GOLD STANDARD

Parity Final Rule:
State Codification Gold Standards

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THE KENNEDY FORUM

LAC LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Contents

The State Parity Gold Standards

Mental health parity enforcement is complex. Each module of the State Parity Gold Standard Toolkit breaks down essential concepts for regulators, advocates, and lawmakers, mapping out a clear map for understanding and implementation.

Ultimately, this enhances fidelity to the federal Parity law, ensuring better access to mental health and substance use treatment for more Americans.

Each toolkit was developed in collaboration with experts to ensure each module provides the most comprehensive set of guidelines for states. For more information about the State Parity Gold Standard Toolkit, contact **info@thekennedyforum.org**

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In September 2024, the Departments of Labor, Health and Human Services, and Treasury (Tri-agencies) released updated **regulations** implementing provisions of the Consolidated Appropriations Act of 2021 and updating 2013 regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (Parity Act). At its foundation, the federal Parity Act bars most health insurance plans from discriminating against mental health and substance use disorder (MH/SUD) benefits when compared to medical and surgical (med/surg) benefits.

The federal Parity Act regulations are the floor, not the ceiling, and "states have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law."[1]

States should explicitly codify – and strengthen – these critical provisions by introducing a bill that includes all of the components of the 2024 regulations.

States can directly incorporate the federal rule as published in September 2024 into statute, or include all its components by including the text in the appendices of this toolkit. This will ensure individuals in state-regulated plans have fair access to mental health and substance use disorder (MH/SUD) care.[2] In the following pages, we offer more detail on the included components, all of which work together to strengthen parity.

The final rule[27]:

Focuses attention on access with a data-driven approach

Closes potential loopholes and offers more guidance

Enhances transparency and streamlines oversight

Defining and Classifying MH/SUD Benefits

Definitions [3]

The final rule aligns definitions with clinical science, removing any non-clinical considerations from definitions of MH/SUDs. States should align their definitions with the final rule to avoid contradicting, discriminatorily limiting language.

In defining the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits," the final rule makes clear that how a plan characterizes its benefits must be consistent with generally recognized standards of current medical practice - not state guidelines if those conflict. Specifically, coverage for all diagnoses that are listed as MH conditions in the most current version of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) must be considered "mental health benefits," and coverage for all diagnoses that are listed as SUDs in the most current version of the ICD or DSM must be considered "substance use disorder benefits."[4] These updates are particularly important for ensuring parity for people seeking treatment for autism spectrum disorders, eating disorders, and other frequently denied MH conditions, as a number of states have inconsistent definitions that enabled plans to discriminatorily limit coverage for these conditions.

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States should update their definitions of these terms in law or regulations to mirror those in the federal regulations – specifically, the alignment with the ICD and DSM – to ensure there is no confusion or misclassification of benefits.

Meaningful Benefits [5]

The final rule ensures meaningful MH/SUD coverage at all levels by establishing a meaningful benefits standard across all classifications where medical/surgical benefits are offered.

This ensures patients have access to core treatments based on recognized medical stands, not just minimal or ancillary services. Consistent state implementation of this standard is critical to achieve the rule's intended effect of eliminating discriminatory coverage gaps and ensuring comprehensive MH/SUD care at every level of benefit.

At a minimum, if a plan covers MH/SUD benefits in one classification (inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care, prescription drugs), it must cover benefits for that condition in all of those classifications. Under the new regulations, such coverage must be "meaningful," defined as a core treatment for that condition, rather than just screenings or ancillary benefits, to the extent that one or more meaningful medical/surgical benefits are provided in that classification.[6] Plans are instructed to consult the generally recognized independent standards of current medical practice to determine what benefits are considered meaningful.[7]

States should codify this meaningful benefits standard in law or regulations. As a gold standard, states should add a definition of "meaningful benefits" specifying that plans must follow the generally accepted standards of care which are reflected by published peer-review research and consensus recommendations from non-profit professional societies for the relevant clinical specialty, including LOCUS/CALOCUS for MH benefits and The ASAM Criteria for SUD benefits.

Non-Quantitative Treatment Limitations

The final rule significantly strengthens Parity Act implementation through comprehensive NQTL reforms. It **clarifies critical terminology, eliminates potential compliance loopholes, and requires that NQTLs be comparable in both design and application between MH/SUD and medical/surgical benefits**. The rule **prohibits the use discriminatory factors or standards** that systematically disadvantage MH/SUD care, while **mandating data-driven monitoring** through required analysis plans. Plans must evaluate both individual NQTLs and their aggregate impact on access to care, with particular attention to network adequacy issues. When material differences in access are identified, plans must take reasonable corrective actions to ensure compliance with parity requirements.

Illustrative, Non-Exhaustive List of Non-Quantitative Treatment Limitations [8]

The Parity Act regulations include a list of non-quantitative treatment limitations (NQTLs), which were updated in the new regulations. The Departments clarified that this list is "non-exhaustive" and that plans must be analyzing all of the NQTLs identified, as well as any others they may employ. The list now identifies prior authorizations, standards related to network composition (including determining reimbursement rates, credentialing standards, and procedures for ensuring an adequate network), and methods for determining out-of-network rates.[9]

If states have a list of NQTLs in law or regulations, this list should be updated to mirror those in the federal regulations. As a gold standard, state agencies should collaborate with consumers and providers to identify any other NQTLs that should be added to this list that pose barriers to accessing MH/SUD benefits.

NQTL Compliance Test | Part One:

Design & Application: Prohibition on Discriminatory Factors and Evidentiary Standards [10]

Plans have to show that the way they design and apply NQTLs is comparable and no more stringent for MH and SUD benefits compared to medical and surgical benefits.

In designing NQTLs, plans may no longer use discriminatory factors or evidentiary standards – those that are biased or not objective in a way that systematically disfavors access or are designed to disfavor access to MH and SUD benefits as compared to medical and surgical benefits – unless the plan takes steps to correct, cure, or supplement them. Plans also cannot rely on historical data or information from before the Parity Act was enacted or from a time when the plan was not complying with the Parity Act.[11]

States should codify this prohibition on discriminatory factors and evidentiary standards in the design of NQTLs in law or regulations.

NQTL Compliance Test | Part Two:
Outcomes Data & Material Difference Standard [12]

As a new step in demonstrating compliance with the Parity Act, plans must now collect and evaluate relevant outcomes data to assess the impact of all NQTLs on access to benefits. While the rules do not specify the types of data plans must use, they give some examples (such as claims data, in- and out-of-network use, and reimbursement rates), and do not allow plans to disregard data they know or should reasonably know suggest a material difference in access. A material difference in access to MH or SUD benefits compared to medical and surgical benefits is a strong indicator of noncompliance, and plans must take reasonable actions to correct such disparities when they are caused by the NQTL.[13] State law or private accreditation standards may require specific data.[14]

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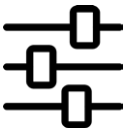
States should codify the requirement that plans collect and evaluate relevant data to assess the impact of the NQTL on outcomes related to access to mental health and substance use disorder benefits. As a gold standard, states should require in law or regulations the specific data points that would be most meaningful or effective. States should also mandate that plans collect and evaluate the relevant data that the Departments have recommended related to network composition:

In-network and out-of-network utilization rates (including data related to provider claim submissions);



Network adequacy metrics (including time and distance data, and data on providers accepting new patients);

Provider reimbursement rates (for comparable services and as benchmarked to a reference standard).[28]

Transparency

The final rule enhances transparency of compliance. Upon request, plans and issuers are required to provide their comparative analysis to state regulators and consumers or their authorized representatives.

NQTL Comparative Analysis[15]

The Consolidated Appropriations Act of 2021 requires plans to perform and document analyses showing that they are designing and applying NQTLs in a comparable way. The updated regulations go into far greater detail about this six-step process and the contents for the comparative analysis.[16]

Comparative analyses must include, at minimum:

1. A description of the NQTL and which benefits are 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 that the NQTL for MH and SUD benefits is comparable to and no more stringent than for medical and surgical benefits as written (i.e. in documents);
5. A demonstration that the NQTL for MH and SUD benefits is comparable to and no more stringent than for medical and surgical benefits in operation, including the outcomes data and their evaluation, an explanation of any material differences in access, and a description of reasonable actions taken to address such differences; and
6. Findings and conclusions.

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States should codify this full comparative analysis process and content requirements.

Consumer Access to Information [17]

Consumers or their authorized representatives in any commercial health insurance plan may request their plan's NQTL comparative analysis – which all insurers subject to the Parity Act are required to perform and document – when they receive an adverse benefit determination of MH/SUD benefits, such as a denial or partial denial.[18] Consumers in ERISA plans or their authorized representatives may request these analyses at any time, not just when they receive an adverse benefit determination.[19] Plans may not withhold information from consumers in these analyses by claiming they are proprietary or commercially protected.

