefits or substance use disorder benefits…for purposes of compliance with MHPAEA."

Specific Conditions Considered Mental Health Conditions

Due to many comments from stakeholders asking for clarity on specific conditions and if they would be considered mental health conditions, the Departments addressed these comments in the preamble by stating that if a health plan provides coverage for benefits related to eating disorders (including anorexia nervosa, bulimia nervosa and binge-eating disorder), autism spectrum disorder (ASD) and gender dysphoria, that these would be considered mental health conditions and therefore subject to the protections under MHPAEA.

[5] Originally, under the proposed rules, State law definitions could not be used by a plan/insurer. The final rules do allow State law definitions to be used by the plan/insurer, so long as it is consistent with generally recognized independent medical standards.

[6] "Specifically, under these final rules, the most current version of the ICD as of November 22, 2024, the effective date of these final rules, is the International Classification of Diseases, 10th Revision, Clinical Modification adopted for the period beginning on October 1, 2015, through HHS regulations at 45 CFR 162.1002 (or successor regulations). Any subsequent version of the ICD adopted through 45 CFR 162.1002 (or successor regulations) after November 22, 2024, will be considered the most current version beginning on the first day of the plan year that is one year after the date the subsequent version is adopted."

"The Departments are also finalizing the definition of "DSM" as proposed, with similar clarifications, which note that the most current version as of November 22, 2024, the effective date of these final rules, is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.

[7] A subsequent version of the DSM published after November 22, 2024, will be considered the most current version beginning on the first day of the plan year that is one year after the date the subsequent version is published (as the DSM is published, rather than made applicable). Consistent with this clarification, if a new version of the DSM is published in the middle of a plan year, plans and issuers will have at least one full year before they are required to use the updated version with respect to a plan year. For example, if a new version of the DSM is published on August 1, 2025, for a calendar year plan, that version of the DSM would be the most current version with respect to the plan year beginning on January 1, 2027."

Treatment Limitations

Complete Exclusion from a Plan is not a Treatment Limitation

Previously, under the proposed rules, the Departments included an "illustrative list of NQTLs" within the definition of "treatment limitations" and explained that the list was not intended to be an exhaustive list of NQTLs. Under the proposed rules, the word "complete" was used to replace the word "permanent" under the previous definition of treatment limitations to ensure that health plans understood that a complete "exclusion of all benefits for a particular condition or disorder is not [considered] a treatment limitation for purposes of the definition." These rules were adopted under the final rules.

Other Rules that Apply under the Definition of Treatment Limitations

The preamble to both the proposed rules and final rules state that although the rules generally define NQTLs as non-numerical treatment limitations on MH/SUD benefits, a health plan that applies an NQTL in a numerical way does not modify its "non-quantitative character." Also, the preamble to the final rules stated that if a plan/issuer provides any benefits "for a mental health condition or substance use disorder but excludes benefits for items or services for that condition or disorder in a classification in which it provides medical/surgical benefits, such an exclusion of a benefit for a condition or disorder that is otherwise covered is a treatment limitation because it is a limit on the scope or duration of treatment offered."

Prohibition on Treatment Limitations Applicable Only to Mental Health or Substance Use Disorder Benefits

The preamble to the final rules states that plans and issuers may not apply any NQTL to MH/SUD benefits that does not apply to any M/S benefits in the same benefit classification. For this purpose, excluding MH/SUD benefits in a classification that is "merely an expression of another NQTL, such as medical necessity requirements or experimental or investigational exclusions that is applied with respect to M/S benefits in the same classification would not be considered a separately applicable treatment limitation." For example, a plan's exclusion of coverage for ABA therapy is not an expression of a broader NQTL if it was not generated through a process or strategy or informed by an evidentiary standard of a broader NQTL, like medical necessity.

New Definitions for Processes, Strategies, Evidentiary Standards and Factors Apply Under the No More Restrictive Standard

The Departments largely adopt the approach set forth in the proposed rules regarding the rules surrounding NQTLs that apply to MH/SUD benefits. Generally, a plan must ensure that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply an NQTL to MH/SUD benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, and factors used to design and apply the NQTL to M/S benefits offered under the plan. Although a requirement for health plans to perform and document a comparative analysis between NQTLs that apply to MH/SUD benefits and those imposed on M/S benefits predated both the proposed and final rules, the proposed and final rules adopted further instructions and clarifications on what information should be included in a health plan's required comparative analysis.

