GBS Health Benefits Compliance

Mental Health Parity: Final Rules Expand Group Health Plan Compliance Requirements

In September 2024, the DOL, HHS, and IRS released final rules (and an associated fact sheet) under the Mental Health Parity and Addiction Equity Act (MHPAEA), focusing on nonquantitative treatment limitations (NQTLs) and the written comparative analysis requirement that was previously established under the CAA, 2021.

The final rules amended existing MHPAEA regulations to incorporate new and revised definitions of key terms and to specify the steps that plans (or insurers) must take to comply with MHPAEA. They also include provisions codifying minimum standards for NQTL comparative analyses and reflect the sunset of the non-federal governmental plan opt-out election.

Legal challenges were expected for some portions of the Final Rules, especially in light of the *Loper Bright* Supreme Court decision earlier in 2024 (holding that regulatory agencies are no longer given the same type of deference to interpret statutes when they issue regulations).

In January 2025, the ERISA Industry Committee ("ERIC") filed a lawsuit in the US District Court for the District of Columbia, asking the court to invalidate, and prevent enforcement of, the Final Rule, alleging the rule is in violation of the federal Administrative Procedure Act ("APA").

The impact of *ERIC v. US Dept. of Health and Human Services* on the Final Rule remains uncertain. However, as of now, the rules remain in effect with no immediate impact. So, as a reminder, here are the Final Rule highlights most important to group health plan sponsors:

- **Applicability date.** The final rules generally apply to group health plans for plan years beginning on or after January 1, 2025. However, several provisions–including those implementing the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, required use of outcomes data, and certain related comparative analysis requirements–will not apply until plan years beginning on or after January 1, 2026. Until these effective dates, plans still must continue to comply with existing requirements, including the CAA, 2021 amendments to MHPAEA that generally requires the written NQTL comparative analysis.

- **Meaningful benefit requirement.** Plans that provide any benefits for a mental health (MH) condition or substance use disorder (SUD) must provide "meaningful benefits" for that condition or disorder in every benefit classification in which meaningful medical/surgical benefits are provided. Meaningful benefits require coverage of a core treatment for the condition or disorder in each classification in which the plan covers a core treatment for one or more medical conditions or surgical procedures. For example, if a plan generally covers autism but excludes coverage for applied behavior analysis (ABA) for autism spectrum disorder, it would almost certainly violate the meaningful benefits requirement.
- **Requirements for NQTLs.** Plans may not impose NQTLs with respect to MH/SUD benefits in any classification that are more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical/surgical benefits in the same classification. Acknowledging concerns that NQTLs are inherently nonquantifiable, the agencies declined to finalize a proposed mathematical test for defining "substantially all" and "predominant." In implementing an NQTL, the plan must satisfy two sets of requirements:
    - *Design and application requirements*. The plan must examine the processes, strategies, evidentiary standards, and other factors used in designing and applying an NQTL to MH/SUD benefits in the classification to ensure they are comparable to, and applied no more stringently than, those used in designing and applying the limitation with respect to medical/surgical benefits in the same classification. Also, plans may not use discriminatory factors and evidentiary standards in designing an NQTL to be imposed on MH/SUD benefits. Generally recognized independent professional medical or clinical standards are considered nonbiased and objective, as are carefully circumscribed measures reasonably designed to detect or prevent and prove fraud and abuse and minimize the negative impact on access to appropriate MH/SUD benefits.
    - *Relevant data evaluation requirements*. Plans must (1) collect and evaluate relevant data, which may vary based on the facts and circumstances, but includes data on network composition; (2) assess the data and determine whether the data suggest an NQTL contributes to material differences in relevant outcomes related to access to MH/SUD benefits compared with medical/surgical benefits; and (3) if material differences in relevant outcomes related to access exist, take reasonable action to address the material differences to ensure operational compliance. When collecting and evaluating data to assess the NQTLs' impact on relevant outcomes, this may entail reviewing in-network and out-of-network utilization rates, provider reimbursement rates, and the number of providers within a certain geography or providers accepting new patients. If the number of providers in the network is too low, reasonable steps should be taken to correct or expand the network.
- **Comparative analysis requirement.** Plans must perform and document NQTL comparative analyses and submit them to a requesting agency (e.g., the DOL) within ten business days of the request. The analysis must:

- (1) Describe the NQTL, including identification of benefits subject to the NQTL.
- (2) Identify and define the factors and evidentiary standards used to design or apply the NQTL.
- (3) Describe how factors are used in the design or application of the NQTL.
- (4) Evaluate whether processes, strategies, evidentiary standards, or other factors are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits, as written.
- (5) Evaluate whether processes, strategies, evidentiary standards, or other factors are comparable to, and applied no more stringently than, those with respect to medical/surgical benefits, as applied 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.
- (6) Address findings and conclusions regarding comparability and relative stringency.

Plans must also prepare and make available to the agencies, upon request, a written list of all NQTLs imposed under the plan. An exhaustive list of NQTLs was not provided by the regulatory agencies (as was requested by commenters)–so, plans should use a best faith effort to analyze any NQTL that limits the scope or duration of treatment. The agencies intend to provide additional examples of NQTLs in future updates to the MHPAEA Self-Compliance Tool.

› **Requirement to provide comparative analysis to individuals.** For plans subject to ERISA, they must provide a copy of their NQTL comparative analyses to any participant, beneficiary, or enrollee within 30 days upon the individual's request.

› **Fiduciary certification.** For plans subject to ERISA, the comparative analysis must now include a certification stating that a plan fiduciary has undertaken a prudent process to select one or more qualified service providers to perform and document the comparative analysis of any NQTLs applied to MH/SUD benefits under the plan. The fiduciary must also confirm it has fulfilled its obligation to oversee and monitor those service providers.

- Note the certification requirement may come from any of the plan's named fiduciaries, which could include a board of trustees, a benefits committee, or other relevant entities, depending on the plan's structure.
- The signed certification would be kept as part of its internal group health plan records along with the comparative analysis, so both can be provided if/when requested.

This document is not intended to be exhaustive, nor should any information be construed as tax or legal advice.