States should require all state-regulated insurance plans to provide plan participants or their authorized representatives with the federally-mandated NQTL comparative analysis at any time, not just when they receive an adverse benefit determination, consistent with the requirement for ERISA plans. States should also explicitly codify the requirement that plans may not withhold any information from consumers in these analysis.

For more information on key takeaways of state codification of these standards on consumers, please see the following Legal Action Center resource, for which this brief draws:

https://www.lac.org/assets/files/LAC-fact-sheet-2024-Parity-Regulations-final.pdf

Enforcement [20]

The final rule establishes mechanisms for enforcement by clarifying the authority of the Departments and states to require remedies for non-compliance, including stopping NQTLs from being imposed.

State regulators may request NQTL comparative analyses at any time[21] and many states require plans to submit their analyses on a regular basis. Federal regulators must request no fewer than 20 comparative analyses annually. Upon a request from federal regulators, plans must submit these comparative analyses or any additional information within 10 business days. Upon an initial finding of non-compliance, plans must identify actions they will take to comply and provide updated analyses within 45 days. Upon a final determination of non-compliance, plans must notify enrollees within 7 business days and include information about opportunities to have affected claims reprocessed or newly submitted.[22] Regulators may require a plan to stop using an NQTL if it does not comply with the Parity Act, or if the plan's analysis was incomplete or insufficient to show it complied with the law.[23] Regulators may also take any other enforcement actions available to them.

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States should require plans to submit their NQTL comparative analyses annually, or at a minimum specify how many comparative analyses they will review each year. States should retain the authority to issue a finding of noncompliance for insufficient comparative analyses without a correction period.[24] States should also codify the timeframes in which plans must respond to requests and notify plan participants upon a final determination of noncompliance, which should be no less stringent than those in the final rules for federal regulators. States should further provide that a final determination of noncompliance, including when an analysis was incomplete or insufficient, will result in the plan being required to cease using that NQTL. States should also identify and include in law or regulations sufficient penalties to impose on plans for such noncompliance, which can be tied to other legal provisions such as failure to comply with form filings or acts of discrimination and unfair trade practices. States may also wish to consider additional provisions to ensure plans are held accountable for actions or omissions of third-party administrators.

Appendix

Directly Referencing Federal Regulations

"The provisions of 89 Fed. Reg. 77586 et seq., as published on September 23, 2024, and any guidance issued by federal departments of health and human services, labor, and the treasury to implement the rules adopted in September 2024 are incorporated in this section in their entirety."

If this language is used, there is no need to directly codify any further language.

Regulatory Language to Codify

The following language from the federal regulations can be used directly to codify the federal requirements into state laws. We are happy to work with you to fit these into your laws and regulations as appropriate.

Defining and Classifying MH/SUD Benefits

Appendix I. **Definitions (45 C.F.R. 146.136(a)(2))**

"Medical/surgical benefits" means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the group health plan (or health insurance coverage offered by an issuer in connection with such a plan) and in accordance with applicable Federal and State law, but does not include mental health benefits or substance use disorder benefits. Notwithstanding the preceding sentence, any condition or procedure defined by the plan or coverage as being or as not being a medical condition or surgical procedure must be defined consistent with generally recognized independent standards of current medical practice (for example, the most

current version of the ICD). To the extent generally recognized independent standards of current medical practice do not address whether a condition or procedure is a medical condition or surgical procedure, plans and issuers may define the condition or procedure in accordance with applicable Federal and State law.

"Mental health benefits" means benefits with respect to items or services for mental health conditions, as defined under the terms of the group health plan (or health insurance coverage offered by an issuer in connection with such a plan) and in accordance with applicable Federal and State law, but does not include medical/surgical benefits or substance use disorder benefits. Notwithstanding the preceding sentence, any condition defined by the plan or coverage as being or as not being a mental health condition must be defined consistent with generally recognized independent standards of current medical practice. For the purpose of this definition, to be consistent with generally recognized independent standards of current medical practice, the definition must include all conditions covered under the plan or coverage, except for substance use disorders, that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed in the most current version of the DSM. To the extent generally recognized independent standards of current medical practice do not address whether a condition is a mental health condition, plans and issuers may define the condition in accordance with applicable Federal and State law.