Definitions of the terms "processes," "strategies," "evidentiary standards," and "factors" were added to the rules to help provide further guidance for comparing NQTLs that apply to MH/SUD and M/S benefits. The definitions of these terms were included in the proposed rules and were slightly modified, as described below, in the final rules. The Departments note that the intent of these terms is not to create an "algorithmic" decision-making process for plans but a framework for approaching what the Departments may be looking for as they review health plans for compliance under MHPAEA. Therefore, anything a plan uses to decide whether to apply an NQTL should be considered and documented within a health plan's comparative analysis and will be considered a process, strategy, evidentiary standard or factor (or as a basis for these standards).

Evidentiary Standards

The proposed rules and final rules are very clear in differentiating the term "evidentiary standards" from the word "factors." The Departments define evidentiary standards as 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, including specific benchmarks or thresholds." Evidentiary standards can include many varieties of evidence that are scientifically/medically based, such as medical books or clinical research/treatment guidelines and studies put out by independent and objective third parties, payment rates for certain items/services and health plan claims and utilization data or other information that can assist with providing a robust provider network under the plan. This data may be "empirical, statistical, or clinical in nature." Although these requirements are not meant to provide a rigid structure to the review of evidentiary standards under the rules, they must be reviewed from a lens of compliance under MHPAEA. Also, the above is not meant to provide an exhaustive list of items required to be analyzed under the rules.

Factors

The proposed rules sought to make the term "factors" used in a plan's comparative analysis more inclusive so that the term would apply to all information utilized by a plan, including "processes" and "strategies." However, both the proposed and final rules state that the definition of factors does not include evidentiary standards. The Departments' intention in adopting a larger application of the term was to ensure that a plan would need to collect as much information as possible regarding the information the plan used in implementing an NQTL. According to the final rule, "Factors include, but are not limited to: provider discretion in determining diagnosis or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; claim types with a high percentage of fraud; quality measures; treatment outcomes; severity or chronicity of condition; variability in the cost of an episode of treatment; high cost growth; variability in cost and quality; elasticity of demand; and geographic location."

The Departments noted in the preamble that "factors" would include information that the plan/issuer considered but ultimately rejected in their consideration when implementing an NQTL. This is to prevent a plan or issuer from using information that would benefit their conclusion of adopting the NQTL under the plan. For further clarification, the preamble states that the term "factors" does not include information considered early in the NQTL's "design process" but focuses more on information that the plan or issuer "relied upon and rejected."

Processes

When a plan documents the "processes" used to implement an NQTL, it should illustrate the "actions, steps, or procedures established by the plan or issuer as requirements for a participant or beneficiary to access benefits…"

Processes include, but are not limited to "…procedures to submit information to authorize coverage for an item or service prior to receiving the benefit or while treatment is ongoing (including requirements for peer or expert clinical review of that information); provider referral requirements that are used to determine when and how a participant or beneficiary may access certain services; and the development and approval of a treatment plan used in a concurrent review process to determine whether a specific request should be granted or denied."

Processes also include the specific procedures used by staff or other representatives of a plan (or the service provider of a plan) to administer the application of nonquantitative treatment limitations, such as how a panel of staff members applies the nonquantitative treatment limitation (including the qualifications of staff involved, number of staff members allocated, and time allocated), consultations with panels of experts in applying the nonquantitative treatment limitation, and the degree of reviewer discretion in adhering to criteria hierarchy when applying a nonquantitative treatment limitation."

The Departments indicated that processes are not entirely centered around the "end result of the access to benefits" but also include the "operational" application of NQTLs. The preamble provides one example of this: "[f]or example, prior authorization processes include the procedures established by a plan or issuer for a review to determine how a specific request for prior authorization should be granted or denied. Concurrent review processes include the procedures established by a plan or issuer for a review to determine whether a specific request should be granted or denied, such as when peer-to-peer review is required."

