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Final Mental Health Parity Rule Spells Compliance Changes

by Kaitlyn Malkin on October 17, 2024

The long-anticipated final rule under the Mental Health Parity and Addiction Equity Act (MHPAEA) was published on September 9, 2024. The MHPAEA prohibits group health plans that provide mental health and substance use disorder (MH/SUD) benefits from imposing more restrictive coverage limitations on such benefits than the plan imposes on medical and surgical (M/S) benefits. The Consolidated Appropriations Act of 2021 (CAA) requires group health plans to document comparative analyses of nonquantitative treatment limitations (NQTLs) to ensure compliance with the MHPAEA. The final rule ensures that group health plan sponsors evaluate participant access to MH/SUD benefits and amend their plans if necessary to provide greater access to MH/SUD benefits.

Many of the requirements under the final rule are effective for plan years beginning on or after January 1, 2025. Certain requirements that necessitate substantial changes to plan administration will not be effective until plan years beginning on or after January 1, 2026.

Plan sponsors need to be aware of the extensive MHPAEA compliance requirements under the final rule and the new requirement that plan fiduciaries certify they are acting prudently to follow MHPAEA requirements.

What is Effective in 2025?

The final rule contains the following important changes, effective for plan years beginning on or after January 1, 2025:

- **Requires Group Health Plans to Define whether a Condition or Disorder is an MH Condition or SUD:** Group health plans must define whether a condition or disorder is classified as MH/SUD, consistent with the most current version of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders (commonly known as DSM).
- **Requires Group Health Plans to Make Changes when it Provides Inadequate Access to MH/SUD Care:** Group health plans must collect and evaluate data to determine if there are material differences in access to MH/SUD benefits as compared to M/S benefits from the application of an NQTL. NQTL testing outcomes will show where a plan is failing and where it must be updated to achieve compliance. Group health plans cannot use restrictive medical management techniques or narrow networks to make it more difficult for participants to access MH/SUD benefits than M/S benefits.

- **Codifies the NQTL Comparative Analysis Requirement:** Group health plans must conduct a comparative analysis to measure the effect of NQTLs on its plan both as written and in operation. This analysis includes a review of standards related to network composition, out-of-network reimbursement rates, utilization, and medical management NQTLs.
- **Clarifies the Meaning of Terms:**
  - The final rule refines the definitions of medical/surgical benefits, mental health benefits, and substance use disorder benefits by removing references to state guidelines. In practice, a plan can no longer refer to state insurance requirements as justification for any limitation in its benefit offerings.
  - The final rule adds definitions to terms relevant to how an NQTL is designed and applied, including definitions for evidentiary standards, factors, processes, and strategies.
- **Eliminates the MHPAEA Opt-Out:** The final rule eliminates the ability of state and local government group health plans to opt out of compliance with the MHPAEA on and after December 29, 2022.

What is Effective in 2026?

The final rule delays implementation of the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the required use of outcomes data, and related NQTL comparative analysis requirements until plan years that begin on or after January 1, 2026.

- **Meaningful Benefits Standard**: If a plan provides any benefits for a mental health condition or substance use disorder in any benefit classification, it must provide meaningful benefits, including core treatments, in all classifications where core treatments are provided for M/S conditions.
- **Prohibition on Discriminatory Factors and Evidentiary Standards:** Group health plans are prohibited from using factors, information, evidence sources, and evidentiary standards to design or apply NQTLs that discriminate against MH conditions and SUDs.
- **Use of Outcomes Data and Revised NQTL Standards:** Group health plans cannot impose an NQTL in any classification that is “more restrictive” on MH/SUD benefits, as written or in operation, than is imposed on substantially all M/S benefits in the same classification. The final rule adds two metrics to determine whether an NQTL is more restrictive to MH/SUD benefits: design/application and data evaluation.
  - **Design and application of the NQTL:** Group health plans cannot apply an NQTL to MH/SUD benefits unless the processes, strategies, evidentiary standards, and factors

used to design and apply the NQTL are comparable to and applied no more stringently than those used for M/S benefits in the same classification.

- **Data evaluation:** Group health plans must collect and evaluate relevant outcomes data and take reasonable actions to address any material differences in access between MH/SUD and M/S benefits.

The Departments plan to issue additional guidance and update the MHPAEA self-compliance tool to provide information regarding the data that should be collected and evaluated to assist group health plans in satisfying the comparative analysis requirements. Plan sponsors should continue to follow the comparative analysis requirements under the CAA and the final rule.