"Substance use disorder benefits" means benefits with respect to items or services for substance use disorders, as defined under the terms of the group health plan (or health insurance coverage offered by an issuer in connection with such a plan) and in accordance with applicable Federal and State law, but does not include medical/surgical benefits or mental health benefits. Notwithstanding the preceding sentence, any disorder defined by the plan or coverage as being or as not being a substance use disorder must be defined consistent with generally recognized independent standards of current medical practice. For the purpose of this definition, to be consistent with generally recognized independent standards of current medical practice, the definition must include all disorders covered under the plan or coverage that fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the ICD or that are listed as a Substance-Related and Addictive Disorder (or equivalent category) in the most current version of the DSM. To the extent generally recognized independent standards of current medical practice do not address whether

a disorder is a substance use disorder, plans and issuers may define the disorder in accordance with applicable Federal and State law.

Appendix II. **Meaningful Benefits (45 C.F.R. § 146.136(c)(2)(ii)(A))**

If a plan (or health insurance coverage) provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical/surgical benefits are provided. For purposes of this paragraph, whether the benefits provided are meaningful benefits is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the plan (or coverage) provides benefits for one or more medical conditions or surgical procedures. A plan (or coverage) does not provide meaningful benefits under this paragraph unless it provides benefits for a core treatment for that condition or disorder in each classification in which the plan (or coverage) provides benefits for a core treatment for one or more medical conditions or surgical procedures. For purposes of this paragraph, a core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the plan (or coverage) is not required to provide benefits for a core treatment for such condition or disorder in that classification (but must provide benefits for such condition or disorder in every classification in which medical/surgical benefits are provided). In determining the classification in which a particular benefit belongs, a plan (or health insurance issuer) must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits.

GOLD STANDARD: Incorporating "generally accepted standards of care":

If your state has a law requiring "generally accepted standards of care," we recommend using this language instead of "generally recognized independent standards of current medical practice" and referencing that statutory definition.

- If your state does not have require "generally accepted standards of care," we recommend adding a definition of "generally recognized independent standards of current medical practice" that mirrors this gold standard [link to toolkit, or insert language here]. For example, see Colorado HB 25-1102 (2025):

If a health benefit plan provides any benefits for a mental health condition or substance use disorder in any classification of benefits, it must provide meaningful benefits for that mental health condition or substance use disorder in every classification in which medical or surgical benefits are provided. Whether the benefits provided are meaningful benefits is determined in comparison to the benefits provided for medical conditions and surgical procedures in the classification and requires, at a minimum, coverage of benefits for that condition or disorder in each classification in which the health benefit plan provides benefits for one or more medical conditions or surgical procedures. A health benefit plan does not provide meaningful benefits unless it provides benefits for a core treatment for that condition or disorder in each classification in which the health benefit plan provides benefits for a core treatment for one or more medical conditions or surgical procedures. A core treatment for a condition or disorder is a standard treatment or course of treatment, therapy, service, or intervention indicated by generally accepted standards of behavioral, mental health, and substance use disorder care. If there is no core treatment for a covered mental health condition or substance use disorder with respect to a classification, the health benefit plan is not required to provide benefits for a core treatment for such condition or disorder in that classification, but must provide benefits for such condition or disorder in every classification in which medical or surgical benefits are provided.

Non-Quantitative Treatment Limitations

Appendix III. **Illustrative, Non-Exhaustive List of NQTLs**

(45 C.F.R. § 146.136(c)(4)(ii))

Illustrative, non-exhaustive list of nonquantitative treatment limitations. *Nonquantitative treatment limitations include—*

(A) Medical management standards (such as prior authorization) limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;

(D) Standards related to network composition, including but not limited to, standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage;

(E) Plan or issuer methods for determining out-of-network rates, such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates;

(F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);

(G) Exclusions based on failure to complete a course of treatment; and

(H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

GOLD STANDARD: If there are other barriers to care that disproportionately burden people with mental health conditions or substance use disorders in your state, you may want to consider adding those to this list.

Appendix IV. **Prohibition on Discriminatory Factors and Evidentiary Standards (45 C.F.R. § 146.136(c)(4)(i))**

Prohibition on discriminatory factors and evidentiary standards. *For purposes of determining comparability and stringency under this section, a plan (or health insurance coverage) may not rely upon discriminatory factors or evidentiary standards to design a nonquantitative treatment limitation to be imposed on mental health or substance use disorder benefits. A factor or evidentiary standard is discriminatory if the information, evidence, sources, or standards on which the factor or evidentiary standard are based are biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits.*

(1) Information, evidence, sources, or standards are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits if, based on all the relevant facts and circumstances, the information, evidence, sources, or standards systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits. For purposes of this paragraph, relevant facts and circumstances may include, but are not limited to, the reliability of the source of the information, evidence, sources, or standards, including any underlying data; the independence of the information, evidence, sources, and standards relied upon; the analyses and methodologies employed to select the information and the consistency of their application; and any known safeguards deployed to prevent reliance on skewed data or metrics. Information, evidence, sources, or standards are not considered biased or not objective for this purpose if the plan or issuer has taken the steps necessary to correct, cure, or supplement any information, evidence, sources, or standards that would have been biased or not objective in the absence of such steps.