Strategies

The final rules define "strategies" as the "practices, methods, or internal metrics that a plan [or issuer] considers, reviews, or uses to design [an NQTL]." The final rules did not change the proposed rules' definition of "strategies" but modified examples provided for under the proposed rules to include "the development of the clinical rationale used in approving or denying benefits; the method of determining whether and how to deviate from generally accepted standards of care in concurrent reviews; the selection of information deemed reasonably necessary to make medical necessity determinations; reliance on treatment guidelines or guidelines provided by third-party organizations in the design of a nonquantitative treatment limitation; and rationales used in selecting and adopting certain threshold amounts to apply a nonquantitative treatment limitation, professional standards and protocols to determine utilization management standards, and fee schedules used to determine provider reimbursement rates, used as part of a nonquantitative treatment limitation…"

The Departments explicitly stated they would not add a reference to actions to detect or prevent fraud, abuse, or waste to the definition of "strategy" (or the definition of "strategy"). A plan may generally consider that kind of information when reviewing the strategies behind the NQTL.

Final Rules Adopt Proposed Rules on Illustrative List of NQTLs

Both the proposed and final rules made minor amendments to the illustrative list of MH/SUD NQTLs that were provided for under the rules that preceded both the proposed and final rules. The final (and proposed) rules clarify that this illustrative list[8] is not exhaustive, and other NQTLs may exist outside of this list. Therefore, if a plan contains limitations for MH/SUD benefits not specifically listed in the rules, they would still be considered NQTLs that are subject to the MHPAEA rules.

[8] Illustrative list is referenced later in this article, referencing the 13 NQTLs included in the final regulations, below.

NQTL Requirements

Final Rules do not adopt Proposed Rules "No More Restrictive" Four Prong Test Approach

Generally, "a group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) may not impose any NQTL with respect to mental health or substance use disorder benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical/surgical benefits in the same classification."

Initially, the Departments proposed a four-prong test for the "no more restrictive" requirement for NQTLs under MHPAEA. However, one of the most significant changes between the proposed rules and the final rules is that they rejected the four-prong test in favor of a new standard that will now apply to health plans when reviewing whether a MH/SUD NQTL is more restrictive than those imposed on the M/S benefits offered under the health plan. Generally, plans must now satisfy: "(1) the design and application requirements and (2) the relevant data evaluation requirements," which are discussed later in this section of the article.

Design and Application Requirements

For a plan to meet its "no more restrictive" standard, it must illustrate its compliance by showing that the plan's "processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than those used in designing and applying the limitation with respect to medical/surgical benefits in the classification." The Departments believe (as written in the preamble) that this comparative review methodology will assist plans/issuers in gaining a better understanding of their NQTL compliance obligations, "by emphasizing that, as written and in operation, the design of an NQTL is equally relevant as how it is applied." Therefore, under the final rules, the Departments structured the design and application requirements to belong under the no more restrictive requirements.

Nondiscrimination in Evidentiary Standards and Factors

The final rules adopted a prohibition on using discriminatory factors and evidentiary standards in the design phase of NQTLs that apply to MH/SUD benefits to ensure there are no inherent biases against MH/SUD benefits within them. If a plan or issuer relies upon factors or evidentiary standards when designing NQTLs that "systematically disfavor access or are specifically designed to disfavor access to [MH/SUD] benefits," the NQTL would be considered discriminatory.

Although the final rules emphasize that plans or issuers should utilize independent information, evidence, sources or standards to avoid using discriminatory factors and standards, the Departments also clarify that internal claims data (although not independent third-party evidence) would not necessarily be considered discriminatory. Also, as discussed in the preamble to the final rules, historical plan data that includes evidentiary standards and factors from a time the plan was not subject to MHPAEA could be utilized under a plan's comparative analysis, so long as "the relevant facts and circumstances indicate that the supplemented information, evidence, sources, or standards do not systematically disfavor access and are not specifically designed to disfavor access to mental health and substance use disorder benefits as compared to medical/surgical benefits."

In addition, if a plan utilizes information generally recognized as independent clinical/professional medical standards, "along with fraud and abuse measures that minimize the negative impact on access to appropriate mental health and substance use disorder benefits, this information is not considered biased or not objective." In the same vein, although the use of a Medicare Physician Fee Schedule is used as evidence to illustrate non-bias in the NQTL, this does not, by default, cause the NQTL to be considered non-discriminatory. It is still possible that if this was the only evidence used to justify an NQTL, it may also be necessary to utilize historical data to ensure compliance under the rules.

