2025 MHPAEA Report to Congress

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PREFACE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that any financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) that apply to mental health and substance use disorder (MH/SUD) benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical (M/S) benefits in a benefits classification.[1] In addition, MHPAEA prohibits separate financial requirements or treatment limitations that apply only to MH/SUD benefits.

The Consolidated Appropriations Act, 2021 (CAA)[2] amended MHPAEA, in part, by expressly requiring plans and issuers that provide both M/S benefits and MH/SUD benefits and that impose nonquantitative treatment limitations (NQTLs)[3] on MH/SUD benefits to perform and document comparative analyses of the design and application of NQTLs and make their analyses available to the Secretaries of the Treasury (Treasury), Health and Human Services (HHS), and Labor (DOL) (collectively, the Secretaries), as applicable, or to an applicable State authority upon request.[4] The CAA amendments to MHPAEA also require the Secretaries to report to Congress annually on the results of these NQTL comparative analyses reviews conducted by the Secretaries.[5]

Following the enactment of MHPAEA, the Departments of Labor, Treasury, and HHS (collectively, the Departments) issued implementing regulations and guidance. In 2013, they promulgated a final rule implementing MHPAEA.[6] In 2024, the Departments issued a final rule amending the 2013 final rule and implementing the CAA's NQTL provisions (2024 final rule).[7]

The Departments acknowledge that implementation and enforcement of MHPAEA to date has presented numerous challenges for employers and other plan sponsors. Not only do these challenges frustrate good faith efforts to comply with the law, but these challenges can also negatively impact individuals' access to care if health plans do not have a clear understanding of how to offer their MH/SUD benefits in accordance with the law. The Departments also

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[1] Pub. L. 110-343, 122 Stat. 3765, as amended by the Patient Protection and Affordable Care Act, Pub. L. 111-148, 12 Stat. 119, and the Consolidated Appropriations Act, 2021, Pub. L. 116-260, 134 Stat. 1182. Additionally, requirements related to mental health parity were included in the 21st Century Cures Act (Cures Act), Pub. L. 114-255, 130 Stat. 1033, as amended by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Support Act), Pub. L. 115-271, 132 Stat. 3894.

[2] Pub. L. 116-260, 134 Stat. 1182.

[3] NQTLs are generally non-numerical limits on the scope or duration of benefits (such as prior authorization requirements, step therapy protocols, and methodologies for establishing provider reimbursement rates).

[4] Internal Revenue Code (Code) section 9812(a)(8)(A); Employee Retirement Income Security Act (ERISA) section 712(a)(8)(A); and Public Health Service Act (PHS Act) section 2726(a)(8)(A).

[5] Code section 9812(a)(8)(B)(iv); ERISA section 712(a)(8)(B)(iv); PHS Act 2726(a)(8)(B)(iv). In addition, the Secretaries were required to send Congress, over a 6-year period, an annual report on complaints and investigations concerning compliance with the requirements of MHPAEA. See section 13003 of the Cures Act, Pub. L. 114-255, 130 Stat. 1033, 1285, as amended by section 7182 of the SUPPORT Act, Pub. L. 115-271, 132 Stat. 3894, 4070.

[6] https://www.federalregister.gov/documents/2013/11/13/2013-27086/final-rules-under-the-paul-wellstone-and-pete-domenici-mental-health-parity-and-addiction-equity-act

[7] https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act

acknowledge that MHPAEA contemplates that plans be able to continue to apply NQTLs to MH/SUD benefits based on a variety of factors (e.g. licensing and accreditation of providers and claim types with a high percentage of fraud), provided that the NQTLs comply with MHPAEA's requirements, including the comparative analysis requirements.

In January 2025, the ERISA Industry Committee (ERIC) filed a lawsuit challenging the 2024 final rule.[8] On May 15, 2025, the Departments issued a nonenforcement policy, which states, among other things, that the Departments will not enforce the 2024 final rule or otherwise pursue enforcement actions, based on a failure to comply that occurs prior to a final decision in the litigation, plus an additional 18 months.[9] The policy states that enforcement relief applies only with respect to those portions of the 2024 final rule that are new in relation to the 2013 final rule and notes that MHPAEA's statutory obligations, as amended by the CAA (which requires that plans and issuers perform and document comparative analyses on the design and application of NQTLs imposed on their MH/SUD benefits) continue to have effect. During this period, the Departments are reconsidering whether to issue a notice of proposed rulemaking rescinding or modifying the existing regulation through notice and comment rulemaking. The Departments are also undertaking a broader reexamination of each department's respective enforcement approach under MHPAEA, including those provisions amended by the CAA.

