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Brown & Brown

Mental Health Parity and Addiction Equity Act (MHPAEA)

January 2025

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MHPAEA: Timeline

MHPAEA Timeline

Date	Law	Content
October 3, 2028	Emergency Economic Stabilization Act of 2008	MHPAEA becomes law and is intended to create parity (i.e., equality) between mental health and substance use disorder (MH/SUD) benefits and medical/surgical benefits (M/S).
November 13, 2013	Final Rules Implementing MHPAEA	These rules were issued to implement MHPAEA, including: • Establishing 6 classifications of benefits when comparing MH/SUD and M/S benefits • Parity in benefits requirements apply to financial requirements, numerically expressed QTLs, **and** NQTLs
December 27, 2020	CAA 2021	Amendment requiring group health plans and insurers to document and perform a comparative analysis of NQTLs under the plan to determine if plan's design and application of NQTLs are more stringent on MH/SUD benefits than M/S benefits
Various	Variety	Departments released a variety of FAQs, fact sheets, compliance assistance tools, templates, reports, and publications on complying with MHPAEA
December 29, 2022	CAA 2023	Sunsets ability of large, self-funded non-governmental employers to opt-out of MHPAEA requirements
July 25, 2023	Proposed Rules – Requirements Related to the MHPAEA	Proposed parameters for data necessary to complete NQTL analyses relative to network composition, evaluation of access to behavioral health care providers and network adequacy, and demonstration of compliance in the plan's operation
September 23, 2024	Final Rules – Requirements Related to the MHPAEA	Focused on NQTLs and the NQTL comparative analysis requirement. Provided more clearly defined standards to ensure that health plan sponsors and insurers do not apply more stringent limits on access to MH/SUD benefits as compared to M/S benefits within a health plan or policy

MHPAEA: The Rule

General Parity Requirements

"A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder **benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification**. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation."

(Treas. Reg. §54.9812-1(c)(2)(i))

MHPAEA: General Requirements

MHPAEA: To Whom Does it Apply?

WHO MUST COMPLY?

Group Health Plans

- Fully insured and self-insured
- Grandfathered and Non-Grandfathered
- Both ERISA/Non-ERISA Health plans
- Generally, employers with ≥ 50 employees (on business days in the preceding calendar year)
- For non-federal governmental plans, employers with ≥ 100 employees in states that define large group as 100 or more employees

Insurance Carriers

Health insurance issuers (therefore, even small group fully insured plans could be subject to MHPAEA due to Essential Health Benefit requirements)

MHPAEA: Exceptions

COVERAGE THAT MAY NOT BE SUBJECT TO MHPAEA

Certain coverages may not be subject to the MHPAEA

1) Group health plans only offering **excepted benefits** (e.g., stand-alone dental/vision coverage)
2) Retiree-only coverage
3) Plans subject to the “Increased Cost Exemption”

Non-Federal Governmental Plan Opt-Out:

Previously, self-funded plans could opt-out of MHPAEA requirements, but as of December 29, 2022, no new MHPAEA opt-outs were allowed, and any MHPAEA opt-outs that expired on or after June 27, 2023, were unrenewable (a limited exception may apply for plans that adopted multiple collective bargaining agreements).

Note: Health plan may be exempt from MHPAEA if (1) plan changes have been made to comply, resulting in increased costs of **at least 2% in the first plan year that MHPAEA applied** to the health plan**, and** (2) compliance with MHPAEA will result in **increased costs of at least 1% in subsequent plan years**. Exemption only applies in the plan year following the year the increased costs were incurred.

MHPAEA: What Does it Compare?

WHAT DOES IT COMPARE?