Relevant Data Evaluation Requirements

Under the final rules, when a plan designs and applies an NQTL, it must "collect and evaluate relevant data in a manner reasonably designed to assess the aggregate impact of all such nonquantitative treatment limitations on access to mental health and substance use disorder benefits and medical/ surgical benefits." The proposed rules included certain generally acceptable data types for evaluation by health plans of their NQTLs, and any relevant data sets (e.g., non-duplicative or redundant data sets) related to network composition standards. Once relevant data (plans need not "exhaustively survey" all available data) is collected, if such data exposes that the plan has significant differences concerning access to MH/SUD services versus M/S services, this could indicate that the plan/issuer is out of compliance with MHPAEA and a plan may want to consider modifying/removing the NQTL, or a government agency may require the plan to do so by taking reasonable actions to cure the plan of these deficiencies. The final rules adopted all these provisions from the proposed rules under the relevant outcomes data analysis requirement for NQTLs.

The final rules provide examples of relevant data for NQTLs related to network composition, 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), and provider reimbursement rates (for comparable services and as benchmarked to a reference standard)." The Departments clarify that if a plan or issuer chooses not to consider specific data knowing that such data would reasonably suggest that the NQTL causes significant access limitations to MH/SUD benefits/providers, this is considered non-compliant under the rules because it would mean that the NQTL causes the plan to be more restrictive in providing MH/SUD benefits than M/S benefits in operation.

The preamble states that the Departments intend to issue future guidance as to "the type, form, and manner of collection and evaluation for the data required and the lists of examples of data that are relevant across the majority of NQTLs, as well as additional relevant data for NQTLs related to network composition" and update the MHPAEA Self-Compliance Tool with this information.

"Under these final rules, relevant data for the majority of NQTLs could include, as appropriate, but are not limited to, the number and percentage of claims denials in a classification of benefits and any other data relevant to the NQTL required by State law or private accreditation standards… and utilization data for mental health and substance use disorder services and medical/surgical services. For NQTLs such as prior authorization, relevant data could include rates of approvals and denials of prior authorization requests, rates of denials of post-service claims, application of penalties for a failure to obtain prior authorization, and turnaround times for prior authorization requests." Also, "a plan or issuer could look at the turnaround time for applications to be approved for a provider to join the plan's or issuer's network and the approval and denial rates for applications submitted by mental health and substance use disorder providers as compared to medical/surgical providers." These examples are not exhaustive of all relevant data a plan could consider but could help better assess if a plan complies with the MHPAEA rules.

Independent Professional Medical or Clinical Standards and Standards to Detect or Prevent and Prove Fraud, Waste and Abuse

The proposed rules identified two types of NQTLs[9] that were exceptions to (and therefore not subject to) the relevant data evaluation requirements. However, the final rules did not adopt those exceptions, and the final rules provide that even NQTLs designed or applied based on (or related to) independent professional medical or clinical standards or fraud and abuse measures are still subject to the design and application requirements and the data evaluation requirements. The final rules explain how plans and issuers can account for these standards and measures when analyzing NQTLs. If a plan or issuer attributes differences in access to these independent professional medical or clinical standards or fraud and abuse measures, they must explain the basis for that conclusion in their comparative analysis.

[9] *1. "NQTLs that impartially apply generally recognized independent professional medical or clinical standards (consistent with generally accepted standards of care) to M/S benefits and MH/SUD" and 2. "NQTLs reasonably designed to detect or prevent, and prove fraud, waste, and abuse, based on indicia of fraud, waste, and abuse that have been reliably established through objective and unbiased data."*

Material Differences in Access to Networks

The Departments also finalized the rule providing that, if the evaluation of all relevant data suggests an NQTL contributes to material differences in access to MH/SUD benefits as compared to M/S benefits, this would be a "strong indicator" of non-compliance by the plan. Under the final rules, an NQTL is assumed to contribute to a material difference if relevant data indicates that the NQTL likely has a negative impact on access to MH/SUD benefits in operation. When analyzing the facts and circumstances of relevant data that impacts access, plans may consider fraud and abuse as relevant factors in creating an NQTL, so long as the basis is reliable and factual. Those NQTLs are reasonably designed to prevent, detect or prove fraud and abuse in a manner that minimizes any "negative impact" to a plan member's access to MH/SUD benefits, so long as it does not cause a "material difference" in "appropriate access" to MH/SUD benefits as compared to medical/surgical benefits.

