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What the Final Mental Health Parity Rules Mean for Employers

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The wait is over, and now the work begins for health plan sponsors.

Much-anticipated final rules implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were recently released by the U.S. Departments of Health and Human Services, Labor, and the Treasury and scheduled to be published in the *Federal Register* on September 23, 2024.

The rules—which are generally slated to take effect January 1, 2025, with certain provisions delayed until January 1, 2026—make several significant changes to the proposed regulations published last year. With a relatively short time in which to achieve compliance and the U.S. Department of Labor's intense focus on MHPAEA enforcement, plan sponsors have their work cut out for them.

Quick Hits

- The final rules increase scrutiny of network adequacy and introduce core treatment coverage requirements to the meaningful benefit standard.
- In a departure from the proposed rules, the final rules do not require mathematical testing of nonquantitative treatment limitations (NQTLs), as is required for financial requirements and quantitative treatment limitations.
- Instead of mathematical testing (the proposed "predominant" and "substantially all" tests), employers will instead be required to evaluate relevant data regarding NQTLs beginning in 2026 to ensure compliance with MHPAEA in operation.
- The final rules set forth specific actionable steps for plans that are found noncompliant, including a transparent process for corrective action and participant notification.

The bulk of the changes made by the final rules were to the parity test for NQTLs and the "comparative analysis" required to demonstrate compliance with that standard. The final rules made minor changes to definitions such as evidentiary standards, factors, processes, and strategies. We

summarize some key provisions below.

Meaningful Benefits

Plans that provide benefits for a mental health or substance use disorder condition in any relevant classification have to provide “meaningful benefits” for that condition in every classification where medical/surgical benefits are provided. Under the final rules, benefits will not be “meaningful” unless they cover “core treatments” for that condition, meaning “a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice.”

An example considers a plan that provides benefits through a health maintenance organization (HMO) and that does not cover the full range of medical/surgical benefits, including core treatments, in the outpatient, out-of-network classification. In this scenario, the plan is not obligated to provide meaningful benefits for mental health or substance use disorders in that classification. However, in any classification in which the plan does provide meaningful medical/surgical benefits, it plan must ensure that meaningful mental health and substance use disorder benefits are also offered.

NQTL Comparative Analysis

Since 2022, plans have been required to have—and to provide to U.S. regulators upon request—written comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply an NQTL (such as prior authorization or a fail-first requirement) to mental health/substance abuse benefits are comparable to and applied no more stringently than those used to apply that same NQTL to medical/surgical benefits.

The departments made a couple of significant changes in the final rules. First, a plan fiduciary will be required to attest that he or she has engaged in a prudent process to select a qualified service provider to perform and document the comparative analysis. (Under the proposed rules, a fiduciary would have had to attest that the comparative analysis actually met some of the legal requirements.)

Second, the departments bulked up the requirements for operational compliance. Under the final rules, a comparative analysis will have to document the outcomes that resulted from the application of the NQTL to mental health/substance abuse disorder and medical/surgical benefits, including an explanation of why any material differences in access were not caused by the NQTL. Additional details on the data requirements are below.

NQTL Data Evaluation

The final rules require plans to collect and evaluate data to assess the impact of NQTLs on access to mental health and substance use disorder benefits. As in the proposed rules, relevant data includes the number and percentage of claim denials and any other data relevant to the NQTL required by state law or private accreditation standards.

Under the final rules, if relevant data is temporarily unavailable, the plan must explain, in its comparative analysis, the absence of the data and detail how it will be collected and analyzed in the future. Further, plans will have to provide a “reasoned justification” for a conclusion that there is no data that can reasonably assess the NQTL’s impact, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with MHPAEA. The final rules also

introduce a facts-and-circumstances test for when relevant data suggests that the NQTL contributes to material differences in access to mental health and substance use disorder benefits compared to medical/surgical benefits, resulting in an NQTL testing failure.

Network Adequacy

The final rules demonstrate an increased focus by the departments on network adequacy for mental health and substance use disorder providers.

Plans are required to collect and evaluate relevant data to assess the aggregate impact of NQTLs on access to mental health benefits. Relevant data includes utilization rates, network adequacy metrics, and provider reimbursement rates benchmarked to a reference standard. If the data suggests a material difference in access to mental health and substance use disorder providers, the plan must take action to comply with parity requirements, including (1) strengthening efforts to recruit mental health and substance use disorder providers, (2) expanding telehealth options under the plan, (3) assisting plan enrollees in finding available in-network mental health and substance use disorder providers, and (4) ensuring that provider directories are accurate and reliable.

Discriminatory Factors

The final rules also provide guidance on when factors and evidentiary standards may be discriminatory against mental health or substance use disorder benefits. Factors and evidentiary standards are discriminatory if, based on all relevant facts and circumstances, they systemically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits compared to medical/surgical benefits. If a plan takes steps to correct, cure, or supplement the factors or evidentiary standards, the factors or standards will not be considered biased or not objective.

The rules illustrate this with an example of a plan that considers a treatment experimental if no recognized treatment guidelines include it as a standard of care and if fewer than two randomized controlled trials support its use. If a plan excludes coverage for applied behavior analysis therapy for autism spectrum disorder by deeming it experimental, despite existing recognized treatment guidelines and supportive trials, the plan will not satisfy parity requirements.

Effective Dates

Many parts of the final rules become effective on the first day of the first plan year, beginning on or after January 1, 2025.

However, the new “meaningful benefits” standard, the prohibition on discriminatory factors and evidentiary standards, and the relevant data evaluation requirements will be effective on the first day of the first plan year, beginning on or after January 1, 2026.

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