(2) For purposes of this paragraph, historical plan data or other historical information from a time when the plan or coverage was not subject to PHS Act section 2726 or was not in compliance with PHS Act section 2726 are considered to be biased or not objective in a manner that discriminates against mental health or substance use disorder benefits as compared to medical/surgical benefits, if the historical plan data or other historical information systematically disfavor access or are specifically designed to disfavor access to mental health or substance use disorder benefits as compared to medical/surgical benefits, and the plan or issuer has not taken the steps necessary to correct, cure, or supplement the data or information.

Appendix V. **Outcomes Data & Material Difference Standard (45 C.F.R. 146.136(c)(4)(iii))**

To ensure that a nonquantitative treatment limitation applicable to mental health or substance use disorder benefits in a classification, in operation, is no more restrictive than the predominant nonquantitative treatment limitation applied to substantially all medical/surgical benefits in the classification, a plan or issuer must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits and carefully consider the impact as part of the plan's or issuer's evaluation. As part of its evaluation, the plan or issuer may not disregard relevant outcomes data that it knows or reasonably should know suggest that a nonquantitative treatment limitation is associated with material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits. The [Department of Insurance] may specify in guidance the type, form, and manner of collection and evaluation for the data required under this paragraph.

GOLD STANDARD: State law can require specific data points to be collected. In addition to any data that you believe would be appropriate or helpful in your state, we recommend identifying the following data points as required by your state law, which were listed as optional in the regulations:

The number and percentage of claims denials

- In-network and out-of-network utilization rates (including data related to provider claim submissions)
- Network adequacy metrics (including time and distance data, and data on providers accepting new patients)
- Provider reimbursement rates (for comparable services and as benchmarked to a reference standard).

Appendix IV. **Comparative Analysis (45 C.F.R. § 146.137)**

(a) ***In general.*** *In the case of a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits and that imposes any nonquantitative treatment limitation on mental health or substance use disorder benefits, the plan or issuer must perform and document a comparative analysis of the design and application of each nonquantitative treatment limitation applicable to mental health or substance use disorder benefits. Each comparative analysis must comply with the content requirements of this section.*

(b) ***Comparative analysis content requirements.*** *With respect to each nonquantitative treatment limitation applicable to mental health or substance use disorder benefits under a health plan, the comparative analysis performed by the plan or issuer must include, at minimum, the elements specified in this paragraph. In addition to the comparative analysis for each nonquantitative treatment limitation, each plan or issuer must prepare and make available to the [Department of Insurance], upon request, a written list of all nonquantitative treatment limitations imposed under the plan or coverage.*

(1) ***Description of the nonquantitative treatment limitation.*** *The comparative analysis must include, with respect to the nonquantitative treatment limitation that is the subject of the comparative analysis:*

(i) Identification of the nonquantitative treatment limitation, including the specific terms of the plan or coverage or other relevant terms regarding the nonquantitative treatment limitation, the policies or guidelines (internal or external) in which the nonquantitative treatment limitation appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the nonquantitative treatment limitation;

(ii) Identification of all mental health or substance use disorder benefits and medical/surgical benefits to which the nonquantitative treatment limitation applies, including a list of which benefits are considered mental health or substance use disorder benefits and which benefits are considered medical/surgical benefits; and

(iii) A description of which benefits are included in each classification.

(2) ***Identification and definition of the factors and evidentiary standards used to design or apply the nonquantitative treatment limitation.*** *The comparative analysis must include, with respect to every factor considered or relied upon to design the nonquantitative treatment limitation or apply the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits:*

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which mental health or substance use disorder benefits and which medical/surgical benefits are subject to the nonquantitative treatment limitation; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (b)(2)(i) of this section; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective in the absence of such steps.