If material differences do exist when comparing access to MH/SUD benefits with M/S benefits, the final rules would require plans and issuers to take reasonable action to address the material differences in access as necessary, such as temporary non-enforcement of the NQTL until issues related to it can be resolved to ensure compliance in the operation of the plan to align with the "no more restrictive" standard and "design and application" requirements. Plans must also document the corrective action taken to address any material differences caused by NQTLs on MH/SUD benefits within the plan.

Material Differences in Network Composition and Removal of Proposed Special Rule of Automatic Failure for Material Difference in Network Composition under MHPAEA

The final rules do not adopt the proposed special rule for network composition NQTLs that the plan or issuer would automatically fail to meet the requirements of MHPAEA if relevant data showed material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits. Instead, the final rules state that material differences in access related to network composition NQTLs are considered a strong indicator of a violation. The final rules also guide how plans and issuers can comply with the relevant data evaluation requirements for network composition NQTLs.

The final rules require plans and issuers to collect and evaluate data in "a manner reasonably designed to assess the aggregate impact of all" NQTLs related to network composition on access to MH/SUD benefits and M/S benefits to determine if there is a material difference in such access. This aggregate approach differs from the final rules for other NQTLs unrelated to network composition, where relevant data for each NQTL is evaluated separately to determine how it impacts access to MH/SUD and M/S benefits. The final rules also provide examples of what would qualify as "reasonable actions" a plan or issuer can take to comply with MHPAEA where network composition NQTLs contribute to material differences in access to in-network MH/SUD benefits as compared to in-network M/S benefits. "Reasonable actions" by a plan or issuer may include:

- Working with service providers to strengthen efforts to recruit and encourage a broad range of available MH/SUD providers and facilities to join the plan's or issuer's network of providers (e.g., increase compensation, streamline credentialing, etc.)
- Expanding the availability of telehealth arrangements to mitigate shortages of MH/SUD providers in a geographic area
- Providing additional outreach and assistance to participants and beneficiaries for finding available in-network MH/SUD providers and facilities
- Ensuring provider directories are accurate and reliable

For network composition NQTLs (similar to other NQTLs), plans and issuers must explain in their comparative analysis the circumstances for any material differences in access and the plan's or issuer's actions to address those differences. If the actions do not resolve the material difference, the plan or issuer must provide a reasoned explanation in the comparative analysis as to why the differences in MH/SUD benefits access and M/S benefits access continue to persist within the health plan.

NQTL Examples

The final regulations include 13 examples illustrating the application of the NQTL requirements. These examples are modified from the proposed rules, primarily in response to the Departments declining to adopt certain proposed regulations (e.g., the proposed mathematical substantially all and predominant tests and exceptions for NQTLs). The final 13 examples focus on final substantive provisions, including the no more restrictive requirement as written and in operation, the design and application requirements and the relevant data evaluation requirements.[10]

The illustrative list of NQTLs was also expanded to include: "standards related to network composition, including, but not limited to, 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."

Meaningful Benefit Requirement

The final rules adopt the proposed rule that if any benefits are provided for a MH/SUD condition or disorder in any classification, then "meaningful benefits" for that MH/SUD condition or disorder must be provided in every classification in which M/S benefits are provided. To ensure that the plan covers benefits for a range of services and treatments for MH/SUD conditions in a classification, the final rules clarify what constitutes "meaningful benefits." To offer "meaningful benefits" for a MH/SUD condition or disorder, the plan must, at a minimum, cover benefits for that condition or disorder in each classification in which the plan provides benefits for one or more M/S conditions or procedures. A plan will not be considered to offer "meaningful benefits" unless it provides benefits for at least one core treatment (although plans are encouraged to provide more robust coverage) 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. The final rules define "core treatment" as a "standard treatment or course of treatment, therapy, service or intervention indicated by generally recognized independent standards of current medical practice." If the core treatment for a condition or disorder encompasses a combination of items and services, the plan or issuer should cover the core treatment's components (e.g., prescription drugs and psychotherapy if that is the core treatment for major depressive disorder).

