June 12, 2025

Enforcement of the 2024 Mental Health Parity Regulations Suspended

But the suspension applies only to new rules

In September 2024, the U.S. Departments of Labor, Health and Human Services, and Treasury (the "Departments") published a new set of final regulations for the Mental Health Parity and Addiction Equity Act (MHPAEA). We will refer to the 2024 final regulations as the "2024 NQTL Regulations" and broadly refer to MHPAEA, its regulations, and other related guidance together as the "parity rules" for the remainder of this Alert.

In reaction to a recent lawsuit, the Departments issued a statement of non-enforcement on May 15, 2025. This statement indicates that the Departments will not enforce any new rules added by the 2024 NQTL Regulations (with some caveats) while they reconsider whether to withdraw and/or modify them. The Departments also intend to evaluate their approaches to enforcement of the parity rules. Please note that all other parity rules remain valid and enforceable, which includes the dreaded NQTL comparative analysis requirement.

This Alert will address the lawsuit, the non-enforcement position taken by the Departments, observations about the status of certain parity issues, and employer considerations. Our Alert is relevant for all employers sponsoring group health coverage, but it is most relevant for employers sponsoring self-insured medical and prescription drug coverage.

Some basics

This Alert assumes the reader has a working knowledge of certain parity rule terms and concepts. A very high-level overview appears in the attached Appendix A if you would like to review before reading further.

Intent of the 2024 NQTL Regulations

The 2024 NQTL Regulations focused on compliance for what are known as nonquantitative treatment limitations (NQTLs), which are plan design and administration limitations that affect access to mental health and substance use disorder benefits under group health plans. The Regulations: (i) formalized years of informal guidance and

Highlights

Overview

On May 15, 2025, the U.S. Departments of Labor, Health and Human Services, and Treasury (the "Departments") issued a statement of non-enforcement for the final parity regulations published in September 2024.

The 2024 regulations contained several new rules applicable to non-quantitative treatment limitations (NQTLs) under the Mental Health Parity and Addiction Equity Act.

Key provisions

The statement of non-enforcement indicates the following:

- It applies only to "new rules" added by the 2024 regulations. All other parity rules remain valid and enforceable. The Departments reserved the right to update prior guidance.
- The Departments will consider whether to amend or withdraw the 2024 regulations and intend to review their enforcement approaches.

Employer action items

Employers sponsoring self-insured group health plans should seek the assistance of appropriate advisors before making changes to plan design or administration.

The NQTL comparative analysis remains in effect. We recommend employers continue to make good-faith efforts to comply.

positions taken by the U.S. Department of Labor (DOL) with respect to MHPAEA and NQTLs; (ii) more fully developed and formalized the requirements for the NQTL comparative analysis; and (iii) introduced a number of new NQTL rules.

The 2024 NQTL Regulations were also a reaction to the Departments' continuing frustration with what they viewed as consistent, persistent, and widespread NQTL compliance failures by insurance carriers and group health plans.[1]

Lawsuit and suspension of enforcement

The ERISA Industry Committee (ERIC), a third-party benefit industry organization for large employers, filed a lawsuit on behalf of its members challenging the 2024 NQTL Parity Regulations on January 17, 2025, alleging that:

- The regulations exceeded the Departments' rulemaking authority;
- The Departments did not follow certain required rulemaking procedures; and
- The regulations are vague and did not provide sufficient time for insurers and group health plans to comply.

The Departments responded in mid-May, and the following actions occurred within days of each other:

1. **Suspension of enforcement –** The Departments issued a statement of non-enforcement for the 2024 NQTL Regulations while they reconsider whether to withdraw and/or modify them. The statement also indicates the Departments intent to evaluate their approaches to enforcing the parity rules.

2. **Lawsuit delayed –** The Departments filed a motion requesting the court delay the case (with ERIC's approval) during the non-enforcement period while the Departments consider the 2024 NQTL Regulations, which the court quickly granted.

Scope and duration of enforcement relief

The statement of non-enforcement applies only to "new rules" added by the 2024 NQTL regulations, but it does leave some gray areas.

New rules suspended

The following are new rules added by the 2024 NQTL Regulations that are subject to the suspension of enforcement, with the plan year the rule applied to in parentheses:

- **MH/SUD definition benchmarking (2025) –** The regulations require plans to define mental health (MH) and substance use disorder (SUD) conditions using either the current edition of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM). The current editions are the ICD-10 and DSM V.

- **Certain NQTL comparative analysis requirements (2025 and 2026) –** The fiduciary certification (2025) and significant data-driven analysis (2026) requirements were new. The new analysis requirements include both the material differences standard and data-driven evaluation to demonstrate network adequacy. Other more subjective network adequacy rules pre-date the 2024 NQTL Regulations and remain in effect.