Mental Health & Substance Use Disorder Benefits

- IF a health plan provides mental health/substance use disorder (MH/SUD) benefits, parity rules apply
- Regulations clarify that benefits for MH/SUD must be defined under generally recognized independent standards and current medical practice (e.g., DSM, ICD, state laws)

Medical Surgical Benefits

Benefits for medical or surgical items that are consistent with generally recognized independent standards of current medical practice (e.g., ICD or independent standards)

MHPAEA: Financial-QTL-NQTL

Three Elements of Parity between MH/SUD Benefits and M/S Benefits

- Financial Requirements (e.g., Copays/Deductibles/MOOPs)
- Quantitative Treatment Limitations (QTLs) (e.g., Number of Visits)
- Non-Quantitative Treatment Limitations (NQTLs) (e.g., Prior Authorizations)
  - » Plan sponsors must perform a comparative analysis for NQTLs that can be provided to the Departments/State authorities

MHPAEA: Current Rules

REQUIRED CLASSIFICATIONS OF BENEFITS USED:

- Inpatient, In-Network
- Outpatient, In-Network
- Emergency Care
- Inpatient, Out-of- Network
- Outpatient, Out-of-Network
- Prescription Drug Formularies

MHPAEA: Financial Requirements and Treatment Limitations

MHPAEA

FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

GENERAL RULE: Plans must provide parity in both the financial requirements and quantitative treatment limitations between MH/SUD and M/S benefits in the same classification

Financial Requirements

Examples:
Deductibles, co-pays, co-insurance, MOOPs

Note: MH/SUD and M/S cost sharing must both count towards a combined deductible, MOOP

Quantitative Treatment Limitations

Examples:
Number of treatments, visits, or days of coverage

Note: Visit cap applies to both MH/SUD and M/S benefits

MHPAEA

NO SEPARATE CUMULATIVE FINANCIAL LIMITATIONS FOR M/S VS. MH/SUD

MH/SUD must accumulate towards the same cumulative financial requirements under the rules

A health plan cannot have two separate financial cumulative amounts (Deductible or MOOP) for M/S and MH/SUD

Example: A plan has both M/S items and services and MH/SUD items and services for a plan participant's out-of- pocket expenses for a plan year they accumulate towards the same $1,500 deductible and $5,000 MOOP under the plan.

The plan is considered compliant because the MH/SUD and the M/S out-of-pocket expenses accumulate towards the same $1,500 deductible under the plan (rather than the MH/SUD benefits accumulating towards a $1,500 deductible that is separate than the accumulation towards the M/S $1,500 deductible).

MHPAEA: Terms and Definitions

Terms and Definitions

Term	Definition
Classification	In-patient In-network, In-patient out-of-network, Out-patient in-network, Out-patient out-of-network, Emergency care, Prescription drug formularies
No More Restrictive	Are the financial requirements or treatment limitations placed on MH/SUD benefits greater than those imposed on M/S benefits?
Type	Comparison of the exact same restriction/financial requirement within the classification (e.g., copayment of in-network out-patient MH/SUD benefit as compared only to copayment of in-network out-patient M/S, annual visit limits on MH/SUD as compared to annual visit limits on M/S benefits)
Substantially All	Applies to at least 2/3 of all medical surgical benefits in the classification, based on a dollar amount of all payments for the M/S benefits in the classification (for financial and quantitative parity, substantially all may be different analysis for NQTLs). Cannot be applied to book of business, however if plan-level claims data is not credible, qualified actuary may utilize reasonable claims data from outside structured products/plans to make an actuarial projection.
Predominant	MH/SUD benefits cannot be more restrictive than the predominant financial requirement/treatment limitation applied to M/S benefits. Predominant means the most common/frequent occurrence for such financial requirement/treatment limitation.

MHPAEA: Classifications

MHPAEA: Permitted Classifications (Reminder)

Inpatient, In-Network

Outpatient, In-Network

Emergency Care

Inpatient, Out-of- Network

Outpatient, Out-of-Network

Prescription Drug Formularies

MHPAEA: Classification Rule

Classifications of benefits used for applying rules:

In addition, MHPAEA requires that if the plan covers mental health or substance abuse treatment in any classification, the plan must provide coverage in every/all category classification(s) that medical/surgical benefits are also provided.