The Departments remain committed to ensuring that individuals receive protections under the law in a way that is not unduly burdensome for plans and issuers while ensuring that plans and issuers come into compliance with MHPAEA. We understand this requires a complex and careful balance between ensuring parity in access to care and ensuring protections against high costs as well as waste, fraud, and abuse are not unduly encumbered.

This report fulfills the Departments' obligation to report on the results of the NQTL comparative analysis review activities during August 1, 2023, through July 31, 2025 (the Reporting Period). The Departments intend to provide more information on their reexamination efforts referenced above in the next report to Congress.

[8] https://www.eric.org/wp-content/uploads/2025/01/Parity-Rule-Complaint.pdf

[9] https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/statement-regarding-enforcement-of-the-final-rule-on-requirements-related-to-mhpaea.

TABLE OF CONTENTS

I. EBSA's MHPAEA NQTL Enforcement Work

During the Reporting Period**,** the Employee Benefits Security Administration's (EBSA) enforcement work on NQTLs resulted in corrections under MHPAEA affecting more than 18 million participants across more than 39,000 group health plans. This includes corrections affecting over:

- 130,000 participants who now have new or newly expanded access to critical treatments for opioid use disorder (OUD);
- 800,000 participants who now face fewer barriers to getting treatment for autism spectrum disorder (ASD);
- 2 million participants whose plans have reduced preauthorization or concurrent care review requirements for MH/SUD services; and
- million participants who now have easier access to nutritional counseling services for eating disorders, a mental health condition.

These results come from EBSA's enforcement activity during the Reporting Period, in which the agency issued:

- 42 initial letters requesting comparative analyses for 77 NQTLs;
- 14 insufficiency letters covering 32 NQTLs;
- 25 initial determination letters findings plans/issuers had violated MHPAEA for 43 NQTLs; and
- 5 final determinations of noncompliance finding MHPAEA violations for 7 NQTLs.

Since 2021, EBSA's MHPAEA NQTL enforcement work has cumulatively led to over 77,000 group health plans and issuers achieving compliance. Over 23 million American workers and their families were covered by these plans and now have fuller access to MH/SUD benefits.[10] The supplemental funding from the CAA to support EBSA's NQTL enforcement work ended in December 2024, and no funds will be available beyond 2025.

EBSA continues to focus on limitations that impact access to care.[11] Examples of EBSA's enforcement results include:

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[10] This includes 400,000 participants who now have expanded access to life-saving treatments for opioid addiction, and over 2.1 million participants and their children who have access to critical treatments for ASD or face fewer barriers to obtaining treatment for ASD.

[11] *See, e.g.,* pages 19–37 of the 2024 MHPAEA Report to Congress (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2024.pdf) and pages 26–29 of the 2023 MHPAEA Report to Congress (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023) for more detail about EBSA's MHPAEA enforcement priorities and EBSA's approaches for implementing its priorities.

- A large, self-funded plan implemented new policies and procedures to monitor the adequacy of its network and ensure participants have price protections if they seek out-of-network care when in-network MH/SUD care is unavailable;[12]

- A national service provider removed an exclusion of Applied Behavioral Analysis (ABA) therapy to treat Autism Spectrum Disorder (ASD) from its self-funded line of business, affecting all plan clients using the template documents and more than 319,000 covered participants;[13]

- A large service provider removed an exclusion of methadone maintenance treatment for OUD from 10 of its client plans covering more than 50,000 participants, amended its template plan documents, and paid claims that were improperly denied under this exclusion;[14]

- A national service provider removed several limitations that were implemented using outdated, legacy systems that were not in compliance with MHPAEA. The limitations included preauthorization, utilization management criteria, concurrent review criteria, reimbursement rates, and exclusions of certain services to treat mental health conditions and substance use disorders. The service provider updated its systems and coverage documents, and it also paid more than $3 million in claims and $540,000 in interest to participants and their providers.[15]

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[12] EBSA's San Francisco Regional Office identified a large self-funded health plan whose participants sought out-of-network providers more often for MH/SUD than for M/S services, particularly for inpatient care. EBSA found that the plan and its service provider used noncomparable processes, strategies, evidentiary standards, and other factors to measure provider access, monitor network adequacy, and pay network providers. As a result, the network administrator revised and expanded how it measures the adequacy of its network on a national level, and it adopted a new network adequacy policy for addressing network gaps for one of its regional markets. The plan separately enacted certain balance billing protections for its participants, increased efforts to help participants find network providers, and implemented its own policy to monitor its chosen network, including a review of out-of-network utilization.

