



Insights: Alerts

MHPAEA 2024 Final Rule Requires Action by Plan Sponsors

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I. Summary of the Final Rule

On September 9, 2024, the Departments of Treasury, Labor and Health and Human Services published the much-anticipated final rule implementing parts of the Mental Health Parity and Addiction Equity Act (MHPAEA). The primary force of the final rule is to implement new requirements adopted by Congress in amendments to the MHPAEA under the Consolidated Appropriations Act of 2021, which required health plans to conduct meaningful comparative analyses to ensure parity in access to mental health and substance use services as compared to medical and surgical services.

For background, the MHPAEA (in tandem with the Affordable Care Act) requires small group and individual plans to provide meaningful benefits for covered mental health conditions and substance use disorders in each classification where they provide medical/surgical benefits. While not required to provide behavioral health coverage, large-group plans and self-insured employer health plans that choose to cover behavioral health care are required to ensure parity between behavioral health benefits and other health benefits.

The final rule strengthens compliance requirements for health plans under the MHPAEA, specifically relating to non-quantitative treatment limitations (NQTLs) - the methods and processes utilized by health plans to manage benefits other than through quantitative limits (i.e. dollar amount limits or visit limits). It requires that plans and issuers implement certain compliance processes to ensure that the processes, strategies, evidentiary standards, and other factors used in applying NQTLs to mental health and substance use disorder (MH/SUD) benefits are comparable to those used for medical/surgical benefits, and not more restrictive.

In general, the final rule is effective for plan years beginning on or after January 1, 2025 but there are some provisions (described below) that do not take effect until 2026. Legal challenges to the scope of the final rule are widely anticipated, but at this time it is unclear how those challenges might impact the effective dates.

II. What Is In the Final Rule?

The final rule includes several key provisions impacting health plans, including meaningful departures from the proposed rule in response to public comments and further analysis:

1. Meaningful Benefit Requirement

The final rule clarifies that plans that provide any MH/SUD benefits must provide “meaningful benefits” for those conditions or disorders in every benefit classification in which meaningful medical/surgical benefits are provided. The six classifications under the MHPAEA are: (1) emergency services; (2) in-network inpatient; (3) out-of-network inpatient; (4) in-network outpatient; (5) out-of-network outpatient; and (6) prescription drugs. “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.

2. Comparative Analysis Requirement

As anticipated, the final rule requires plans to demonstrate compliance by regularly conducting detailed comparative analyses of the design and application of NQTLs. The final rule provides additional detail on what must be included in comparative analyses of NQTLs, which must include the following six required elements:

- A description of the NQTL, including a listing of the benefits subject to it;
- Identification of the factors and evidentiary standards used to design or apply the NQTL;
- A description of how the factors are used;
- Demonstration of comparability and stringency, as written;
- Demonstration of comparability and stringency, in operation (including required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences); and
- Findings and conclusions.

Plans are required to make copies of their comparative analyses available to plan participants (or relevant state or federal authority) upon request.

3. Mathematical Tests Not Adopted

The proposed rules included mathematical tests for plans to assess compliance. Specifically, the “substantially all” test required plans to determine if an NQTL applied to at least two-thirds of all medical/surgical benefits within a classification. If the NQTL passed the “substantially all” test, the plan would apply the “predominant” test, which involved determining the predominant level of the NQTL that applied to at least two-thirds of medical/surgical benefits in the classification. Those tests were not included in the final rule. Instead, the final rule adopts the more flexible comparative analyses approach.

4. Monitoring for Material Differences in Access to Services

The final rule specifies that plans must collect and evaluate data to assess the impact of NQTLs on access to mental health services and take reasonable action when they know or should know that NQTLs may be causing “material differences in access” to MH/SUD benefits compared to medical/surgical benefits.

5. Use of Discriminatory Standards

The final rule specifically bars plans from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD services when designing NQTLs.

6. Definitions

The final rule modified the definitions of several key terms under the MHPAEA regulations, including “medical/surgical benefits”, “mental health benefits” and “substance use benefits”. Importantly, those terms no longer incorporate state guidelines, but instead point plans to follow the most current version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM). The final rule also redefined several key terms used in performing comparative analyses, including “evidentiary standards”, “factors”, “processes”, and “strategies”.

7. Fiduciary Certification

For ERISA plans, the final rule requires that one or more named fiduciaries review and understand any NQTL comparative analysis prepared by or on behalf of the plan. The fiduciary must also certify that the fiduciary prudently selected qualified service providers to perform and document the analysis and that the fiduciaries have satisfied their duty to monitor those service providers. *Note: The proposed rule also required a fiduciary to certify that the comparative analysis complies with regulatory content requirements. That requirement was removed in the final version.*

8. Delayed Applicability Date

The final rules go into effect beginning the first plan year beginning on or after January 1, 2025. However, the applicability date for certain new requirements – the prohibition on discriminatory factors and evidentiary standards, data evaluation requirements, and related requirements for comparative analyses – has been delayed to allow plans more time to comply. These requirements will apply to plan years beginning on or after January 1, 2026.

9. Enforcement

The final rule also includes an overview of a fast-paced comparative analysis request and review process the agencies will utilize to ensure compliance. In the event that a plan is determined to be out of compliance, the plan must implement corrective action procedures and notify participants and beneficiaries of noncompliance (with a copy to the Department of Labor). The DOL may also direct the plan to cease operation of the NQTL until the plan comes into compliance.

III. What Health Plans Need to Do to Implement the Final Rule

Employers with insured health plans will largely be able to rely on the insurer for compliance. To comply with the final rule, employers with self-insured health plans will need to take several steps:

1. Update TPA Agreements

As in the past, employers will be required to rely heavily on their third-party administrators (TPAs) for compliance with the final rule. While not required by the final rule, plan sponsors should evaluate and update

their agreements with their TPAs to facilitate compliance. TPAs may be unwilling to provide specialized assistance, but plans sponsors should consider the following:

- Agreements should specifically require that TPAs comply with the final MHPAEA rules, including adherence to the requirements for NQTLs. Agreements should also clarify who – the TPA or plan sponsor (working with a consultant or other third party) – is responsible for conducting comparative analyses of all NQTLs utilized by the plan.
- Agreements should also outline the TPA's responsibilities for collecting and/or monitoring relevant data – such as claims denial rates, network adequacy metrics, and provider reimbursement rates – needed to assess any material differences in access to MH/SUD benefits.
- Agreements should require TPAs to take reasonable actions to address material differences in access to MH/SUD benefits, including implementing corrective measures such as increasing provider reimbursement rates, expanding telehealth services, and improving provider network directories.
- Agreements should also require TPAs to maintain thorough documentation of all processes, strategies, and actions taken to comply with the MHPAEA requirements. This includes documenting the steps taken to correct or adjust NQTLs to ensure they are not more restrictive for MH/SUD benefits.
- The agreement should obligate TPAs to provide comparative analyses and other relevant information to the Departments upon request. This includes readiness for compliance reviews and audits by the agencies.
- The agreement should outline the TPA's role in providing notice to participants and beneficiaries in the event the plan is found to be noncompliant.

2. Meaningful Benefit Requirement

Plan sponsors should ensure that the plan is assessed to ensure MH/SUD benefits offered by the plan satisfy the “meaningful benefit” requirement for each of the six MHPAEA benefit classifications. This is one of the requirements that is not effective until 2026.

3. Conduct Detailed Comparative Analyses

Plans must perform and document comparative analyses of the design and application of NQTLs. These analyses must include the six elements detailed above. Plans must demonstrate that NQTLs are applied comparably and no more stringently to MH/SUD benefits. Most plan sponsors will have to delegate this function to their TPA, but even then the plan should have measures in place to monitor the TPA's compliance with the MHPAEA requirements. This may include periodic audits, reviews of comparative analyses, and independent assessments of the data collected.

4. Collect and Evaluate Relevant Data

Plans must collect data to assess the impact of NQTLs on access to MH/SUD benefits. Relevant data can include rates of claim denials, utilization rates, network adequacy metrics, and provider reimbursement rates.

Plans must evaluate this data to identify any “material differences in access” to MH/SUD benefits compared to medical/surgical benefits.

5. Take Reasonable Actions to Address Material Differences

If the data suggests that NQTLs contribute to “material differences in access”, plans must take reasonable actions to address these differences. Actions could include, for instance, increasing provider reimbursement rates, expanding telehealth services, or improving provider network directories.

6. Update and Document Policies and Procedures

Plans must update their policies and procedures to ensure compliance with the new requirements. Documentation should include explanations of any steps taken to correct or adjust NQTLs to ensure they are not more restrictive for MH/SUD benefits.

7. Fiduciary Certification

Plan sponsors should ensure that a named fiduciary completes the fiduciary certification requirement described above.

8. Prepare for Compliance Reviews

Plans must be prepared to provide their comparative analyses and other relevant information to the responsible federal agencies or participants upon request. This includes being prepared to demonstrate how the plan has complied with the requirements for each NQTL.

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