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Employee Benefits Compliance

Mental Health Parity, It's Time for a Checkup

Background on Mental Health Parity Legislation

1996	2008	2013
The Mental Health Parity Act (MHPA) was enacted in 1996 but contained loopholes that prevented true parity.	The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted on October 3, 2008, and effective for plan years beginning after October 3, 2009.	MHPAEA final regulations were issued in November 2013 and apply to plan years beginning on or after July 1, 2014.

2020: Under the Consolidated Appropriations Act of 2021, plans must perform NQTL testing and make results and information listed below available to Departments, or any State authority, upon request within 45 days of enactment of the Act (February 10, 2021).

2024*: Final rules outline the requirements around the use of NQTLs and add new content requirements and timeframes for responding to requests for NQTL comparative analyses. However, the Departments later announced a non-enforcement policy for the 2024 final rules, including the new content requirements for the NQTL comparative analysis. This pause will last through the current litigation and for 18 months after it ends. Plan sponsors must still comply with the 2013 final regulations and the CAA, 2021and should continue working with carriers and TPAs to meet those obligations.

Mental health parity is a complex topic, especially as it relates to group health plan compliance. A determination that a plan is compliant requires not only an understanding of concepts, terms, and phrases generally used only in relation to this topic, but also actual plan utilization and claims data. This Insight helps explain the concepts, terms, and phrases (in **bold** throughout this piece) required to understand mental health parity requirements. Plans should rely primarily on third party administrators or insurance carriers for MHP compliance. Note that the mathematical analysis required to assess quantitative limits is based on claims paid and can require an actuarial analysis to ultimately determine a plan's compliance where cost sharing varies. A comprehensive NQTL analysis likely requires engaging a 3rd party vendor when third party administrators or insurance carriers fail to provide this analysis.

MHPAEA Rules and Requirements

A group health plan is not required to cover any mental health (MH) or substance use disorder (SUD) benefits. However, group health plans and health insurance issuers that cover MH/SUD benefits must ensure that any:

- **financial requirements** (copays, deductibles, etc.),
- **quantitative treatment limits** (visit limits), and

- **non-quantitative treatment limits (NQTL)** (medical management standards, network access, and formulary design)

applicable to MH/SUD benefits are not more restrictive than the requirements or limitations for medical/surgical (MS) benefits.

Medical/surgical benefits are benefits for medical or surgical services or items as defined under the plan and do not include mental health or substance use disorder benefits. Mental health benefits are benefits with respect to services or items for mental health conditions as defined under the plan. Substance use disorder benefits are services or items for substance use disorders as defined by the plan. A plan, however, does not have full discretion to define these terms. A plan's definition of whether a condition or disorder is a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice. For this purpose, the plan must follow the most current version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Coverage Classifications under MHPAEA

Many MHPAEA rules apply or require parity within **specific coverage classifications**. The six coverage classifications are:

- inpatient, in-network;
- inpatient, out-of-network;
- outpatient, in-network;
- outpatient, out-of-network;
- emergency care; and
- prescription drugs.

After July 1, 2014, plans can divide outpatient benefits into two sub classifications: (1) office visits; and (2) all other outpatient items and services. Plans can also create separate sub classifications for each tier of in-network provider if a plan has two or more tiers of in-network providers.

Example: A plan covers treatment for Autism Spectrum Disorder (ASD), a MH condition under generally recognized independent standards of current medical practice, and covers outpatient, out-of-network developmental screenings for ASD, but excludes all other benefits for outpatient treatment for ASD, including applied behavior analysis (ABA) therapy, when provided on an out- of-network basis. The plan generally covers the full range of outpatient treatments (including core treatments) and treatment settings for MS conditions and procedures when provided on an out-of-network basis. Under the generally recognized independent standards of current medical practice consulted by the plan, developmental screenings alone that are covered for diagnostic purposes, without any coverage for a therapeutic intervention, do not constitute a core treatment for ASD.

Conclusion: Although the plan covers benefits for ASD in the outpatient, out-of-network classification, it only covers developmental screenings. Therefore, it does not cover a core treatment for ASD in the classification. Since the plan generally covers the full range of MS benefits including a core treatment for one or more MS conditions or procedures in the classification, if fails to provide meaningful benefits for treatment of ASD in the classification, as required under the final rules of MHPAEA.

