What Plan Sponsors Need to Know About the Final Rule under the Mental Health Parity and Addiction Equity Act

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The final regulations amending the existing Mental Health Parity and Addiction Equity Act ("MHPAEA") regulations were released in September of this year by the Departments of Labor ("DOL"), Treasury, and Health and Human Services (collectively the "Departments") (the "Final Rule"). The chief focus of the Final Rule is ensuring parity in *access* to mental health/substance use benefits as compared with medical/surgical benefits. The Departments make it clear they believe that despite MHPAEA being in effect since 2008, disparities between coverage of mental health /substance use disorder benefits and medical/surgical benefits are actually getting worse. For example, the preamble to the Final Rule cites a study by RTI International which found that out-of-network use was 3.5 times higher for all behavioral health clinician office visits compared to medical/surgical office visits and that this was not fully attributable to behavioral health provider shortages. The preamble notes that the RTI study also revealed material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits, as reflected in much greater use of out-of-network providers for mental health/substance use disorder benefits.

Amended and New Definitions

The Final Rules provide amended definitions for the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits."

What are Medical/Surgical Benefits? The term "medical/surgical benefits" means benefits for medical or surgical procedures, as defined under the plan or health insurance coverage. While a plan sponsor has some discretion in defining "medical/surgical benefits," the preamble to the Final Rules clarify that this discretion must "comport with generally recognized independent standards of current medical practice." In other words, the plan's definition of medical/surgical benefits must follow the most current version of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM).

Note: Prior law required that the term "medical/surgical benefits" also must be defined in accordance with applicable state guidelines. Effective for plan years beginning or after January 1, 2025, the Final Rules eliminate the requirement that the "medical/surgical benefits" definition must comply with applicable state guidelines. However, if generally recognized independent standards of current medical practice do not address whether a condition or procedure is medical/surgical, then the plan sponsor may define such condition or procedure in accordance with applicable federal and state law.

What are Mental Health Benefits? Mental health benefits are benefits with respect to services or items for mental health conditions, as defined under the plan. For this purpose, when defining "mental health benefits," the plan sponsor must include all conditions covered under the plan that fall under any of the diagnostic categories listed in the mental, behavioral and neurodevelopmental disorders chapter of the most current version of the ICD or that are listed in the most current version of the DSM. These standards are required to ensure that the plan does not misclassify benefits to avoid the parity requirements.

Note: Similar to "medical/surgical benefits," effective for plan years beginning or after January 1, 2025, the Final Rules eliminate the requirement that "mental health benefits" must be defined in accordance with applicable state guidelines. To the extent that generally recognized independent standards of current medical practice do not address whether a condition or procedure is a mental health benefit, then the plan may define the condition or procedure in accordance with applicable federal and state law.

What are Substance Use Disorder Benefits? Effective for plan years beginning on or after January 1, 2025, a plan's definition of "substance use disorder" benefits must include all disorders covered under the plan that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use in the mental, behavioral, and neurodevelopmental disorders chapter of the most current version of the ICD or that are listed as a Substance-Related and Addictive Disorder in the most current version of the DSM. The Final Rules clarify that the plan is not required to define "substance use disorder benefits" in accordance with applicable state guidelines.

New definitions added. The MHPAEA rules state that a "plan or issuer may not impose an NQTL with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan…as written and in operation, any "processes," "strategies," "evidentiary standards," or "other factors" used in 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 applying the limitation with respect to medical/surgical benefits in the same classification." The Final Rules create new definitions of these terms as follows:

- "Processes" are actions, steps, or procedures that a plan uses to *apply* an NQTL
- "Strategies" are practices, methods, or internal metrics that a plan considers, reviews, or uses to *design* an NQTL
- "Evidentiary standards" are any evidence, sources, or standards that a plan considered or relied upon in designing or applying a factor with respect to an NQTL
- "Factors" are all information, including processes and strategies that a plan considered or relied upon to design an NQTL or to determine whether or how the NQTL applies to benefits under the plan

Two Sets of Requirements When Imposing NQTLs. A group health plan cannot impose an NQTL on mental health/substance use disorder benefits in any classification that is more restrictive (as written or in operation) than the predominant NQTL limitation that applies to substantially all medical/surgical benefits in the same classification. Under the Final Rules (effective for plan years beginning on or after January 1, 2026), an NQTL for mental health/substance use disorder benefits must satisfy two new standards: (1) the design and application requirements; and (2) the relevant data evaluation requirements.