- **No discrimination in NQTL design and application (2025 and 2026) –** This is a subjective standard for 2025 and becomes part of the more objective data-driven analysis in 2026.

- **Meaningful benefits standard (2026) –** This standard requires meaningful coverage for MH/SUD benefits consistent with coverage for medical/surgical benefits in the same parity classification. The standard also requires plans to cover at least one medically recognized "core treatment" for any covered MH or SUD condition. In the absence of a medically recognized core treatment, any coverage will generally suffice.

[1] See the 2024 MHPAEA Comparative Analysis Report to Congress, pages 25 – 36 and 51, which indicates compliance is beginning to improve. By comparison, the prior reports to Congress were harsher.

What remains in effect

The statement of non-enforcement indicates the following are not subject to the suspension and remain valid and enforceable:

1. The MHPAEA statute;
2. The 2013 final parity regulations (these contain all of the existing quantitative treatment limitation (QTL) regulations and some NQTL guidance);
3. The amendments to the MHPAEA statute made by the Consolidated Appropriations Act, 2021 (CAA 2021); and
4. Until further notice, all existing guidance for #1 – #3. The Departments reserved the right to update prior guidance as part of its reconsideration of the 2024 NQTL Regulations.

We believe any guidance in the 2024 NQTL Regulations that merely clarifies #1 – #3 is not a new rule and also remains valid and enforceable. We will address two examples of this below.

Wolf in sheep's clothing: The CAA 2021 amended MHPAEA by adding the unpopular NQTL comparative analysis requirement. The enforcement suspension blocks certain changes, but the analysis requirement otherwise remains in effect. We'll address this in more detail below.

Duration of the enforcement relief

The short answer is the enforcement relief is effectively indefinite, allowing the Departments time to communicate any changes before it ends.

The official duration is subject to circular reasoning: (i) the non-enforcement relief ends 18 months after the conclusion of ERIC's lawsuit; but (ii) the lawsuit is delayed during the non-enforcement period subject only to periodic progress reports to the court.

Observations about the status of certain parity issues

This section attempts to address the status of certain parity issues during the non-enforcement period in the absence of clarifying guidance from the DOL or the U.S. Department of Health and Human Services (HHS). This is not intended to be an exhaustive discussion of potential parity issues and may be affected by future guidance.

The NQTL comparative analysis is still a thing

Although the statement of non-enforcement indicates the NQTL comparative analysis remains valid and enforceable, the applicable compliance standard is unclear. The 2024 NQTL Regulations attempted to more clearly define this, but the non-enforcement policy applies to any new rules added by those regulations.

Unless and until we receive clarifying guidance, we think the compliance standard might best be described as falling somewhere along a range with a lower and upper limit.

- **Lower limit –** The lower limit is the compliance standard implemented by the CAA 2021 and the existing MHPAEA self-assessment tool,[2] but with greater detail and evidentiary support than provided in any analysis reviewed by the DOL and HHS from 2022 – 2024.

[2] 29 USC §1185a(a)(8) and 42 USC §300gg-26(a)(8); Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), Section F. In a set of 2021 FAQs, the Departments indicated that plans that "carefully applied" the self-assessment tool would be in a strong compliance position.

The DOL and HHS did not give an initial passing grade to any analysis reviewed during that period and cited broad, unsupported statements and a lack of meaningful analysis as a consistent problem.[3] To our knowledge, this included the analyses provided to employers at no additional charge by most or all of the major TPAs.

- **Upper limit –** The upper limit incorporates any guidance from the 2024 NQTL Regulations that merely *clarifies* prior NQTL comparative analysis guidance. The fiduciary certification requirement, significant data-driven analysis requirement, and its related material differences and network adequacy standards were "new rules" and do not apply.

  The 2024 NQTL Regulations describe the comparative analysis content requirements as six data and analysis points for NQTLs. The six points are so similar to the content description in the MHPAEA statute and process in the self-assessment tool that we view them as a mere restatement of that prior guidance (at best) or a clarification (at worst).[4] Less clear is whether *some* of the additional comparative analysis detail required by the 2024 NQTL Regulations can be construed as a mere clarification of prior guidance in reaction to the Departments' feedback in their annual MHPAEA Report to Congress that broad, unsupported statements and a lack of meaningful analysis are consistent problems.

Good-faith compliance?

We have no information to suggest or support a view that previous comparative analysis efforts deemed insufficient by the DOL and HHS will now be considered compliant for 2025. Unless and until further clarification appears, the following approach appears to be a reasonable, good-faith compliance effort:

- The NQTL comparative analysis should follow the six data and analysis points laid out in the 2024 NQTL Regulations,
- The analysis should provide greater detail and evidence to support assertions of NQTL compliance than the prevailing standard from 2024, but it should not have to rise to the 2025 standard specified in the 2024 NQTL Regulations, and
- The fiduciary certification requirement does not apply.[5]

Frequency?

