May 27, 2026

The Honorable Daniel Aronowitz
Assistant Secretary
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Washington, D.C. 20210

Ms. Helen Morrison
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Mr. Peter Nelson
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United States Internal Revenue Service
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Re: 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), AHIP and the Blue Cross Blue Shield Association (BCBSA) 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.

Our organizations fully support mental health parity and share the same goal as the Departments, promoting access to comprehensive, high-quality MH/SUD care for those who need it. We are committed to working collaboratively with regulators and the Administration to ensure that the compliance oversight of the Mental Health Parity and Addiction Equity Act (MHPAEA) is both effective and feasible. To achieve this aim, 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.

The following recommendations would provide certainty and significantly improve and simplify the parity compliance process for regulators, health plans, issuers, providers, and patients:

I. Issue a New Rule on Mental Health Parity.

We are grateful to hear that the Departments plan to issue a new proposed rule before the end of this year to provide greater clarity and alignment with congressional intent regarding MH/SUD parity. The 2024 Final Rule, as issued, exceeds the Departments' 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 and complexity, as some states have proceeded with enforcement since 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 proposed rule that aligns squarely with the statutory directives outlined in the Consolidated Appropriations Act, 2021 (CAA 2021). The CAA 2021 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 proposed rule implementing the CAA 2021 should also clarify expectations and be consistent with these standards.

Any proposed new rule should avoid several of the requirements imposed by the 2024 MHPAEA Final Rule that represented overreaches of MHPAEA Statute. This includes the meaningful benefits requirement for MH/SUD treatment, the material difference standard for relevant data to determine compliance, and the determination of noncompliance allowance that the Departments may direct plans not to impose an NTQL if the plan is found noncompliant with comparative analysis requirements.

A proposed new rule should also 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. Develop an Enumerated List of NQTLs.

We recommend that the Departments publish a set list of NQTLs for which health plans are required to provide upon the initial request from the relevant Secretary for a comparative analysis within 15 business days, consistent with the Consolidated Appropriations Act of 2021 requirements. While we understand the Departments' reluctance to narrowly constrain the universe of NQTLs, the absence of clearer guardrails continues to create confusion, elevates compliance risk, and diverts significant plan resources toward documentation rather than focus on members. The current list of NQTL examples remains incomplete and, in some cases, relies on overly broad descriptors (e.g., implied restrictions on billing codes), making it difficult for health plans to determine whether a particular practice should be treated as an NQTL. We recommend that the Departments utilize the list enumerated from the MHPAEA

Interim Final Rule of 2010[1] and referenced in the 2013 MHPAEA Final Rule, published on November 13, 2013.

We encourage the Departments to publicly identify a core set of NQTLs through the Reports to Congress and expect auditors to target only those NQTLs that are the primary focus of DOL audit and enforcement activity each year.

The core NQTLs for which health plans and carriers should be required to proactively document comparative analyses should be:

1. **Specified Medical Management NQTLs**: utilization management (prior authorization, concurrent review, retrospective review) and determining coverage when a treatment is experimental or investigational.
2. **Network Composition Standards**: methods for determining reimbursement rates and credentialing standards.
3. **Exclusions Based on Failure to Complete a Course of Treatment;** and
4. **Out-of-Network Provider Reimbursement Rate Setting Methodology**[2].

The following are additional NQTL types that the Departments could incorporate into the required set of comparative analyses in future years, should the Departments determine that their inclusion would serve the public interest:

5. **Prescription Drug Formulary Design,**
6. **Network Tier Design** for health plans with multiple tiers such as preferred versus participating provider tiers.
7. **Step Therapy or Fail-First Protocols for** refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective.
8. **Coverage Restrictions based on Geographic Location, Facility Type, Provider Specialty**, or other criteria that limit the scope or duration of benefits for services provided under the plan.

Additionally, we request guidance to clarify that provider directories are not an independent NQTL type under MHPAEA, as they do not function as limits on the scope or duration of treatment.[3] Provider directories are informational resources, typically required under separate transparency and consumer protection frameworks, and do not independently limit

[1] 75 Fed. Reg. 5410 (Feb. 2, 2010), *Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008*.

[2] We note that we recommend deleting the explanatory phrasing for this NQTL type in the 2024 Rule ("such as allowed amounts; usual, customary, and reasonable charges; or application of other external benchmarks for out-of-network rates"), given the potential for this language to be misinterpreted to define the NQTL type to mean the allowed amounts themselves, rather than the methodology for determining such amounts. Guidance should be clear that reasonable data measures based on allowed amounts may be used to evaluate compliance in operation for the plan or carrier's Out-of-Network Provider Reimbursement Rate-Setting Methodology, but just like data measures for other NQTL types, quantitative comparisons of out-of-network allowed amounts would not be dispositive as to compliance. Instead, disparate outcomes for such data measures would require the plan to evaluate whether the disparity is caused by a disparity in the factors, sources, or evidentiary standards that are used in the design or application of the NQTL.