Design and Application Requirements. A group health plan may not impose an NQTL for a mental health or substance use disorder benefit unless, under the terms of the plan (as written and in operation), the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL are *comparable to*

and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitations with respect to medical/surgical benefits.

When determining whether the NQTL is "comparable," the plan sponsor must make sure not to rely on discriminatory factors or evidentiary standards when designing an NQTL for mental health/substance use disorder benefits. When determining whether a factor or evidentiary standard is discriminatory, the plan sponsor must evaluate whether the information, evidence, sources, or standards on which they are based are biased or not objective in a manner that discriminates against the mental health/substance use disorder benefit in comparison to medical/surgical benefits.

Note: The Final Rule does allow the plan sponsor to use generally recognized independent professional medical or clinical standards, as well as measures designed to detect, prevent and prove fraud or abuse, provided that any negative impact on access to mental health and substance use disorder benefits are minimized.

Relevant Data Evaluation Requirements. To ensure that NQTLs for mental health/substance use disorder benefits are not more restrictive than those for medical/surgical benefits in operation, plan sponsors must gather and evaluate "relevant data" to ensure that access to mental health/substance use disorder benefits is not unduly restricted compared with medical/surgical benefits. These requirements will be effective for the first plan year beginning on or after January 1, 2026. The Final Rules provide two illustrative examples of "relevant data" that may be utilized:

- The number and percentage of claims denials
- Network composition: in-network and out-of-network utilization relates, network adequacy metrics (e.g., time and distance data; and data on providers accepting new patients), and provider reimbursement rates

If plan sponsor discovers that the "relevant data" shows significant differences in access between mental health/substance use disorder benefits and medical/surgical benefits — the plan sponsor must take action to address these disparities. Further, the plan sponsor must document the actions that were taken by the plan to address any material differences in access to mental health or substance use disorder benefits, as compared to medical/surgical benefits.

Network Adequacy: The regulators place special emphasis on NQTLs related to network composition. These requirements will be effective for the first plan year beginning on or after January 1, 2026. The Final Rules provide that if "relevant data" shows that access to mental health/substance use disorder benefits related to network composition is materially different from access to medical/surgical benefits, the plan sponsor should take actions such as the following:

- Strengthening efforts to recruit and encourage a broad range of available mental health and substance use disorder provider and facilities to join the plan's network of providers (e.g., by increasing provider compensation, streamlining credentialing processes, etc.
- Expanding the availability of telehealth arrangements to help with provider shortages in certain geographic regions
- Providing additional outreach assistance to participants enrolled in the plan (e.g., to assist them in finding available in-network mental health providers and facilities)
- Ensuring that provider directors are accurate and reliable

Meaningful Benefits Requirement

The Final Rule requires that if a plan provides any benefits for a mental health or substance use disorder condition in any classification,[1] it must provide "meaningful" benefits for that mental health condition or substance use disorder in every classification in which medical/surgical benefits are provided. Whether benefits are "meaningful" is determined in comparison to the benefits provided for medical conditions and surgical procedures. To be "meaningful" the plan must provide benefits for a "core treatment" for the condition or disorder in each classification in which the plan provides benefits for a "core treatment" for one or more medical conditions or surgical procedures.

A "core treatment" means a standard treatment or course of treatment, therapy, service or intervention indicated by a generally recognized standards of current medical practice. The Final Rule provides examples specifying that coverage of ABA therapy is a "core treatment" for Autism Spectrum Disorder and nutritional counseling is a "core treatment" for eating disorders.

Note: While not characterized as such, this requirement is, in effect, a benefits mandate with regards to the kinds of treatments that plans must provide for covered mental health conditions and substance use disorders.

The "meaningful benefits" requirement will be effective for plan years beginning on or after January 1, 2026.

NQTL Comparative Analysis Requirements

As noted above, the CAA amended MHPAEA to require that plans perform and document comparative analyses of the design and application of each NQTL applicable to mental health/substance use disorder benefits. The Final Rule provides the following with regard to the comparative analysis:

Content Requirements – For each NQTL applicable to mental health/substance use disorder benefits the comparative analysis must include, at a minimum, the six content elements specified in the Final Rule, which include: (1) a description of 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 and application of the NQTL; (4) a demonstration of comparability and stringency as written; (5) a demonstration of comparability and stringency in operation; and (6) findings and conclusions.