[13] EBSA's Atlanta Regional Office identified a large, national service provider that was administering an ABA exclusion for some of its self-funded plan clients. These plans covered ASD as a mental health condition but did not apply comparable exclusions to M/S conditions. ABA therapy is a key treatment for ASD. This service provider worked with EBSA to correct the violation by removing the ABA exclusion and notifying its client plans of the change. These changes affected 97 client plans, covering more than 319,000 participants and their families. The service provider also re-adjudicated and paid 1,407 denied claims for ABA therapy that totaled over $1,050,000 and affected 28 members and their families.

[14] In an investigation of a service provider that was both an issuer to fully-insured plans and an administrator to self-funded plans, EBSA's Atlanta Regional Office identified a large self-funded plan that covered methadone to treat M/S conditions, such as chronic pain, but excluded methadone maintenance treatments for opioid use disorder. In response to EBSA's initial determination, the plan promptly removed the methadone maintenance exclusion from the plan documents and notified participants of its removal. The plan's service provider checked coverages for its other ERISA plan clients to ensure the exclusion was not present.

[15] In a cross-regional MHPAEA investigation led by EBSA's Cincinnati Regional Office, the agency followed up on leads from several investigations into the same large, national service provider. The cross-regional investigation found several longstanding limitations that were not administered in accordance with MHPAEA, including preauthorization, utilization management practices, concurrent review criteria, reimbursement rates, and exclusions of certain services to treat mental health conditions and substance use disorders. EBSA found that the service provider applied these limitations pursuant to legacy business decisions using outdated claims processing systems, failing to update its processes the same way it had done for M/S benefits. The service provider amended its coverage

- Another national service provider removed a nutritional counseling exclusion from its self-funded line of business, affecting all plan clients using the template documents and over 289,000 participants covered by the impacted group health plans.[16]

A. EBSA's Statutory Reporting Requirements

1. EBSA's Summary of Requested Comparative Analyses and Identification of Noncompliant Plans and Issuers

Over the 2-year period from August 1, 2023, through July 31, 2025, EBSA issued 42 letters requesting comparative analyses, 30 letters to plans and 12 letters to issuers across 28 investigations. These letters requested comparative analyses for a total of 77 NQTLs,[17] as detailed in the table below.[18]

Type of Limitation Covered by New Requests in the Reporting Period	Number of Comparative Analyses Requested
Provider network admission standards	14
Exclusion of speech or occupational therapy	8
Limit on autism services (age limit, parental participation requirement, diagnostic confirmation by specific specialist, other limit on ABA therapy or intensive behavioral therapies, etc.), but not an ABA therapy exclusion	8
Exclusion of nutritional counseling	7
Exclusion of ABA therapy (Applied Behavioral Analysis for autism)	6
Exclusion of residential care or partial hospitalization	5

documents, conducted claims reviews, and ultimately identified more than 900 participants who were negatively impacted by the limitations.

[16] EBSA's San Francisco Regional Office identified an exclusion for nutritional counseling for eating disorders, a covered mental health condition, in over 500 of a service provider's client plan documents. EBSA also found that nutritional counseling claims were routinely approved for M/S conditions but were often denied as excluded for mental health conditions. The service provider and its subsidiary voluntarily removed the exclusion from template documents and worked with group health plan clients to remove the nutritional counseling exclusion from their coverage. This correction affected 521 plans that covered over 289,000 participants. The service provider and its subsidiary also identified and paid wrongly denied nutritional counseling claims.

[17] In prior reports, EBSA noted how many "unique NQTLs" were among each NQTL count for requests and findings letters. EBSA will no longer make this distinction going forward. Counts of "unique NQTLs" captured those that were not identical across coverage options within a plan or investigation. EBSA used "unique" to provide more accurate information about the volume of its work at the time it was newly implementing its comparative analysis review processes in 2021. Since then, the "unique NQTL" counts have gradually become closer to the NQTL counts such that "unique NQTLs" is no longer a helpful descriptor.