The final rules include examples to illustrate how the "meaningful benefit" requirement applies.

Example from Final Regulations: A plan covers treatment for autism spectrum disorder (ASD) (a MH condition). 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 benefits 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 therapeutic intervention, do not constitute a core treatment for ASD. The plan violates the final rules because although it covers benefits for ASD in the outpatient, out-of-network classification, it only covers developmental screenings, so 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 medical conditions or surgical procedures in the classification, it fails to provide meaningful benefits for treating ASD.

Classification of Benefits

The final rules confirm that a plan or issuer is not permitted to categorize benefits into sub-classifications other than those explicitly allowed under the rules.

Further, in response to requests for guidance on how plans can comply with the MHPAEA rules regarding telehealth benefits, the final rules confirm that plans and issuers should classify (or sub-classify) telehealth benefits the same way they would if the benefit was provided in person.

[10] The illustrative list appears in the final rules at 26 CFR 54.9812–1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), and 45 CFR 146.136(c)(4)(ii) instead of 26 CFR 54.9812–1(c)(4)(iii), 29 CFR 2590.712(c)(4)(iii), and 45 CFR 146.136(c)(4)(iii) as in the proposed rules.

Additional Content of NQTL Comparative Analysis

The Departments confirm the statutory requirement that plans and issuers offering coverage that provides both M/S benefits and MH/SUD benefits and imposes NQTLs on MH/SUD benefits perform and document a comparative analysis of the design and application of each NQTL. While the Departments declined to provide examples of compliant comparative analysis, they will continue to consider what additional resources and guidance are necessary to ensure future compliance by plans/issuers, including making updates to the MHPAEA Self-Compliance Tool.

The final rules adopt the requirement that the comparative analysis for each NQTL imposed under the plan include, at a minimum, the six content elements listed in the proposed rules. Limited substantive modifications and clarifications were made to the information regarding the six content elements in the proposed rules.

The six specific elements include:

1. Description of the NQTL
2. Identification and definition of the factors used to design or apply the NQTL
3. Description of how factors are used in the design or application of the NQTL
4. A demonstration of comparability and stringency, as written
5. A demonstration of comparability and stringency in operation
6. Findings and conclusions

The final rules provide that plans and issuers must develop and make available a written list of all NQTLs imposed under the plan or coverage in addition to the necessary comparative analysis for each NQTL. However, to avoid unnecessary duplication of information, the Departments removed the separate requirement that ERISA-covered plans and issuers provide a general description of any information considered or relied upon by the plan or issuer in preparing a comparative analysis for an NQTL, stating that this information should already be included in a sufficient comparative analysis.

Furthermore, as part of the findings and conclusions element, the comparative analysis must include the date, title and credentials of all relevant persons who participated in the performance and documentation of the analysis. If the comparative analysis relies upon the evaluation of a third-party reviewer (whom the plan considers an expert), an assessment of the third party's qualifications and the extent to which the plan relied on their evaluation must be included.

The Departments modified the requirement under the proposed rules that would have required, for plans subject to ERISA, that fiduciaries must certify that they found the comparative analysis to comply with the content requirements. Under the final rules, as part of the findings and conclusions analysis, fiduciaries must 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 and have satisfied their duty to monitor those service providers. According to the preamble, the DOL expects the plan fiduciary making the certification will, at a minimum, review the comparative analysis, develop an understanding of the findings and conclusions, and ensure that the third party responsible for the comparative analysis provides assurances (to the best of its ability) that the comparative analysis complies with the MHPAEA rules.

Sunset of Opt-Out Opportunity for Non-Federal Governmental Plans

The final rules adopted the proposed regulations that modify the existing MHPAEA regulations to reflect the sunset provision in the CAA of 2023. Under the law's sunset provision, non-federal governmental plans can no longer make or renew elections to opt out of complying with MHPAEA on or after December 29, 2022. A later date may apply for collectively bargained plans.

Effective Date of Regulations

Many of the final rules will apply to group health plans (and health insurance coverage) on the first day of the first plan year beginning on or after January 1, 2025. This includes the requirement for the fiduciary of the health plan to certify, in the comparative analysis, 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, as well as satisfied their duty to monitor those service providers. However, the rules regarding the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the comparative analysis requirements related to those specific requirements will not apply until the first day of the first plan year beginning on or after January 1, 2026.