(3) ***Description of how factors are used in the design and application of the nonquantitative treatment limitation.*** *The comparative analysis must include a description of how each factor identified and defined under paragraph (b)(2) of this section is used in the design or application of the nonquantitative treatment limitation to mental health and substance use disorder benefits and medical/surgical benefits in a classification, including:*

(i) A detailed explanation of how each factor identified and defined in paragraph (b)(2) of this section is used to determine which mental health or substance use disorder benefits and which medical/surgical benefits are subject to the nonquantitative treatment limitation;

(ii) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the nonquantitative treatment limitation, including in the determination of whether and how mental health or substance use disorder

benefits or medical/surgical benefits are subject to the nonquantitative treatment limitation;

(iii) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualifications of each decision maker;

(iv) If more than one factor is identified and defined in paragraph (b)(2) of this section, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors; and

(v) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which each evidentiary standard was derived), such as how the factor is used differently to apply the nonquantitative treatment limitation to mental health or substance use disorder benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

(4) ***Demonstration of comparability and stringency as written.*** *The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits. The comparative analysis must include, with respect to the nonquantitative treatment limitation and the factors used in designing and applying the nonquantitative treatment limitation:*

(i) Documentation of each factor identified and defined in paragraph (b)(2) of this section that was applied to determine whether the nonquantitative treatment limitation applies to mental health or substance use disorder benefits and medical/surgical benefits in a classification, including, as relevant:

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the nonquantitative treatment limitation applies, mental health or substance use disorder benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the nonquantitative treatment limitation would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(ii) In each classification in which the nonquantitative treatment limitation applies to mental health or substance use disorder benefits, a comparison of how the nonquantitative treatment limitation, as written, is designed and applied to mental health or substance use disorder benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the nonquantitative treatment limitation or that address the application of the nonquantitative treatment limitation;

(iii) Documentation demonstrating how the factors are comparably applied, as written, to mental health or substance use disorder benefits and medical/surgical benefits in each classification, to determine which benefits are subject to the nonquantitative treatment limitation; and

(iv) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the nonquantitative treatment limitation, or the application of the nonquantitative treatment limitation, to mental health or substance use disorder benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the nonquantitative treatment limitation.

(5) ***Demonstration of comparability and stringency in operation.*** *The comparative analysis must evaluate whether, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying*

the nonquantitative treatment limitation to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits. The comparative analysis must include, with respect to the nonquantitative treatment limitation and the factors used in designing and applying the nonquantitative treatment limitation:

(i) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the nonquantitative treatment limitation with respect to medical/surgical benefits, including:

(A) An explanation of any methodology and underlying data used to demonstrate the application of the nonquantitative treatment limitation, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the mental health or substance use disorder benefits and medical/surgical benefits to which the nonquantitative treatment limitation is applicable;

(C) With respect to a nonquantitative treatment limitation for which relevant data is temporarily unavailable, a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to a nonquantitative treatment limitation for which no data exist that can reasonably assess any relevant impact of the nonquantitative treatment limitation on relevant outcomes related to access to mental health and substance use disorder benefits and medical/surgical benefits, a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the nonquantitative treatment limitation's impact, an explanation of why the nature of the nonquantitative treatment limitation prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of

any additional safeguards or protocols used to ensure that the nonquantitative treatment limitation complies with parity;

(ii) Identification of the relevant data collected and evaluated;

(iii) Documentation of the outcomes that resulted from the application of the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data; and

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the nonquantitative treatment limitation contributes to material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits;

(iv) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (b)(5)(iii) of this section, including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the nonquantitative treatment limitation as applied to mental health or substance use disorder benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the nonquantitative treatment limitation; and

(B) To the extent differences in access to mental health or substance use disorder benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate mental health and substance use disorder benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply a nonquantitative treatment limitation, documentation explaining how any such differences are attributable to those standards or measures; and

(v) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking to address material differences to comply, in operation, with parity including, as applicable:

(A) A reasoned explanation of any material differences in access to mental health or substance use disorder benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more nonquantitative treatment limitations related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network mental health and substance use disorder benefits as compared to in-network medical/surgical benefits.

(6) ***Findings and conclusions.*** *The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:*

(i) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of parity, including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(ii) A reasoned and detailed discussion of the findings and conclusions described in paragraph (b)(6)(i) of this section;

(iii) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions described in paragraph (b)(6)(i) of this section not otherwise discussed in the comparative analysis;

(iv) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(v) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the nonquantitative treatment limitation applicable to both mental health or substance use disorder benefits and medical/surgical benefits.

Appendix VII. **Consumer Access to Information (45 C.F.R. 146.137(e))**

Requests for a copy of a comparative analysis.