Required Elements for an NQTL Comparative Analysis

As described above, a group health plan may not impose any NQTL that is more restrictive on MH/SUD benefits, as written or in operation, than the predominant NQTL that applies to substantially all M/S benefits in the same classification.

Under the final rule, the following specific elements must be included in a NQTL comparative analysis:

1. A description of the NQTL, including identification of benefits subject to the NQTL;
2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;
3. A description of how factors are used in the design or application of the NQTL;
4. A demonstration of comparability and stringency under the design and application requirements of the factors and evidentiary standards relied upon, as written. The plan demonstrates the comparability and stringency of the NQTL by comparing how the NQTL is applied to MH/SUD benefits and to M/S benefits, including any documentation used in designing and applying the NQTL or that addresses the application of the NQTL. The plan will need to provide an explanation of the reasons for any deviation or variation in the application of a factor used to apply the NQTL to MH/SUD benefits as compared to M/S benefits and how the plan established that deviation or variation;
5. A demonstration of comparability and stringency in operation, including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences; and
6. Findings and conclusions.

The proposed rule included mathematical tests to determine whether the benefits met the "substantially all" test (as described above) or "predominant" test (whether the NQTL, as applied to MH/SUD benefits in a classification, is more restrictive than the predominant variation of the NQTL as applied to substantially all M/S benefits in that classification) and were similar to the *quantitative* treatment limitation tests for those metrics already in place. Of note, the mathematical tests were not retained in the final rule, likely in recognition of the challenges associated with implementing

them and the legal challenges that may confront the final rule following the reversal of agency deference by the Supreme Court in *Loper Bright Enterprises v. Raimondo*, 144 S.Ct. 2244 (2024).

Group health plans must have a current NQTL Comparative Analysis report on file. The report must be made available within ten business days of a request by the Departments of Labor, Health and Human Services, the Treasury, any applicable state authority, or a plan participant or beneficiary in the group health plan. Since the comparative analysis requirement has been in effect since February 2021, the Departments are not likely to accept a request for an extension to produce a comparative analysis.

Effect of Final Determination of Noncompliance

If a group health plan receives a determination from the Department of Labor, Health and Human Services, or the Treasury that an NQTL is not in compliance with the NQTL comparative analysis requirements, the Department that made the determination may prohibit the plan from imposing the NQTL for MH/SUD benefits until the plan proves compliance or remedies the violation.

If the relevant Department Secretary makes a final determination of noncompliance, the group health plan must notify all participants and beneficiaries, all service providers involved in the claims process, and any fiduciary responsible for deciding benefit claims of the plan's noncompliance within seven business days. Affected service providers must consider whether changes in claims adjudication are required and must implement those changes to comply with the final determination of noncompliance.

Added Fiduciary Requirements for ERISA Plans

For plans subject to ERISA, the comparative analysis must include a certification by a plan fiduciary that it has engaged in a prudent process to select a service provider to perform and document a comparative analysis in connection with any NQTLs under the plan and has satisfied its duty to monitor those service providers concerning their performance.

Self-funded group health plans are responsible for drafting the NQTL Comparative Analysis, while insurers are responsible for drafting the NQTL Comparative Analysis for fully insured group health plans. Drafting a comparative analysis report is a service not typically included in an administrative service agreement between a third-party administrator and a self-funded group health plan. In many cases, the third-party administrator declines to perform the comparative analysis despite being the entity in the best position to do so. Accordingly, fiduciaries of self-funded plans often need to find a different service provider to perform the analysis.

Selecting a service provider as part of a prudent process under the new fiduciary requirements may be difficult, as not every service provider will perform a complete analysis that will comply with the terms of the final rule. Some service providers that perform NQTL comparative analyses for self-funded group health plans do not certify that their analysis complies with the MHPAEA requirements or that the plan itself complies with the MHPAEA. To ensure satisfaction of fiduciary requirements, the plan should engage service providers who will certify that their analysis complies

with the MHPAEA. If a service provider is unwilling to make this certification, the plan fiduciary should engage experienced employee benefits counsel to review the report to ensure compliance. Verrill can analyze the sufficiency of a comparative analysis prepared by a third party, complete a certified comparative analysis report on behalf of our clients, and analyze whether the plan complies with the MHPAEA.

If you have questions about the effect of the MHPAEA final rule on your group health plan or how to obtain a compliant NQTL Comparative Analysis, please contact kmalkin@verrill-law.com or any member of our Employee Benefits & Executive Compensation Group.

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