"If a plan (or health insurance coverage) provides mental health or substance use disorder benefits in any classification of benefits described in this paragraph (c)(2)(ii), mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided."

Exception: Group health plans or issuers that provide coverage for mental health or substance use disorder benefits only to the extent required to comply with the ACA's preventive care mandate (under PHSA §2713) are not required to provide additional mental health or substance use disorder benefits in any classification in accordance with the mental health parity rules.

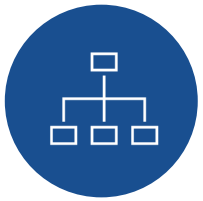
(Treas. Reg. §54.9812-1(c)(2)(ii))

MHPAEA: Subclassifications

ARE THERE ANY "SUBCLASSIFICATIONS" ALLOWED UNDER THE PLAN?

Office Visits

Final regulations provide that office visits may be a separate subclassification from all other outpatient services



Multiple Tiers for Network Providers

If a plan has multiple tiers for network providers, subclassifications can be created provided:

- Network tiering is based on reasonable factors (e.g., quality, performance and market standards)
- Without regard to whether a provider provides medical/surgical or mental health/substance use disorder services.
- A special rule applies if there are an uneven number of tiers between MH/SUD and M/S providers

MHPAEA

NO GENERALIST VS. SPECIALIST SUBCLASSIFICATION

Cannot Subclassify Generalists vs. Specialists

Generally, there can be no financial requirement/treatment limitation associated with a Generalist vs. Specialist (e.g., Psychotherapist) subclassification for MH/SUD benefits

Could occur IF – The predominant level of a type of financial requirement (e.g., copay) applies to "substantially all" M/S benefits in a classification is the one charged for a M/S specialist, then the specialist financial requirement may apply to all MH/SUD within that classification

Cannot occur IF – The predominant level of a type of financial requirement (e.g., copay) is charged for a M/S generalist, then the financial requirements for MH/SUD benefits (in the classification) cannot be greater than the M/S generalist financial requirement.

MHPAEA: Substantially All and Predominant Level Test for Financial and Quantitative Treatment Limitations

MHPAEA - Substantially All and Predominant (Financial and QTL)

APPLICATION OF THE “SUBSTANTIALLY ALL" AND “PREDOMINANT LEVEL" TESTS

Tests Based Upon Spending Associated within a Health Plan

Generally, this is based upon the expected "dollar amount of all plan payments for the M/S benefits in the classification" that will be" paid under the plan for the plan year."

Health Plan Expenses – These tests are based solely upon the health plan of the plan sponsor, and typically cannot be based upon the overall book of business to be paid for the year, or even on local/regional book of business

If Health Plan does not have Credible Data – A plan sponsor may utilize a qualified actuary that uses reasonable claims data from other comparable/similarly situated products/plans to draw a conclusion for an actuarily sound projection for those plan payments for the plan year.

MHPAEA: Substantially All (Financial and QTL)

“

For purposes of financial requirements and quantitative treatment limitations (QTLs), “substantially all” means that the limitation *“applies to at least two-thirds of all medical/surgical benefits in that classification. (For this purpose, benefits expressed as subject to a zero level of a type of financial requirement are treated as benefits not subject to that type of financial requirement, and benefits expressed as subject to a quantitative treatment limitation that is unlimited are treated as benefits not subject to that type of quantitative treatment limitation.) If a type of financial requirement or quantitative treatment limitation does not apply to at least two-thirds of all medical/surgical benefits in a classification, then that type cannot be applied to mental health or substance use disorder benefits in that classification.”*

(Treas. Reg. 54.9812-1(c)(3)(i)(A))

MHPAEA: Substantially All Test (Financial and QTL)

WHAT HAPPENS AFTER APPLYING THE "SUBSTANTIALLY ALL" TEST?

Does not satisfy "substantially all" test

The financial requirement/treatment limitation cannot apply to MH/SUD benefit

Satisfies the "substantially all" test

Go on to the "predominant benefits" test

MHPAEA: Predominant Test (Financial and QTL)

IF PLAN SPONSOR PASSES THE "SUBSTANTIALLY ALL" TEST, WHAT HAPPENS NEXT WITH THE "PREDOMINANT TEST”?

Predominant Test

The application of the financial requirement/treatment limitation to MH/SUD in the classification (or subclassification) cannot be more restrictive than the "predominant" financial requirement/treatment limitation that applies to M/S benefits

Comparison of Predominant Level(s) vs. Substantially All

Once the "type" of restriction/limit that is permitted is understood (substantially all test), then we discuss how much the plan will actually cover/level of treatment is covered under the health plan (predominant benefits test)

Definitions

Predominant:

"(1) If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification as determined under paragraph (c)(3)(i)(A) of this section, the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to ***more than one-half of medical/surgical benefits in that classification*** *subject to the financial requirement or quantitative treatment limitation.*

(2) If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all medical/surgical benefits in a classification, there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)"

MHPAEA: Predominant Level Test (Financial and QTL)

HOW TO APPROACH THE "PREDOMINANT LEVEL" TEST?

Predominant Test: Single Level

If there is only a single level of requirement/limitation that applies to more than 50% of the M/S benefits, then this one level is considered the "predominant level."

Predominant Test: Multiple Levels

If no single level applies to more than 50% of M/S benefits subject to limit/requirement, then health plan can combine levels until the level applies to more than 50% limit/requirement within the classification (Aggregate rule), and the least restrictive level in the combined levels is considered the "predominant level."

MHPAEA: Predominant Level Test (Financial and QTL)

EXAMPLES – SINGLE PREDOMINANT LEVEL TEST

Examples of the single "predominant levels" of benefits test:

If a plan has two different levels of copayments - $20 (PCP), $40 (Specialist)

- 60% of all in-network copayments are projected to be for primary care, subject to a $20 copay, and 40% of in-network copayments are projected to be for specialty visits.
- Office visits (OV) constitute 80% of all outpatient, in-network services.
- The PCP copay constitutes the predominant level if:
  - The OV copay applies to substantially all benefits for in-network outpatient care, and
  - More than 50% of copayments for office visits (60%) apply to the PCP network.

MHPAEA: Predominant Level Test (Financial and QTL)

EXAMPLES OF "AGGREGATE RULE" FOR PREDOMINANT LEVEL TEST

When doing an analysis of the "predominant levels" of benefits and the “aggregate rule”:

If a plan has THREE different levels of copayments $20 (PCP) Preferred Network, $40 (PCP) Standard Network, $60 Specialist

- 30% of all in-network copayments are projected to be for preferred network primary care, subject to a $20 copay, 40% of in-network standard PCP copayments ($40) and 30% are projected to be for specialty visits.
- Office visits constitute 80% of all outpatient, in-network services.
- The rule permits aggregation of the two highest network copay tiering levels ($20 and $40)
  - The Standard PCP OV copay ($40) is the least restrictive cost-sharing level for in-network outpatient care and would be considered the predominant level because no single tier is attributable to more than 50%

MHPAEA: Special Rules

WHAT ARE SOME SPECIAL RULES UNDER THE "PREDOMINANT LEVEL" TEST?

Units of Coverage

If there are different plan requirements/limits that apply to different tiers (employee, employee+) then analysis must be done on each unit of coverage.

Example: Different deductible limits for single vs. family coverage.

Multi-tier Rx Benefits

If different $$ requirements are applied to different tiers of Rx drugs, then plan satisfies the parity requirements, so long as:

- The different tiers are based on certain reasonable factors (e.g., generic/non-generic, cost, mail order, efficacy); and
- The Rx drug is generally prescribed to a patient, regardless of whether the Rx drug is used for M/S or MH/SUD

MHPAEA

EXAMPLES OF MULTI-TIERED RX COVERAGE UNDER THE PREDOMINANT LEVEL TEST

Multi-tiered Rx coverage under the "predominant levels" of benefits test:

A plan applies the same financial requirements for use of a prescription drug benefit in both the M/S and MH/SUD environment. In addition to that, any drug tiers (generic, preferred/non-preferred brand name, and specialty) all comply with the non-quantitative treatment limitation (NQTL) rules.