(a) In addition to making a comparative analysis available to the Department of Insurance on an annual basis, a plan or issuer must make available a copy of the comparative analysis when requested by:

(1) Any applicable State authority; and

(2) A participant or beneficiary (including a provider or other person acting as a participant's or beneficiary's authorized representative).

(b) A plan or issuer must provide the requested comparative analysis no later than 30 calendar days after receiving a request under paragraph (a)(2)

(c) A plan or issuer may not withhold any information contained in the comparative analysis, including any information from or developed by third parties.

Enforcement

Appendix VIII. **Enforcement (45 C.F.R. §§ 146.136(c)(4)(v)(A), 146.137(d))**

(a) ***Requirements related to submission of comparative analyses to the [Department of Insurance]****—*

(1) ***Initial submission for comparative analysis.*** *A health plan must submit the comparative analysis to the [Department of Insurance] on [date], and annually thereafter, in the manner required by this section.*

(2) ***Requirement to notify participants and beneficiaries of final determination of noncompliance*** *—*

(i) ***In general.*** *If the [Department of Insurance] makes a final determination of noncompliance, the plan or issuer must notify all participants and beneficiaries enrolled in the plan or coverage that the plan or issuer has been determined to not be in compliance with the requirements of parity or this section with respect to such plan or coverage. Such notice must be provided within 7 business days of receipt of the final determination of noncompliance, and the plan or issuer must provide a copy of the notice to the [Department of Insurance], any service provider involved in the claims process, and any fiduciary responsible for deciding benefit claims within the same timeframe.*

(ii) ***Content of notice.*** *The notice to participants and beneficiaries shall be written in a manner calculated to be understood by the average plan participant and must include, in plain language, the following information in a standalone notice:*

> *(A) The following statement prominently displayed on the first page, in no less than 14-point font: "Attention! The [Department of Insurance] has determined that [insert the name of group health plan or health insurance issuer] is not in compliance with the Mental Health Parity and Addiction Equity Act.";*
>
> *(B) A summary of changes the plan or issuer has made as part of its corrective action plan specified to the Secretary following the initial determination of noncompliance, including an explanation of any opportunity for a participant or beneficiary to have a claim for benefits submitted or reprocessed;*
>
> *(C) A summary of the [Department of Insurance's] final determination that the plan or issuer is not in compliance with parity or this section, including any provisions or practices identified as being in violation, additional corrective actions identified by the [Department of Insurance] in the final determination notice, and information on how participants and beneficiaries can obtain from the plan or issuer a copy of the final determination of noncompliance;*
>
> *(D) Any additional actions the plan or issuer is taking to come into compliance with parity or this section, when the plan or issuer will take such actions, and a clear and accurate statement explaining whether the Secretary has concurred with those actions; and*
>
> *(E) Contact information for questions and complaints, and a statement explaining how participants and beneficiaries can obtain more information about the notice, including:*

(1) The plan's or issuer's phone number and an email or web portal address; and

(2) The [Department of Insurance's] phone number and email or web portal address.

(iii) ***Manner of notice.*** *The plan or issuer must make the notice available in paper form, or electronically (such as by email or an internet posting) if:*

(A) The format is readily accessible;

(B) The notice is provided in paper form free of charge upon request; and

(C) In a case in which the electronic form is an internet posting, the plan or issuer timely notifies the participant or beneficiary in paper form (such as a postcard) or email, that the documents are available on the internet, provides the internet address, includes the statement required in this section, and notifies the participant or beneficiary that the documents are available in paper form upon request.

(b) ***Effect of final determination of noncompliance.*** *If a health plan receives a final determination from the [Department of Insurance] or applicable State authority that the plan or issuer is not in compliance with the comparative analysis requirements with respect to a nonquantitative treatment limitation, the nonquantitative treatment limitation violates parity and the [Department of Insurance] or applicable State authority may direct the plan or issuer not to impose the nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in the relevant classification, unless and until the plan or issuer demonstrates to the [Department of Insurance] or applicable State authority compliance with the requirements of this section or takes appropriate action to remedy the violation.*

GOLD STANDARD: Add financial penalties to the section on the effects of a final determination of compliance, consistent with your state's laws. Your state may already have direct authority to impose penalties for violations of parity, though you could also tie them to unfair and deceptive trade practices, acts of discrimination, or failure to submit timely or sufficient form filings.

Penalties

Below are two existing state examples, from Georgia and Massachusetts.

Georgia has financial penalties in statute, though regulators may wish to consider monetary penalties large enough to act as a deterrent rather than the cost of doing business.

