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EMPLOYEE BENEFITS

Various Requirements and Deadlines under the Final Regulations Related to the Mental Health Parity and Addiction Equity Act (MHPAEA)

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Background

On November 13, 2013, the Department of Labor, Department of Treasury, and Department of Health and Human Services (hereinafter referred to as "the Departments") issued final rules implementing and establishing the basis for the Mental Health Parity and Addiction Equity Act (MHPAEA) rules as we know them today.

These final rules created six (6) 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 provided that, consistent with the statute, plans cannot "impose a greater burden on access" (more restrictive conditions) to mental health/substance use disorder (MH/SUD) benefits under the plan "than they impose on access to medical/surgical (M/S) benefits in the same classification..." These requirements apply 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) within a health plan. They also apply to the non-quantitative treatment limitations (NQTLs) (e.g., non-numerical health plan requirements 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 an NQTL analysis 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 effective date of this requirement was February 10, 2021. The Departments have released multiple sets of fact sheets, compliance assistance tools, templates, reports and publications since the inception of MHPAEA.

On September 23, 2024, the Departments published final rules (Requirements Related to the Mental Health Parity and Addiction Equity Act) specifically relating to NQTLs and a Fact Sheet summarizing the final rules. The following charts illustrate the various requirements and deadlines under the final rules.

Deadlines that Apply to Plan Years Beginning on or After January 1, 2025

Financial and Treatment Limitations Comparative Analysis As of February 10, 2021, a plan subject to MHPAEA (any for-profit, non-profit and governmental group health plan with 50 or more employees) is required to complete a comparative analysis of the non-quantitative treatment limitations (NQTLs) applied to MH/SUD benefits and M/S benefits (pursuant to a statutory amendment under the CAA, 2021 effective on February 10, 2021).	Effective since February 10, 2021
Vendor Assistance with MHPAEA Compliance Plan sponsors should speak with vendors/carriers prior to the plan year that occurs on or after January 1, 2025, to assess whether the carrier/TPA is able to perform and meet the NQTL comparative analysis requirements as required under the final rules (as further described, below). If the plan sponsor is not receiving assistance from the vendor/carrier with a comparative analysis of MH/SUD and M/S benefits that ensures parity pursuant to MHPAEA, the plan sponsor should seek help from a third-party vendor to assist with this comparative analysis.	Completed by the first day of the plan year that begins on or after January 1, 2025

Deadlines that Apply to Plan Years Beginning on or After January 1, 2025

Six Minimum Content Requirements Related to NQTLs

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.

The final rules adopt the requirement that the comparative analysis for each NQTL imposed under the plan include, at a minimum, six (6) content elements.

The six (6) specific elements include:

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

Furthermore, as part of the findings and conclusions element, the comparative analysis must include the date the analysis was completed and the 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.

Effective for all plan years beginning on or after January 1, 2025 (however, certain requirements regarding the content of the comparative analysis related to the substantive provisions of the final rules will be effective for all plan years beginning on or after January 1, 2026)

Fiduciary Certification under the "Findings and Conclusions" Element of the NQTL Comparative Analysis

Employers/plan sponsors subject to ERISA are responsible for certifying that they have engaged in a "prudent process" of selecting one or more service providers to perform and document the comparative analysis in accordance with MHPAEA and have satisfied their duty to monitor those service providers with respect to provision of those services.

The DOL expects plan fiduciaries to, at a minimum, review the comparative analysis, develop an understanding of the findings and conclusions and ensure that the third party responsible for the analysis provides assurances that, to the best of its ability, the comparative analysis complies with MHPAEA.

Deadlines that Apply to Plan Years Beginning on or After January 1, 2025

Design and Application Requirements For a plan to meet the "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…" "…as written and in operation…" Plans may not design or apply any NQTL that would be discriminatory, "as written and in operation" under the Design and Application Requirement (which is separate and distinct from the nondiscrimination in evidentiary standards and factors discussed below that apply to plans with plan years beginning on or after January 1, 2026).	Effective for all plan years beginning on or after January 1, 2025
Adoption of Independent Medical Standards for NQTLs As it relates to the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits," the final rules state that the plan/coverage must define conditions/procedures related to these terms 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 the instance that a condition/procedure is not addressed within these generally recognized independent standards, the final rules state that a plan/issuer may define such condition/procedure in accordance with applicable Federal or State 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 comparison category).	Effective for all plan years beginning on or after January 1, 2025

Deadlines that Apply to Plan Years Beginning on or After January 1, 2026

Application of the Meaningful Benefits Standard If a plan/coverage provides any benefits for a particular MH/SUD condition or disorder in any classification, "meaningful benefits" for that MH/SUD condition or disorder must be provided in every classification in which M/S benefits are provided. 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). **Example** • A plan covers treatment for autism spectrum disorder (ASD) (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 that classification, it fails to provide meaningful benefits for treating ASD in that classification.	Effective for all plan years beginning on or after January 1, 2026

Deadlines that Apply to Plan Years Beginning on or After January 1, 2026	
Nondiscrimination in Evidentiary Standards and Factors The final rules prohibit the use of discriminatory factors and evidentiary standards in the design phase of NQTLs that apply to MH/SUD benefits to ensure that when designing NQTLs for a plan there are not 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, or if based on all the relevant facts and circumstances surrounding the NQTL seem discriminatory, the NQTL would be considered discriminatory.	Effective for all plan years beginning on or after January 1, 2026
Plan Must Meet the "Data Evaluation" Standard When a plan designs and applies an NQTL, it must "collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on access to mental health and substance use disorder benefits and medical/surgical benefits, and consider the impact as part of the plan's or issuer's analysis of whether the NQTL, in operation, complies with …no more restrictive requirement and the design and application requirements." This includes 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 as it relates to 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 the plan may be required to do so by taking reasonable actions to cure the plan of these deficiencies as required by a government agency. This information could include "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)." These comparisons help to ensure that there are no "material differences" in either access or composition of networks to MH/SUD benefits within the plan as compared to M/S benefits.	Effective for all plan years beginning on or after January 1, 2026

Action Plan

The final rules seem to support the general view that the government is serious about enforcing MHPAEA. Plans and issuers must 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 comparative analysis was performed by the plan, the plan must provide additional information to the agency within ten (10) 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. Plans, therefore, should have been completing the NQTL comparative analysis since February 2021 and should currently be able to provide their comparative analyses to plan participants and the government.

By the first day of the 2025 plan year, a plan should ensure that it follows the requirements of the MHPAEA final rules applicable in 2025, including the requirement to include the plan fiduciary's certification (if applicable) as part of the plan's NQTL comparative analysis. 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, the relevant data evaluation requirements, and the related comparative analysis requirements to be fully compliant under the MHPAEA rules.

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 provided to the Departments/state agency within ten (10) 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 analyses 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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