The Final Rule goes into great detail describing what must be included within each of the six content elements. The Final Rule provides much greater detail than prior informal guidance regarding exactly what the DOL expects should be included in a comparative analysis. This is particularly welcome, given that the DOL has generally found all comparative analyses that it previously reviewed to be insufficient in at least some respects.

Fiduciary Certification

For group health plans that are subject to ERISA, the NQTL comparative analysis must include a certification by one or more named fiduciaries that they: (i) have engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis in accordance with applicable law and regulations and (ii) have satisfied their duty to monitor these service providers (as required by ERISA) with respect to the performance and documentation of the comparative analysis. This requirement will go into effect for the plan year beginning on or after January 1, 2025.

In a welcome change, the Final Rule did not adopt the proposed rule's requirements that a fiduciary must certify that the comparative analysis is itself in compliance with the regulations. Instead, the Final Rule relies on general fiduciary standards governing the selection and monitoring of service providers.

As background, ERISA requires that fiduciaries must act prudently when selecting a service provider. Based on previous DOL guidance[2] we believe this would include the following:

- The selection process should be objective and designed to avoid self-dealing, conflicts of interest, and other improper influences
- The fiduciary should obtain information necessary to assess: (i) the qualification of the vendor; (ii) the quality of the work product; and (iii) the reasonableness of the fees charged in light of the services provided
- The fiduciary is not required to select the lowest bidder; however, the fiduciary must determine that the compensation paid to the service provider is reasonable in light of the services provided
- The fiduciary should not consider one factor (such as lowest cost) to the exclusion of any other factors (such as the quality of the work product)
- The selection process should be documented

After engaging the comparative analysis vendor, the fiduciary must continue to monitor the performance of the vendor and document any such monitoring.

The preamble provides a helpful description of DOL's expectations as to the actions that a prudent fiduciary will take with regard to the comparative analysis. At a minimum, the expectations are that the fiduciary will:

- Review the comparative analysis
- Ask questions as needed to understand it
- Ensure that a service provider responsible for performing the comparative analysis provides assurance that, to the best of its ability, the NQTL and associated comparative analysis complies with the requirements of MHPAEA

As noted above, fiduciaries will want to ensure that this process is clearly documented.

Disclosure Requirements

Disclosure to Government Entities. The Final Rule contains a detailed process and time frame by which a plan must submit the comparative analysis upon request by the secretary or applicable state authority (a mere 10 days) as well as the process and time frame that would be followed if the secretary or state authority determines that the comparative analysis or other information submitted by the plan is insufficient. The Final Rule also sets forth actions that plan sponsors will be required to take if there is a final finding of non-compliance which would include notice to all participants and beneficiaries.

Disclosure to Participants. Under the Final Rule, the NQTL comparative analysis must be provided upon request by a participant and in relation to a document request related to an adverse benefit determination.

ERISA Section 104(b) requires that plans subject to ERISA must provide, among other documents, "instruments under which the plan is established or operated" to participants within thirty days of a request. The Final Rule specifies that the NQTL comparative analysis and other documents relating to NQTLs are "instruments" under which a plan is established or operated; therefore, they must be provided to participants.

The ERISA Claims procedure regulations require that plans subject to ERISA must provide certain documents and information to participants upon request that are relevant to the claim for benefits. The Final Rule specifies that (if applicable to the claim determination) this would include the comparative analysis and other information related to the applicable NQTL.

Note: Plan Sponsors will need to ensure they comply with this disclosure requirement when a participant makes a request for relevant information relating to a claim or appeal denial.

Conclusion

We note that the DOL has stated on many occasions that MHPAEA compliance is one of its top enforcement priorities. Compliance with the Final Rule will be a very heavy lift for plan sponsors. For this reason, they will need to work closely with their third-party administrators, consultants, legal counsel and other service providers to ensure that their plan has met all of the many compliance obligations contained in the Final Rule by the various effective dates.

[1] The six classifications include: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

[2] See for example DOL Information Letter 02-19-1998 (February 19, 1998).

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