Compliance Bulletin

Mental Health Parity: New Comparative Analyses Requirements

On Sept. 9, 2024, the Departments of Labor, Health and Human Services, and the Treasury (Departments) released a final rule to strengthen the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). The final rule focuses on **nonquantitative treatment limitations** (NQTLs) that health plans and health insurance issuers place on mental health and substance use disorder (MH/SUD) benefits.

MHPAEA requires plans and issuers to conduct **comparative analyses** of the NQTLs used for medical or surgical (M/S) benefits compared to MH/SUD benefits. The final rule establishes minimum standards for developing comparative analyses to assess whether an NQTL, as written and in operation, complies with MHPAEA's requirements. Significantly, the final rule requires the comparative analyses for ERISA-covered plans to include a **plan fiduciary's certification** that they have engaged in a prudent process to select and monitor their service providers. This Compliance Bulletin provides more information from the final rule.

Action Items

Employer-sponsored health plans must comply with new requirements for comparative analyses, beginning with the 2025 plan year (although some key requirements are delayed until the 2026 plan year). Employers with fully insured health plans should reach out to their issuers to confirm comparative analyses will be completed for their plan's NQTLs for the 2025 plan year in accordance with the final rule's applicable requirements. Employers with self-insured health plans should reach out to their third-party administrators or other service providers for assistance with their comparative analyses. In addition, employers with ERISA-covered health plans must ensure their comparative analyses include the required fiduciary certification that they have prudently selected and monitored their service providers.

Mental Health Parity

MHPAEA requires parity between a group health plan's M/S benefits and MH/SUD benefits. MHPAEA's parity requirements apply to:

- **Financial requirements**, such as deductibles, copayments and coinsurance;
- **Quantitative treatment limitations**, such as day or visit limits; and
- **NQTLs**, which generally limit the scope or duration of benefits, such as network composition, out-of-network reimbursement rates, and medical management and prior authorization requirements.

MHPAEA's parity requirements apply to group health plans sponsored by employers with more than 50 employees. However, due to an Affordable Care Act reform, insured health plans in the small group market must also comply with federal parity requirements for MH/SUD benefits.

MHPAEA requires health plans and health insurance issuers to conduct **comparative analyses** of the design and application of NQTLs used for MH/SUD benefits. Plans and issuers must make their comparative analyses **available upon request** to the Departments, applicable state authorities and covered individuals.

New Comparative Analysis Requirements

The final rule establishes minimum standards for developing comparative analyses to assess whether each NQTL, as written and in operation, complies with MHPAEA's parity requirements. The final rule requires health plans and issuers to collect and evaluate data related to the NQTLs they place on MH/SUD care and make changes if the data shows they are providing insufficient access.

The final rule requires a comparative analysis to contain, at a minimum, six content elements:

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, as written;
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 as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH/SUD benefits and M/S benefits within each classification, as well as and the relative stringency of their application, both as written and in operation.

Upon request, plans and issuers must also provide a written list of all NQTLs imposed by the plan to the Departments.

In addition, for health plans subject to ERISA, the comparative analysis must include a **plan fiduciary's certification** confirming they engaged in a prudent process to select one or more qualified service providers to perform and document the plan's comparative analysis and have satisfied their duty to monitor those service providers.

For this purpose, the Department of Labor expects that a plan fiduciary making such a certification will, at a minimum, take the following steps:

- Review the comparative analysis prepared by or on behalf of the plan with respect to an NQTL applicable to MH/SUD benefits and M/S benefits;
- Ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings and conclusions documented in the analysis; and
- Ensure that a service provider responsible for performing and documenting a comparative analysis provides assurance that, to the best of its ability, the NQTL and associated comparative analysis complies with MHPAEA.

The final rule also requires health plans and issuers to submit comparative analyses to the Departments within **10 business days** of a request. If a comparative analysis is determined to be deficient, health plans and issuers have 45 days to make corrections. If the comparative analysis is still deficient after this 45-day period, the plan or issuer may be required to notify all covered persons of the MHPAEA violation and stop applying the problematic NQTLs until the plan is compliant.

Effective Date

The final rule generally applies to health plans and group health insurance coverage for plan years beginning on or after Jan. 1, 2025. However, several provisions (including certain data requirements related to comparative analyses) apply for plan years beginning on or after Jan. 1, 2026.