We do not interpret either the 2024 NQTL Regulations or prior guidance to strictly require annual completion of the NQTL comparative analysis, although we are aware that a number of third-party vendors providing analysis services take the position that they do.

For now, we recommend performing a new NQTL comparative analysis:

(i) for significant changes in plan design, administration, and/or utilization that may affect the results (including the implementation of a new plan); or
(ii) if there is a change in the parity rules that alters the analysis requirements in a way that the prior report cannot satisfy them, and;
(iii) periodically – such as every three years – even if there are no changes to the rules or significant changes in plan design, administration, and/or utilization.

Clarification from the Departments would be welcome.

[3] 2024 MHPAEA Report to Congress, page 54.

[4] The key difference between the MHPAEA statute and the regulations appears to be that the regulations split one of MHPAEA's compound sentences (compliance in both design and actual operation) into two separate design and operation data elements.

[5] Enforcement of the significant data-driven analysis requirement and its related material differences and network adequacy standards are also suspended, but these were not generally effective until plan years beginning in 2026 and did not apply to a 2025 NQTL comparative analysis.

Enforcement: DOL and HHS reviews of comparative analyses fell sharply in 2024, largely because the process is time-consuming, and many parity reviews initiated in 2022 and 2023 were still active. We expect the volume will remain low through at least 2025, but the NQTL comparative analysis remains a requirement.

Prior primary treatment guidance

The non-enforcement relief applies to the meaningful benefits standard – and its core treatment requirement – that was set to be effective for plan years beginning in 2026. However, this was an expansion of an earlier position taken by the DOL sometime during 2020. This position appeared in print in the DOL's FY 2021 MHPAEA Enforcement Fact Sheet and in greater detail in the 2022 MHPAEA Report to Congress (sometimes referred to as the DOL's primary treatment standard).[6]

The DOL's primary treatment standard states that an exclusion of the primary treatment for a MH/SUD condition is an NQTL violation under the 2013 final parity regulations if there are no similar exclusions for the primary treatments of covered M/S conditions under the plan.[7]

Since the prior primary treatment standard represented the DOL's interpretation of the 2013 final parity regulations, it should remain in effect. The standard applies to all covered MH/SUD conditions, but we will limit this discussion to the three conditions and primary treatments specifically addressed by the DOL in the 2022 – 2024 MHPAEA reports to Congress:

1. ABA therapy for autism spectrum disorder,
2. Nutritional counseling for eating disorders,[8] and
3. Medication assisted treatment for opioid use.

In other words, if a plan provides coverage for any of those three conditions, it is an NQTL violation to exclude the corresponding treatment.

Gender affirming care

The non-enforcement relief also applies to the MH/SUD definition benchmarking requirement that was effective for plan years beginning in 2025. The existing ICD-10 and DSM-V each define gender dysphoria as a mental health condition, which would have subjected any covered gender affirming care to the parity rules.

In the preamble to the 2024 NQTL Regulations, the Departments indicate that gender dysphoria is a mental health condition, because it appears in *both* the ICD-10 and DSM-V.[9] While this initially appears to be a reference to the new benchmarking requirement, the Departments go on to say that benefits for gender affirming care are "*currently subject to the protections of MHPAEA and its implementing regulations*," which means their position is based on prior guidance that predates the 2024 NQTL Regulations. If correct, this means gender affirming care remains subject to the parity rules (at least for now).

The future ICD-11 reclassifies gender dysphoria from a mental health condition to a medical condition. Once adopted to replace the ICD-10, will this change the Departments' stance on whether the parity rules apply to gender affirming care? Under the now-suspended MH/SUD benchmark definition requirement, a plan could simply avoid the parity rules by benchmarking to the ICD-11 once in effect.

Given the recent stance by the federal government on gender affirming care issues, participants seeking to enforce parity rights may have to rely more on the federal courts than the DOL or HHS.

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[6] FY 2021 MHPAEA Enforcement Fact Sheet, page 5; 2022 MHPAEA Report to Congress, page 38.

[7] The DOL agreed with the court's decision in *Doe v. United Behavioral Health* (N.D. Cal. March 5, 2021).

[8] The 21st Century Cures Act (2016) also addressed MHPAEA and coverage requirements for eating disorders.

[9] Preamble to Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586, 77594 (September 23, 2024).

Employer action items

Most of the parity rules remain alive and well, although the Departments did signal that we may see changes to certain rules and enforcement priorities in the future.

We recommend employers sponsoring self-insured group health plans subject to MHPAEA seek the assistance of appropriate advisors before relying on the non-enforcement relief to make changes to plan design or administration with respect to MH/SUD benefits. Appropriate advisors may include insurance brokers, consulting firms, and legal counsel. Mid-year changes may prove difficult and likely require the participation of the plan's TPA and/or pharmacy benefit manager. Please be aware that mid-year changes to plan design and/or administration may trigger various disclosure requirements. Remember that the parity obligations generally fall on the insurance carriers for fully insured coverage, and it seems unlikely the insurers will be interested in making many changes during a plan year in progress.