Lifetime and Annual Limits

MHPAEA compliance for lifetime and annual limits is assessed based on the "One Third Rule" and the "Two Thirds Rule." A plan must determine whether the portion of MS benefits subject to lifetime or annual limit represents one-third or two-thirds of all MS benefits based on the dollar amount of all plan payments for MS benefits in the classification expected to be paid under the plan for the plan year using any reasonable method to determine the dollar amount expected to be paid. This requires an actuarial analysis.

1/3 Rule

IF_____

- A plan has no lifetime or annual limit on any MS benefits, or
- a plan applies a lifetime or annual limit **to less than one-third** of MS benefits

THEN_____

A plan may not impose a lifetime or annual limit on MH/SUD benefits.

2/3 Rule

IF_____

A plan applies a lifetime or annual limit on **at least two-thirds** of all MS benefits

THEN_____

- A plan may apply the lifetime or annual limit in a manner that does not distinguish between MS and MH/SUD benefits; or
- A plan may not include lifetime or annual limit on MH/SUD benefits that is less than the limit on MS benefits.

NOTE: Lifetime and annual limits are increasingly rare because the ACA prohibits these limits on essential health benefits. As a result of the elimination of most lifetime and annual limits under the ACA, plans cannot have lifetime or annual limits on most MH/SUD benefits.

Financial Requirements and Quantitative Limits

A **financial requirement** or **treatment limit** that applies to MH/SUD benefits under a plan cannot be:

- more restrictive than the "predominant" (more than half) financial requirements or treatment limits
- that apply to "substantially all" (at least two-thirds) of the MS benefits
- determined on a classification-by-classification basis for each "type" of "financial requirement or treatment limitation"

If no single level is predominant (applies to more than half of MS benefits in a classification), a plan or issuer may combine levels to reach more than one-half but the least restrictive level within the combination is the predominant level. Again, this calculation is based the dollar amount of all plan payments for MS benefits in each classification expected to be paid under the plan for the plan year using any reasonable method to determine the dollar amount expected to be paid.

Example: If a plan has three different levels of copays—$50, $25, and $15—the three levels combined apply to more than one-half of the plan's MS benefits, then the $15 copayment is considered predominant.

Non-Quantitative Treatment Limits

A group health plan may not impose **non-quantitative treatment limitations (NQTLs)** on MH/SUD benefits in any classification unless certain conditions are met. More specifically, under the terms of the plan (both as written and operated), any processes, strategies, evidentiary standards, or other factors used to apply the **non-quantitative treatment limitation** to mental health or substance use disorder benefits in the classification must be comparable to (and applied no more stringently than) the processes, strategies, evidentiary standards, or other factors used in applying the limitation to MS benefits in the classification.

NQTLS include:

- medical management standards based on medical necessity or medical appropriateness;
- standards on whether the treatment is experimental or investigative;
- formulary design;
- standards for provider admission to a network;
- provider reimbursement rates;
- methods for determining usual, customary, and reasonable charges;
- fail-first policies or step-therapy protocols;
- exclusions based on failure to complete a course of treatment;
- network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- limitations on inpatient services for situations where the participant is a threat to self or others;
- exclusions for court-ordered and involuntary holds;
- experimental treatment limitations;
- exclusions for services provided by clinical social workers; and
- network adequacy.

There are *currently* no numeric tests for NQTLs. Consequently, the focus is on understanding limits and ensuring different limits and standards are not applied to MH/SUD benefits or similar standards are not applied more stringently. This can be challenging where certain benefits are carved out or administered separately from major medical coverage but comparisons are generally within each separate coverage classification.

PERMISSIBLE

Medically Necessary Limitation: The plan limits benefits to treatment that is deemed medically necessary and requires concurrent review for any inpatient care where there are high levels of variation in the length of stay. The application of this standard affects 60% of MH/SUD conditions, but only 30% of MS conditions. Because the evidentiary standard used by the plan is applied no more strictly for MH/SUD benefits than for MS benefits NQTL rules are not violated.