[3] 29 U.S.C. § 1185a(a)(3)(B)(iii); 42 U.S.C. § 300gg-26(a)(3)(B)(iii); 26 U.S.C. §9812(a)(3)(B)(iii)

network access or benefits. While we understand that inaccuracies in directories may affect a member's experience in locating care, these issues are more appropriately addressed through directory accuracy and transparency requirements rather than through the NQTL comparative analysis framework. To the extent they are considered in a parity context, they should not be deemed to constitute an independent NQTL type.

Greater clarity is especially needed where regulatory interpretations have varied. For example, both state and federal regulators have taken inconsistent positions on whether, and under what circumstances case management constitutes an NQTL. In these situations, plans are often required to invest substantial time and resources to effectively prove a negative, underscoring the need for timely, clear guidance from the Departments when recurring uncertainty arises.

III. Define Compliance Safe Harbors 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 operations measure outcomes 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.

IV. Update the Self Compliance Tool

We appreciate the Departments' continued efforts to provide guidance supporting compliance with MHPAEA and remain committed to working collaboratively to enhance the parity compliance process. To enhance clarity, consistency, and usability, we respectfully recommend that the next iteration of the Self-Compliance Tool include the following improvements:

- **Clear and consistent definitions** of key terms (e.g., "factors," "processes," "evidentiary standards") to promote a common understanding across plans and regulators;
- **Model formats** to support more uniform and efficient comparative analyses;
- **Additional illustrative examples**, including, where appropriate to help plans assess sufficiency and compliance expectations;
- **Concrete examples of compliant and non-compliant comparative analyses**, including end-to-end sample analyses, to better demonstrate how requirements can be applied in practice. These examples would be intended to be illustrative rather than prescriptive to support continued innovation and flexibility.

These enhancements would help ensure that the Self-Compliance Tool serves as a practical, actionable resource for plans while supporting more consistent and effective oversight by regulators.

V. Clarify that MH/SUD benefits are treatments for MH/SUD conditions, and determination is not only based on diagnosis.

We urge the Departments to state clearly that plans may use a reasonable and practical approach that does not rely solely on diagnosis codes to define benefits as MH/SUD or medical/surgical (M/S). The preamble to the 2024 Final Rule suggests that MH/SUD benefits under MHPAEA must be determined by the condition being treated, However, because MHPAEA broadly defines MH/SUD benefits as benefits for services or treatments related to a MH/SUD diagnosis, this interpretation risks making diagnosis alone determinative of benefit classification. This requirement conflicts with rules assigning benefits to one classification and can cause confusion when benefits fall into multiple categories. For example, if diagnosis alone determines whether a service is a MH/SUD benefit, then any treatment provided to an individual with an MH/SUD diagnosis could be characterized as an MH/SUD benefit, regardless of the nature of the service itself. A routine urine drug screen ordered for a patient with a SUD, or physical therapy provided to an individual with autism spectrum disorder (ASD), could be treated as MH/SUD benefits solely because of the underlying diagnosis. Further, pharmacy claims for prescription drugs generally do not include diagnosis information, which makes implementing the Departments' interpretation extremely difficult from a compliance perspective. A reasonable and practical approach to defining a MH/SUD benefit would be to allow plans and issuers to consider the treatments and services that are generally delivered to treat MH/SUD conditions to be a MH/SUD benefit and then consider all other benefits as M/S benefits.

VI. Establish and define the administrative process for enforcing the CAA's comparative analysis requirements.

We also encourage the Departments to issue guidance, through notice and comment, that establishes procedural guidelines for the review of NQTL comparative analyses under MHPAEA. Given the ongoing underlying problems in the comparative analysis review process (such as the lack of sufficient guidance on what should be included in a comparative analysis, inconsistent assessments across regions and agencies, and the highly subjective nature of comparative analysis reviews), final determinations of noncompliance may be based on ad hoc and inconsistent reviews of NQTL comparative analyses or based on flawed assumptions or incomplete information.

We further request that the Departments establish an administrative process to appeal determinations made by enforcement authorities. This process should allow for plans and issuers to escalate alleged insufficiencies or violations, as the statutory consequences of a finding of noncompliance are severe — notice to enrollees of noncompliance within seven days and publication of the name of the plan or issuer in a public report to Congress. Plans and issuers face both financial and reputational harm though final agency determinations, with no recourse if arbitrary and capricious determinations are made.

We are committed to working with the Departments to improve behavioral health outcomes for all Americans. We welcome the opportunity to meet with the Departments to discuss these recommendations.

Sincerely,

Association for Behavioral Health and Wellness (ABHW)
AHIP
Blue Cross Blue Shield Association