- This Rx drug program would satisfy the "predominant level" test, along with passing the parity requirements under the rules.

MHPAEA: Non-Quantitative Treatment Limitations and the NQTL Comparative Analysis

Non-Quantitative Treatment Limitations

GENERAL RULE: Plans must also provide parity with respect to non-quantitative treatment limitations between medical/surgical benefits and mental health/substance use disorder benefits in the same classification

Non-Quantitative Treatment Limitations

Examples:

Medical management standards, prescription drug formulary design, prior authorizations

MHPAEA: Final Rules

Final Rules were Released in September 2024 and Focused on the Comparative Analysis of NQTLs for MH/SUD Benefits and M/S Benefits

Generally, a plan must ensure that, as written and in operation, any NQTL that is applied to MH/SUD benefits is comparable to, and applied no more stringently than, the M/S benefits offered under the plan pursuant to the MHPAEA rules. 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 already existed, final rules adopted further instructions and clarifications on what information should be included in a health plan's required comparative analysis.

MHPAEA: MH/SUD vs. M/S Definition

Adoption of Independent Medical Standards for NQTLs

Effective January 1, 2025

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 these conditions/procedures related to these terms that are 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)). If 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 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).

Potential Meaning

Plan cannot classify a condition as a M/S benefit, when in actuality the condition would be considered a MH/SUD benefit under an Independent Medical Standard, in order to avoid MHPAEA parity comparison.

MHPAEA: MH/SUD vs. M/S Definition

All or Nothing Approach to Definitions of MH/SUD under NQTL rules

The final rules also state 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."

Potential Meaning

This generally means that plans may no longer be able to have a treatment limitation on a mental health benefit, even if the MH/SUD could have a treatment component that could be categorized as a M/S benefit (e.g., nutritional counseling).

Example: A plan cannot categorize nutritional counseling as only a medical/surgical benefit, because nutritional counseling would be considered a treatment for mental health conditions (e.g., eating disorders), and therefore nutritional counseling should be an available treatment for **both** mental health and medical conditions.

MHPAEA: Treatment Limitations

Complete Exclusion from a Plan is not a Treatment Limitation

"…exclusion of all benefits for a particular condition or disorder is not [considered] a treatment limitation for purposes of the definition"

Potential Meaning

This could generally mean that plans may exclude a condition from the plan*. However, if a plan offers any kind of coverage for the condition (e.g., diagnosis for Autism Spectrum Disorder) then a comparative analysis of whether the NQTL imposed on that condition is no more restrictive than those NQTLs imposed on M/S benefits would be required (e.g., ABA therapy prior authorization requirements). For plan years on or after January 1, 2026, a plan must offer "meaningful benefits", so complete exclusions of treatments may be problematic as well.

* Exclusions could still implicate discrimination under other laws, potentially creating litigation risk for employers

NQTL – No More Restrictive Requirement

MHPAEA: No More Restrictive Requirement

NQTLS AND THE NO MORE RESTRICTIVE REQUIREMENT

> "…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."

(Preamble, Final Rules)

MHPAEA NQTL Comparative Analysis: No More Restrictive

Plans must generally satisfy these two requirements under the “no more restrictive” rule:

1. Design and Application
2. Relevant Data Evaluation

MHPAEA NQTL Comparative Analysis: No More Restrictive

Effective for PYs beginning on or after January 1, 2025

Design and Application Requirement:

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…"

MHPAEA NQTL: Reasoning Behind NQTL

Effective January 1, 2025

Generally, a plan must ensure that, as written and in operation, any NQTL applied to MH/SUD benefits is comparable to, and applied no more stringently than, the M/S benefits offered under the plan pursuant to the MHPAEA rules.