We expect many employers will adopt a wait-and-see approach, not rush to make changes to their plans, and will simply take relief knowing that the 2024 NQTL Regulations are not enforceable against their plan design or administration.

Please remember that the NQTL comparative analysis requirement is still in effect, and we recommend employers continue to make good-faith efforts to comply. The parity rules allow participants in plans subject to ERISA to request copies of the analysis, so there is still some risk for not having an analysis beyond a DOL-initiated review.

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Appendix A
Some MHPAEA Basics

In triplicate

MHPAEA exists in parallel in three sets of laws: (1) ERISA, (2) the Internal Revenue Code (IRC), and (3) the Public Health Services Act (PHSA). This is also true for most of MPHAEA's regulations and other guidance, including the 2024 NQTL Regulations. The purpose of this overlap is to broadly apply MHPAEA to plans that may be subject to one set of laws but not another. For example, state/local governmental plans are not subject to ERISA, but they are subject to the PHSA. Church plans can also avoid ERISA but are subject to MHPAEA through the IRC and PHSA.

The DOL has primary authority for ERISA plans. HHS and state agencies have primary authority for insurance carriers and state/local governments. HHS has primary authority for fully insured church plans, while the IRS has authority over self-insured church plans.[10]

MHPAEA's purpose (the 50,000 foot view)

In general, MHPAEA prohibits covered group health plans from applying financial requirements and/or treatment limitations that are more burdensome or restrictive for covered mental health or substance use disorder (MH/SUD) benefits than for covered medical/surgical (M/S) benefits.

We broadly refer to MHPAEA, its regulations, and other related guidance together as the "parity rules."

Certain abbreviations and terms

Covered group health plans

The parity rules apply to group health plans, including private sector, state/local governmental, and church plans, unless an exception or other exclusion applies. For the most part, the parity rules primarily affect:

- Medical and prescription drug coverage, and
- General telemedicine coverage.[11]

The parity rules also apply to general purpose HRAs, but these are usually integrated with major medical coverage and rarely present parity issues by themselves. Other group health benefits frequently qualify for one or more exceptions or exclusions from the parity rules (e.g., excepted benefits and retiree-only coverage).

Quantitative treatment limitations (QTLs)

QTLs are financial requirements and treatment limitations for MH/SUD benefits involving numbers (e.g., cost sharing, visit limits, etc.).[12]

Non-quantitative treatment limitations (NQTLs)

NQTLs are other administrative limitations for MH/SUD benefits that do not involve numbers, including:

- Prior authorization/precertification requirements,

[10] We are not aware of the IRS engaging in any pattern of MHPAEA enforcement.

[11] We do not believe most general telemedicine coverage qualifies as an excepted benefit. Further discussion is beyond the scope of this Alert.

[12] The parity rules addressed QTL compliance in 2013 regulations, including the *substantially all* and *predominant* calculations. Please see 29 CFR §2590.712(c). The 2024 NQTL Regulations did not amend or revise the QTL compliance rules, and we do not address them further in this Alert.

Appendix A
Some MHPAEA Basics

- Step therapy,
- Fail first protocols, and
- Network and formulary design.

Six general classifications

The parity rules require group health plans to assign all M/S and MH/SUD benefits to one of the six general classifications.[13] The plan then determines QTL and NQTL parity compliance separately within each classification. Most employers rely heavily on insurers and TPAs for classification and parity compliance purposes. Additional assistance may be available from the employer's insurance broker, consulting firm, and/or other actuarial support.

The six general classifications

1 Inpatient/In-Network	2 Inpatient/Out-of-Network
3 Outpatient/In-Network	4 Outpatient/Out-of-Network
5 Emergency Care	6 Prescription Drugs

There are three additional special rules and/or subclassifications for: (i) multi-tiered prescription drug benefits, (ii) multiple in-network tiers of coverage, and (iii) outpatient office visits. Further discussion of the general classifications and special rules is beyond the scope of this Alert.

Compliance obligations for self-insured and fully insured plans

- **Self-insured coverage –** The employer/plan sponsor ultimately remains responsible for compliance with the parity rules for self-insured coverage even when it delegates plan design and/or administration to third parties. Delegation may provide the employer/plan sponsor with some contractual indemnification protection.

- **Fully insured coverage –** The parity rules apply to insurance carriers for fully insured coverage, and HHS directly regulates them. An employer/plan sponsor generally has no compliance liability under the parity rules unless it exercises discretionary authority or control over the plan's design and/or administration in a way that affects parity compliance.

[13] 29 CFR §2590.712(c)(2)(ii).