Georgia Code 33-1-27(i) [25]

(1) *If the Commissioner determines that a health insurer failed to submit a timely or sufficient report required under paragraph (4) of subsection (b) of this Code section or failed to submit timely and sufficient data pursuant to a data call conducted pursuant to paragraph (1) of subsection (c) of this Code section, the Commissioner may impose a monetary penalty of up to $2,000.00 for each and every act in violation, unless the insurer knew or reasonably should have known that he or she was in violation, in which case the monetary penalty may be increased to an amount of up to $5,000.00 for each and every act in violation.*

(2) *If the Commissioner determines that an insurer failed to comply with any provision of this Code section, the Commissioner may take any action authorized, including, but not limited to, issuing an administrative order imposing monetary penalties, imposing a compliance plan, ordering the insurer to develop a compliance plan, or ordering the insurer to reprocess claims.*

Massachusetts has penalties determined per person affected:

Massachusetts Gen. Law Ch. 26 Sec. 8k(b) [26]

(b) The commissioner may impose a penalty against a carrier that provides mental health or substance use disorder benefits, directly or through a behavioral health manager as defined in section 1 of chapter 176O or any other entity that manages or administers such benefits for the carrier, for any violation by the carrier or the entity that manages or administers mental health and substance use disorder benefits for the carrier of state laws related to mental health and substance use disorder parity or the mental health parity provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 300gg-26, as amended, and federal guidance or regulations issued under the act.

The amount of any penalty imposed shall be $100 for each day in the noncompliance period per product line with respect to each participant or beneficiary to whom such violation relates; provided, however, that the maximum annual penalty under this subsection shall be $1,000,000; provided further, that for purposes of this subsection, the term "noncompliance period" shall mean the period beginning on the date a violation first occurs and ending on the date the violation is corrected.

A penalty shall not be imposed for a violation if the commissioner determines that the violation was due to reasonable cause and not to willful neglect or if the violation is corrected not more than 30 days after the start of the noncompliance period.

References

1 Department of the Treasury, Department of Labor, & Department of Health & Human Services, "Requirements Related to the Mental Health Parity and Addiction Equity Act," 89 Fed. Reg. 77586, 77702 (September 23, 2024)

2 Note: The Parity Act also applies to Medicaid managed care plans, the Medicaid expansion population (alternative benefit plans), and the Children's Health Insurance Program (CHIP). However, these final rules only apply to private insurance plans. However, states should consider applying these standards to Medicaid as well. Please see our issue brief on Medicaid Gold Standards [link when available] for more information on how to mirror these requirements for Medicaid.

3 See Appendix I for model language

4 See 45 C.F.R. 146.136(a)(2)

5 See Appendix II for model language

6 See § 146.136(c)(2)(ii)(A)

7 For more information on how states can implement generally recognized independent standards of current medical practice in fidelity to the federal law, see our issue brief [link when available]

8 See Appendix III for model language

9 See § 146.136(c)(4)(ii)

10 See Appendix IV for model language

11 See § 146.136(c)(4)(i)

12 See Appendix V for model language

13 See § 146.136(c)(4)(iii)

14 See § 146.136(c)(4)(iii)(A)(1)

15 See Appendix VI for model language

16 See § 146.137

17 See Appendix VII for model language

18 See § 146.136(d)(3); § 146.137(e)(2)

19 See 29 CFR § 2590.712(d)(3)

20 See Appendix VIII for model language

21 See § 146.137(e)(1)

22 See § 146.137(d)

23 See § 146.136(c)(4)(v)(A)

24 This authority gives state regulators greater leverage to compel health plans to take parity reporting and remediation of noncompliance findings seriously, particularly during market conduct exams. For example, a state regulator can send the request to the issuer for a comparative analysis on an NQTL, indicating that an insufficient comparative analysis can be deemed out of compliance with 42 U.S.C. 300gg-26(a)(8)(A) and 45 CFR 146.137(c)).

25 **https://codes.findlaw.com/ga/title-33-insurance/ga-code-sect-33-1-27/**

26 **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleII/Chapter26/Section8K**

27 For more detail, see The Kennedy Forum's Analysis of the Mental Health Parity Final Rule from September 10, 2024 **https://www.thekennedyforum.org/blog/analysis-of-the-mental-health-parity-final-rule/** and the Legal Action Center's summary **https://www.lac.org/assets/files/LAC-fact-sheet-2024-Parity-Regulations-final.pdf**

28 See § 146.136(c)(4)(iii)(A)(2)