The Departments note that plans and issuers must continue to comply with existing requirements under MHPAEA until the rules become applicable, such as the general requirement to conduct a comparative analysis of NQTLs.

Regulatory Enforcement

Effect of Final Determination of Noncompliance

The final rules state that the Departments (or State enforcement authority) may require a plan to exclude an NQTL if the governmental agency makes a final determination that a plan failed to comply with the required NQTL comparative analysis under MHPAEA or if an NQTL fails to meet the substantive requirements under MHPAEA after evaluation of all of the facts and circumstances surrounding the plan.

Requirement to Produce NQTL Comparative Analysis to Department and Self-Reporting to Plan Participants

The final rules require plans and issuers to provide a plan's NQTL comparative analysis to a requesting governmental agency within ten (10) business days of a request for such information. Further, the final rules state that if a plan fails to submit sufficient information to the government agency to prove that a sufficient comparative analysis was performed by the plan, the plan must provide additional information to the agency within ten business days of that demand. The Departments emphasize in the preamble that a plan/issuer is statutorily required, even if a governmental agency does not request such comparative analysis, to perform and document the NQTL comparative analysis, and is most likely the reason for the very short timeframe to produce the comparative analysis to the Departments/state agency.

If the agency makes an initial determination of noncompliance after receiving sufficient information from the plan, the plan/issuer is provided up to 45 calendar days to respond to the claim that the plan is noncompliant under MHPAEA. Once a determination of noncompliance is found, the plan must provide to the agency the corrective action it plans to take to remedy the findings of noncompliance, in addition to providing further comparative analysis that is performed by the plan. If after the 45-calendar day period has passed and the plan is still found to be in noncompliance under the law, the plan is required to provide a standalone, noncompliance notice (within seven days) to all plan participants and beneficiaries enrolled in the noncompliant coverage.

Requirement to Produce NQTL Comparative Analysis to Participant and Beneficiaries

The Departments finalized the requirement that plans and issuers must make available a copy of the comparative analysis when requested by a participant or beneficiary who has received an adverse benefit determination related to MH/SUD benefits.

In addition, plans subject to ERISA must provide the comparative analysis within thirty days to any participant or beneficiary who requests the analysis at any time, as required under ERISA § 104.

Action Plan

The final rules seem to support the general view that the government is serious about enforcing MHPAEA. While plans need not yet comply with all aspects of the final rules until January 1, 2026, plans should have already completed their NQTL comparative analysis and be able to provide it to plan participants and the government when requested. These requirements have been in effect since February 10, 2021.

By the first day of the 2025 plan year, a plan should ensure that it is following the requirements of the MHPAEA final rules effective in 2025, including having the fiduciary of the plan (if applicable) certify that they engaged in a prudent process to select (one or more) qualified service providers to perform and document a comparative analysis, as well as monitored those service providers. Finally, as of the first day of the 2026 plan year, a plan should ensure that it is complying with the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, and the relevant data evaluation requirements. It should also ensure that its NQTL comparative analysis reflects compliance with those new requirements.

Plans should, therefore, consider the following:

1. Confirm that the required comparative analysis of NQTLs has been conducted (based on existing guidance from the Departments). This generally involves contacting the plan's insurance carrier or third-party administrator (TPA).

2. When a plan's insurance carrier or TPA does not agree to conduct the comparative analysis (or does not satisfactorily complete the NQTL comparative analysis), a plan should consider this while negotiating new or renewed contracts with the carrier or TPA and hire a third-party vendor to conduct the comparative analysis.

3. Ensure that an NQTL comparative analysis (as required under the MHPAEA rules) is performed. Plans are required to produce the NQTL comparative analysis to the Departments/state agency within **ten** business days of a request for such information.

4. If the plan is subject to ERISA, the ERISA fiduciary should certify that they engaged in a prudent process to select (one or more) qualified service providers to perform and document a comparative analysis and continue to monitor those service provider(s).

5. Track future developments with the final rules and be prepared to make necessary changes to the plan and/or the plan's NQTL comparative analysis by the effective date.

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

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