ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

December 5, 2025

The Honorable Daniel Aronowitz
Assistant Secretary
Employee Benefits Security Administration
United States Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

Mr. Peter Nelson
Director
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Centers for Medicare & Medicaid Services
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Ms. Helen Morrison
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Re: ABHW Recommendations to Improve MH and SUD Parity

Dear Assistant Secretary Aronowitz, Director Nelson, Ms. Morrison, and Mr. Lindenmuth:

Please accept the recommendations below from the Association for Behavioral Health and Wellness (ABHW) to the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, 'the Departments') on ways to reform the mental health (MH) and substance use disorder (SUD) parity compliance process.

ABHW is the national voice for payers managing behavioral health (BH) insurance benefits. Our member companies provide coverage to 200 million people in the public and private sectors to treat MH, SUDs, and other behaviors that impact health and wellness. Since its inception, ABHW has been at the forefront of and an advocate for MH and SUD parity and was instrumental in drafting the legislation for the initial Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Our members have worked tirelessly over the past 17 years to implement parity for behavioral health services.

ABHW fully supports MH and SUD parity, and our members share the same goal as the Departments: promoting access to comprehensive MH/SUD benefits. However, the lack of comprehensive guidance from the federal government has plagued payers for over a decade, particularly for non-quantitative treatment limitations (NQTLs). For years, ABHW members have urged the Departments to provide greater specificity and model examples to guide compliance efforts, such as standardized templates, illustrative case studies, and examples of acceptable comparative analyses, including:

- Identify a core set of NQTLs: While we appreciate the reasons the Departments are hesitant to place a limit on the scope of NQTLs, not having clear boundaries for what constitutes an NQTL continues to create unnecessary confusion and compliance risk, and divert critical resources.
    - For example, case management can vary substantially between plans, and regulators from several states and the federal government have taken different positions on whether and under which circumstances case management is considered an NQTL. In some cases, plans have been forced to invest significant time and resources to effectively prove a negative. When there are clear instances of confusion or regulatory uncertainty like this, the Departments must weigh in timely with new guidance.

- Identify the NQTLs that are the focus of the DOL audit and enforcement activity annually: In both the 2023 and 2024 Reports to Congress, the Departments highlighted the primary NQTLs under review for each year. Continuing this practice will eliminate unnecessary effort and administrative burden by allowing health plans and issuers to focus their compliance resources on the areas that regulators are most interested in.

- Provide a sample analysis for each NQTL: We continue to advocate for an example of information collection or a sample NQTL analysis to help payers respond to information collections and ensure consistent enforcement determinations of insufficiency or non-compliance. This would save tremendous resources and guesswork for health plans, insurers, employers, and regulators, ensure that the documentation submitted to the Departments is compliant, and help maintain consistency in future discussions.

- Promote uniformity between state and federal parity compliance requirements: The federal government must establish and enforce a universal standard to ensure consistent parity compliance across regulators. Promoting uniformity between federal and state compliance reviews and enforcement will reduce confusion, administrative burden, and inconsistent interpretations that complicate compliance for regulators, health plans, insurers, providers, and patients.

We are committed to working collaboratively with regulators and the Administration to ensure that the compliance oversight of MHPAEA is both practical and feasible. To achieve this aim, we believe that compliance requirements should be predictable and consistent.

The requirements should also not be overly burdensome, nor should the implementation of the law and its regulations inadvertently restrict patient access to care. Such a regulatory structure should allow health plans, issuers, and employers to achieve certainty, in advance, that they are in compliance with MHPAEA, rather than solely through the audit or litigation process.

In addition to the aforementioned proposals, the following recommendations would significantly improve the parity compliance process for all health plans, issuers, providers, and patients:

I. Issue a New Rule on MH and SUD Parity.

We respectfully urge the Departments to issue a new proposed rule to provide greater clarity and alignment with congressional intent regarding MH/SUD parity. The 2024 Final Rule, as issued, exceeds the Department's statutory authority and introduces obligations not envisioned under the Mental Health Parity and Addiction Equity Act of 2008, as amended. While we are grateful for the Department's May 15, 2025, Statement Regarding Enforcement, it has created uncertainty, as some states have proceeded with enforcement, given that the 2024 Final Rule technically remains in effect.