- **Evidentiary Standards**
- **Factors**
  - » Does not include information that was considered early on in the "design process" but focuses more on information that the plan "relied upon and rejected."
- **Processes**
- **Strategies**

Health Plans Must Perform Comparative Analysis on NQTL

Therefore, anything used by a plan 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).

This includes information that the plan/issuer considered but ultimately rejected in their consideration when implementing an NQTL.

MHPAEA: Six Elements of NQTL Analysis

Six elements must be contained in NQTL Comparative Analysis (Effective for PYs beginning on or after 1/1/25, except Relevant Data Requirement effective for PYs beginning on or after 1/1/26).

- A description of the NQTL
- The identification and definition of the factors used to design or apply the NQTL
- A description of how factors are used in the design or application of the NQTL
- A demonstration of comparability and stringency, as written
- A demonstration of comparability and stringency in operation
- Findings and conclusions

MHPAEA NQTL: Relevant Data Evaluation

Effective for PYs beginning on or after **January 1, 2026**

Relevant Data Evaluation:

Plans must compare/review quantitative outcomes data, 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).

Material Differences in Access to Networks or Network Composition

If a plan has material differences in **access or its network composition** of its MH/SUD benefits as compared to its M/S benefits, a plan/issuer could be required to take corrective action (and document such corrective action) to resolve any issues that may be related to this **material difference** in access to these services, as this would be considered a "strong indicator" of MHPAEA non-compliance.

The Departments clarify that if a plan or issuer chooses not to consider certain 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."

NQTL – Meaningful Benefits Standard

MHPAEA NQTL: Meaningful Benefits Standard

Effective January 1, 2026

Meaningful Benefits Standard:

If any benefits for a MH/SUD condition or disorder are provided 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.

Presumption of Discrimination

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 condition or procedure. 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.”

MHPAEA NQTL: Meaningful Benefits Standard

Example of Meaningful Benefits Standard

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 a therapeutic intervention, do not constitute a core treatment for ASD. The plan violates the final rules because although the plan 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 that 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 treatment of ASD in that classification.

MHPAEA and ERISA Fiduciary Duties

ERISA Plans

All private plans are subject to ERISA. These are two kinds of health plans <u>not</u> subject to ERISA:

1. Church Plans
2. Governmental Plans

MHPAEA: ERISA and Fiduciary Responsibilities

ERISA AND MHPAEA ANALYSIS

Effective first day of PYs beginning on or after January 1, 2025

- ERISA - NQTL comparative analysis needs to include a certification by a "named fiduciary" as part of the Findings and Conclusions. Certification confirming the fiduciaries engagement in a prudent process to select one or more qualified service providers to perform and document an NQTL comparative analysis, as well as a duty to monitor these service providers.

- **Brown & Brown should not state that just because carrier/TPA agrees to perform test that this satisfies the fiduciary's obligation. Must assess with their own legal counsel.**

Action Plan

Compliance Steps

1. Group health plan sponsors should determine whether the plan is subject to MHPAEA, or if exemptions may apply (e.g., the plan qualifies as an excepted benefit).

2. Review financial and quantitative treatment limitations (QTLs) to ensure the plan design does not contain any restrictions or limitations on MH/SUD that are more restrictive than the restrictions or limitations applicable to M/S benefits. (A self-compliance tool to assist with this review is available on the DOL website.)

3. 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). 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

4. Ensure that an NQTL comparative analysis 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.

5. 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).

Plan sponsors should consult with their employee benefits attorney for specific advice on how to comply with MHPAEA.

Resources

HRCI and SHRM Credits

This Program, **ID No. 688725**, has been approved for 1.00 HR (General) recertification credit hours toward aPHR™, aPHRi™, PHR®, PHRca®, SPHR®, GPHR®, PHRi™ and SPHRi™ recertification through HR Certification Institute® (HRCI®).

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