Variations in Concurrent Review: The plan applies concurrent review to inpatient psychiatric care but uses retrospective review for general medical hospitalizations that are reimbursed based on diagnosis-related group (DRG) codes. The plan determined DRG-based reimbursements incent hospitals to actively manage utilization, but there are no DRG-based fees for psychiatric hospitalizations. The use of concurrent review for psychiatric hospitalizations is permissible if concurrent review is used for medical hospitalizations that are not reimbursed based on DRGs.

PROBLEMATIC

Treatment Attempt Requirements: For inpatient MH/SUD treatment plan the insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care. For inpatient MS services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.

Licensure Requirements: Plan/policy requires that MH/SUD facilities be licensed by a State but does not impose the same requirement on MS facilities.

Prior Authorizations/Approvals: Plan/policy requires prior approval for MS and MH/SUD benefits. For MH/SUD treatments without prior approval no benefits are paid. For MS treatments without prior approval there is a 25% reduction in paid benefits.

NQTL Comparative Analysis

As of February 2021, the DOL (or other applicable regulating entity) can request a group health plan's NQTL comparative analysis**.** This request is most common in the context of a broader DOL group health plan audit. The NQTL comparative analysis should demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MS benefits in the benefits classification. Plans will need to identify the factors used to determine the NQTLs that will apply to MH/SUD benefits and MS benefits as well as the evidentiary standards used for the factors identified and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and MS benefits.

NQTL Comparative Analysis Timelines and Notice Requirements

Plans and issuers should be prepared to provide copies of their comparative analysis to the DOL. If requested, a copy of the comparative analysis must be provided to the DOL within ten business days (or an additional period of time specified by the DOL). If the comparative analysis is deemed insufficient, plans or issuers will have an additional ten business days (or an additional period of time specified by the DOL) to provide additional information requested by the DOL.

If it is determined that the group health plan is not in compliance, the plan or issuer must respond to the DOL and specify the actions they will take to comply and provide additional comparative analysis not later than 45 days after the initial determination that the plan or issuer was not in compliance. Following the 45-day corrective action period, if the DOL makes a final determination that the plan or issuer is still not in compliance, within 7 days of that determination the plan or issuer must notify all individuals enrolled in the plan that the coverage is not compliant.

Plans and issuers must also be prepared to provide a copy of the comparative analysis when requested by any applicable state authority, or a participant or beneficiary who has received an adverse benefit determination related to MH/SUD benefits. Plans subject to ERISA must also provide a copy of the comparative analysis to participants and beneficiaries within 30 days of a written request.

When a plan receives a final determination that an NQTL is not in compliance with the comparative analysis requirements, the DOL may direct the plan to not impose the NQTL with respect to MH/SUD benefits unless and until the plan or issuer demonstrates compliance or take appropriate action to remedy the violation.

Mental Health Parity violations are also subject to Internal Revenue Code Chapter 100 penalties, which are $100 per day per participant.

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Frequently Asked Questions

What about ASD and ABA Therapy?

Historically, some plans categorized Autism Spectrum Disorder (ASD) as a medical condition and not a mental health condition to avoid parity requirements and covering Applied Behavioral Analysis (ABA) therapy. That strategy no longer works because ASD is defined as a mental health condition in:

- the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5);
- the International Classification of Diseases (ICD-10); and
- most state guidelines

Approximately 46 states and the District of Columbia have laws that require insurance coverage of autism and most expressly call it a mental health condition.

How are eating disorders treated under MHPAEA?

The 21st Century Cures Act clarified that eating disorders are mental health conditions and treatment of an eating disorder is a "mental health benefit" as defined by MHPAEA. The 21st Century Cures Act clarified that if a group health plan or health insurance issuer provides coverage for eating disorder benefits, including residential treatment, those benefits must be offered consistent with the requirements of MHPAEA.

Can a group health plan exclude or limit coverage for gender affirming surgeries?