To avoid prolonged uncertainty and increasing conflict between state and federal enforcement requirements, the Departments should immediately issue guidance on their intent for the 2024 Final Rule and develop a new rule that aligns squarely with the statutory directives outlined in the Consolidated Appropriations Act, 2021 (CAA 21). The CAA 21 was designed to clarify expectations regarding the documentation and comparative analyses that health plans and issuers must prepare to demonstrate compliance with NQTL requirements. A rule implementing the CAA 21 should also clarify expectations and be consistent with these standards.

We urge the Departments to issue a new rule that adopts the provisions in ABHW's proposed outline of a new rule linked here. Our proposal reinforces the CAA 21's expectations for the documentation and comparative analyses that health plans and issuers must conduct to demonstrate NQTL compliance.

Any proposed new rule should include a public comment period of at least 60 days to ensure that stakeholders, including those responsible for implementing parity compliance, have an adequate opportunity to provide meaningful input.

II. Define compliance safe harbors based on specified outcome metrics for the most investigated NQTL types.

To further our collective goal of improving access to MH and SUD services, we urge the Departments to create clear compliance safe harbors for the most common types of NQTLs. These safe harbors should outline plan design features and outcome measures that demonstrate when an NQTL is unlikely to create access disparities. If a health plan or issuer meets all the criteria for a safe harbor, regulators could reasonably conclude that further review of that NQTL's comparative analysis is unnecessary.

This approach, similar to how the Office of Inspector General (OIG) administers safe harbors under the Anti-Kickback Statute, will bring needed clarity, reduce administrative burden, and allow the Departments to focus enforcement on actual barriers to care.

Please find ABHW's preliminary recommendations for proposed safe harbor standards related to utilization management (UM) practices.

III. Develop an appeals process to allow health plans and issuers to contest findings of non-compliance that MHPAEA does not adequately substantiate.

We urge the Departments to establish a transparent appeals process that provides health plans and insurers with a fair opportunity to contest findings of non-compliance that are not supported by the MHPAEA statute or related guidance.

The Centers for Medicare & Medicaid Services (CMS) utilizes a useful appeals process model for Medicare Advantage Organizations and civil monetary penalties (CMPs). This framework, in place since 2007, is consistent with other CMS appeals processes, such as those for RADV and RAC audits.

Importantly, we believe such an appeals process could be created under the Departments' existing statutory authority, similar to how CMS implemented its appeals procedures under its authority to establish program standards for Medicare Advantage. This parallels the authority granted under 42 U.S.C. § 300gg-26(a)(8)(C)(ii) for regulations governing NQTL compliance documentation. **Please see our detailed proposal linked here.**

IV. Create a compliance credit for following third-party accreditation standards.

Building on our recommendation to establish a global safe harbor, ABHW urges the Departments to create a compliance credit for health plans and issuers that obtain MHPAEA parity accreditation. Granting "deemed status" to mental health parity accredited entities would acknowledge that they have met key compliance requirements and provide greater certainty for organizations pursuing accreditation aligned with federal and state MHPAEA standards.

These approaches would promote regulatory consistency, enhance transparency, and reduce unnecessary administrative duplication. Importantly, they would also enable the Departments to focus enforcement resources on higher-risk entities, while appropriately acknowledging those that have undergone rigorous, independent, standards-based assessments aligned with federal expectations.

V. Create a Federal Advisory Committee to support ongoing parity compliance tools.

ABHW supports the establishment of a Federal Advisory Committee (FAC) dedicated to the longer-term goal of developing and refining parity compliance tools that provide greater

clarity, consistency, and real-world applicability. Such a committee could produce standardized templates for NQTL comparative analyses, additional illustrative case studies and model examples that demonstrate compliant approaches in practice, and regular updates to the self-compliance tool.

ABHW recommends that the FAC include a diverse group of stakeholders, such as regulators, patients, providers, and health plan representatives with experience developing and implementing policies related to each NQTL. The FAC would help ensure current and future tools are practical, balanced, and effective in supporting consistent regulations and stronger parity implementation at both the federal and state levels. This expert committee should be structured to comply with the Federal Advisory Committee Act, similar to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) for Medicare payment models.

ABHW is committed to working with the Departments to improve access to behavioral health treatment for all Americans. We look forward to meeting with the Departments to discuss these recommendations. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO