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Blog Post

MHPAEA Final Rule: Clarity on Mental Health Parity?

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The three federal agencies tasked with enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) — the Departments of Labor, Health & Human Services (through CMS), and Treasury (the Departments) — issued their Final Rule to implement the MHPAEA on September 9, 2024, to mixed reviews.

Groups composed of providers, such as the American Medical Association and American Hospital Association, responded with support for the Final Rule and welcomed any infusion of certainty that such guidance could provide. However, representatives of the large employer benefit plan sponsor industry and the insurance industry, such as the ERISA Industry Committee and America's Health Insurance Plans, expressed grave concerns about the Final Rule's unintended consequences, including raised costs and, ironically, the potential decrease in access to mental health and substance use services. Litigation regarding the Final Rule is considered likely.

A comprehensive review of the 536-page Final Rule is beyond the scope of this blog, but we highlight here some of the Rule's most significant impacts on health plans, including guidance regarding NQTLs and comparative analyses, the role of third-party

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administrators (TPAs) in MHPAEA compliance, and an expansion of the statute's scope.

Statutory Context

Pursuant to the MHPAEA, group health plans that offer mental health and substance use disorder (MH/SUD) benefits must provide those benefits in parity with the medical/surgical benefits (MED/SURG) that they offer.

Accordingly, the statute prohibits group health plans from imposing *financial requirements* (like deductibles and copays) and treatment limitations (like limits on the number of visits) on MH/SUD benefits that are more restrictive than the "predominant" financial requirements and treatment limitations applicable to "substantially all" MED/SURG benefits in a particular classification.

Likewise, under the MHPAEA plans cannot apply *nonquantitative treatment limitations* (NQTLs), such as preauthorization requirements, concurrent review requirements, and treatment plan requirements, to MH/SUD benefits that are more restrictive, either as written or in operation, than the "predominant" NQTLs applied to "substantially all" MED/SURG benefits in the same classification.

Comparative Analysis

The Final Rule requires plans and insurers "to collect and evaluate data" regarding their application of NQTLs to their MH/SUD and MED/SURG benefits and to take "reasonable action" if the analyses demonstrate material differences in a plan's MH/SUD benefits versus MED/SURG benefits.

The Consolidated Appropriations Act, 2021, requires that plans and insurers provide a comparative analysis of each NQTL to the Departments upon request. The Final Rule lists six content elements that should be included in a comparative analyses of each NQTL:

1. Description of the NQTL
2. Identification and definition of factors and evidentiary standards used to design or apply the NQTL
3. Description of how factors are used in the design and application of the NQTL
4. Demonstration of comparability and stringency, as written
5. Demonstration of comparability and stringency, in operation
6. Findings and conclusions

The Final Rule elaborates substantially on each of these content requirements.

The Role of TPAs

Prior to the issuance of the Final Rule, plan sponsors had lamented the reality that third party administrators played a pivotal role in MHPAEA compliance, yet TPAs had not directly been tasked with responsibility for such compliance. The Departments now openly acknowledge in the Final Rule that many plans and insurers depend upon TPAs or other service providers to administer their plans and that plans may have difficulty obtaining the information necessary to fulfill their comparative analysis obligations from those third parties.

The Final Rule indicates that plans and issuers are ultimately responsible for MHPAEA compliance but that TPAs or other service providers who act as fiduciaries for ERISA-covered group health plans must work with those plan sponsors or issuers to ensure such compliance and that "[a]ny ERISA-governed group health plans that contract with service providers refusing or otherwise failing to provide the requisite information should notify DOL."

The Departments declined to follow commentators' suggestion that the Final Rule require that plans

enter into contracts with TPAs similar to HIPAA business associate agreements that would require TPAs to cooperate with the plans' compliance obligations pursuant to the MHPAEA. However, the Final Rule indicates that such "contract provisions are a best practice that could be helpful to many plans and issuers in complying with their obligations to perform and document comparative analyses of NQTLs applied to [MH/SUD] benefits and [MED/SURG] benefits."

MHPAEA Review Process

Plans must make these comparative analyses and supporting data that show compliance with the MHPAEA available upon the request of any of the Departments. Regulators are demanding production of them in short timeframes, so there is not sufficient time to prepare these analyses after receipt of an information request. Consequently, it is critical for carriers, plan sponsors, and their service providers to prepare and update them before regulators come knocking.

After a plan submits its comparative analyses in response to a Department request, the Department will determine whether the analyses and information provided are sufficient, and the Department may request additional information. The Department will make a determination of whether the comparative analyses and supporting information are adequate and whether they demonstrate the plan's compliance with MHPAEA. If the determination is that the plan's comparative analyses are deficient, and/or the plan is violating MHPAEA in some way, the Department will issue an initial determination letter with one or more findings of noncompliance.

The plan then has 45 calendar days to correct the instances of noncompliance identified in the initial determination letter and to provide updated comparative analyses demonstrating compliance. If the Department determines that the corrections and

updated comparative analyses are inadequate, it will send the plan a final adverse determination letter that will result in required plan participant notification and the plan's inclusion in a report to Congress as one of the plans that failed to demonstrate mental health parity in compliance with the MHPAEA, likely also triggering related public relations issues.

Expansion of Scope

Non-federal governmental health plans, such as state and local government employee plans, must also comply with the MHPAEA because the Final Rule closed their opt-out provision.

Effective Date

Different portions of the Final Rule have different effective dates. For example, some expressly apply to plan years beginning on or after January 1, 2025, and others one year later. As a practical matter, however, it appears that the regulators are currently referencing newly issued content within the Final Rule, as if it were already in effect.

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Despite any clarity the Final Rule sought to provide, MHPAEA compliance continues to present considerable financial and reputational risks and remains a challenging and complicated area of concern for group health plans. Akerman attorneys have experience helping health plans navigate through the MHPAEA drafting, review, and audit process and are glad to assist in this area.

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information contained in this Practice Update without seeking the advice of legal counsel. Prior results do not guarantee a similar outcome.