Probably not. First, under the MHPAEA, if a plan provides MH/SUD benefits in any of the six coverage categories, it must provide MH/SUD benefits in every coverage category in which MS benefits are also provided. For practical purposes this means that if a plan covers gender dysphoria counseling or hormones, it must also cover gender affirming surgeries. Because it is difficult, if not impossible, to screen topics addressed during counseling or discern the reason certain hormones are prescribed, plans cannot effectively exclude all coverage of gender dysphoria. Therefore, plans generally must cover gender affirming surgeries. Lifetime or annual limits on gender affirming surgeries are also problematic under MHP rules because the ACA largely precludes lifetime and annual limits (with respect to Essential Health Benefits). Since few plans apply a lifetime or annual limit on 2/3rds or more of all MS benefits, these limits are generally no longer allowed for MH/SUD benefits. Next, group health plan exclusions for the treatment of gender dysphoria also raise issues under Title VII of the Civil Rights Act, which prohibits discrimination on the basis of an individual's sexual orientation or gender identity. While the Supreme Court's June 2025 decision in *United States v. Skrmetti* upheld a Tennessee state law ban on gender-affirming care for minors and has created new legal risk for plans covering such care, these federal protections continue to apply and the full impact on group health plans remains uncertain. Lastly, for entities that receive federal funds from HHS, like medical providers and employers receiving the Retiree Drug Subsidy, gender dysphoria coverage exclusions are prohibited under Section 1557.

Does providing ACA preventive care coverage for tobacco cessation trigger parity requirements?

Plans are required to cover all ACA preventive care items and covering MH/SUD benefits solely to comply with the ACA preventive services mandate does not trigger MHPAEA requirements to provide additional MH/SUD benefits.

Will state insurance code mandates to cover mental health conditions trigger parity requirements?

Plans subject to insurance codes that require coverage of MH/SU benefits will trigger parity requirements. Note that many insurance mandates facially violate MHPAEA rules. For example, an ABA coverage mandate up to age 6 or up to $35,000 is problematic under the MHPAEA.

Are there exemptions to MHPAEA requirements?

There is technically an increased cost exemption, but it seldom applies and only is good for a single year at a time. The exemption is available for plans that make changes in order to comply and incur a cost increase of at least 1% in that plan year. The plan is then exempt for the plan year following the year the cost was incurred. The exemption lasts one year and then the plan must comply again. If the plan again incurs increased cost of at least 1% it can claim the exemption again for the following plan year. At best, even with the increased cost exemption, MHPAEA compliance is still required every other year.

The MHPAEA does not apply to group health plans that provide only "Excepted Benefits."

Does the MHPAEA have specific disclosure requirements?

Plan administrators or insurance issuers must disclose the following on request to a participant, beneficiary, or a contracting provider:

- Criteria for medical necessity determinations for MH/SUD benefits
- The reason for any denial of reimbursement or payment for services for MH/SUD benefits

Under ERISA, plan documents / SPDs must be furnished to participants within 30 days of request.

Are there additional tools or resources to help plans comply with MHPAEA requirements?

The agencies have released a robust Self-Compliance Tool, FAQs Part 45, and a checklist of problematic provisions titled, Warning Signs- Plan or Policy NQTLs that Require Additional Analysis.

Are there specific NQTL issues we should watch out for with respect to a carved-out prescription drug benefit?

Yes, common NQTLs in the context of pharmacy benefits include prior authorization requirements, fail first requirements, formulary design, and drug exclusions by disorder (e.g., excluding coverage for drugs to treat bipolar disorder when it is covered in the other coverage classifications). Some issues to watch out for are black box exclusions that are not equally applied to medical prescriptions and dosage limits that are not applied in parity (e.g., buprenorphine to treat opioid addiction).

Are there any red flags that should trigger further analysis?

For NQTL compliance watch for different standards for:

- medical necessity
- prior authorizations
- experimental or investigational treatments
- black box exclusions

For quantitative limits compliance watch for the following:

- Lifetime or annual limits on MH/SUD benefits
- Low co-pays on everything MS and high copays on MH/SUD benefits
- Different co-insurance for similar care based on whether the treatment is MS or MH/SUD
- Limits or exclusions for inpatient MH/SUD benefits

Has DOL issued any guidance on NQTL enforcement priorities?

Yes. FAQ guidance identifies four specific areas that the DOL expects to focus on in its initial enforcement efforts: (1) Prior authorization requirements for in-network and out-of-network inpatient services; (2) Concurrent review for in-network and out-of-network inpatient and outpatient services; (3) Standards for provider admission to participate in a network, including reimbursement rates; and (4) Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges). Plans

should also be prepared to make available a list of all other NQTLs for which they have prepared a comparative analysis and a general description of any documentation that exists regarding each analysis.