If EBSA took a different approach and counted each NQTL separately by benefit classification, then the number of NQTLs for which EBSA requested a comparative analysis during the Reporting Period would be over 200.

[18] From the period August 1, 2023, to July 31, 2024, EBSA requested comparative analyses for a total of 48 NQTLs. From the period August 1, 2024, to July 31, 2025, EBSA requested comparative analyses for a total of 29 NQTLs. These requests were made pursuant to 29 U.S.C. Section 1185(a)(8)(B)(i).

Type of Limitation Covered by New Requests in the Reporting Period	Number of Comparative Analyses Requested
Exclusion of Medication Assisted Treatment or Medication for Opioid Use Disorder	4
Other Exclusion[19]	4
Medical necessity standards	3
Out-of-network provider reimbursement	3
Prior authorization	2
Treatment plan requirement	2
Exclusion of prescription drugs for mental health conditions	2
Other NQTL	2
Concurrent care review requirement	1
Fail first policies	1
Telehealth exclusion	1
Failure to complete a course of treatment requirement	1
Exclusion of services provided in an educational setting	1
Other limitation based on chronicity, long term conditions, likelihood of improvement, etc.	1
Requirement to engage with mental health service administrator as gatekeeper to mental health services	1
Total	**77**

The above list reflects EBSA's prioritization of limitations with the most significant impact on access to care, especially limitations related to network adequacy and composition and impermissible exclusions of treatments for mental health conditions and substance use disorders.

During the Reporting Period, EBSA issued five final determinations of noncompliance (two in connection with separate violations by one group health plan), which are described in more detail in Section I.A.5 below, to the following plans and issuers:

- **MDA Health Plan Trust**
    - EIN/Plan Number 38-1300483/501
    - 1,983 participants as of December 31, 2022
    - NQTL: prior authorization requirements
    - Final determination issued on June 28, 2024

[19] "Other Exclusion" and "Other NQTL" in this table capture less common limitations, such as an exclusion of insomnia related to a mental health condition.

- **Sheridan Community Hospital Welfare Benefit Plan**[20]
    - EIN/Plan Number 38-1369796/501
    - 108 participants as of December 3, 2024
    - NQTL: prior authorization requirements
    - Final determination issued on April 25, 2025

- **Priority Health**
    - EIN: 38-2715520
    - 108 participants as of December 3, 2024
    - NQTL: prior authorization requirements
    - Final determination issued on April 25, 2025

- **Local 103, I.B.E.W. Health Benefit Plan**
    - EIN/Plan Number 04-6063733/501
    - 8,056 participants as of November 30, 2024
    - NQTLs: 1) concurrent review; 2) prior authorization; 3) network admission standards, including reimbursement rates and network adequacy; and 4) out-of-network reimbursement methodologies
    - Two final determinations[21] issued on May 6, 2025

2. EBSA's Conclusions Regarding Sufficiency of Responses

During the Reporting Period, EBSA continued to see many comparative analyses that were deficient when initially produced. The reasons for deficiency matched those identified by EBSA in prior Reports to Congress.[22] Many, but not all, of the identified deficiencies were cured through the exchange of additional questions and information, though these exchanges significantly prolonged the duration of NQTL investigations. When plans and issuers proactively considered MHPAEA compliance and had already prepared complete comparative analyses, as required by CAA, EBSA's investigations were resolved more quickly, leading to better outcomes for participants and beneficiaries.

The comparative analysis review process is not a substitute for EBSA's traditional investigative work, including issuing subpoenas or conducting depositions. NQTL investigations historically have taken multiple years and have involved many document requests, interviews,

[20] EBSA engaged with both the Sheridan Community Hospital Welfare Benefit Plan and its health insurance issuer, Priority Health, regarding the prior authorization NQTL. Both plan and issuer received requests for comparative analyses, insufficiency letters, initial determination letters, and a final determinations letter related to this NQTL.
[21] Two separate final determination letters were sent to this plan on the same date covering a total of four NQTLs. The first letter covered listed NQTLs 1–2, and the second letter covered listed NQTLs 3–4.
[22] *See* pages 54–55 of the 2024 MHPAEA Report to Congress, pages 50–53 of the 2023 MHPAEA Report to Congress, and pages 13–18 of the 2022 MHPAEA Report to Congress (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity/reports-to-congress).

and data analyses. Deficient comparative analyses also frequently extended the investigative process.

For example, a number of plans and issuers changed their named factors when EBSA asked questions about definitions of factors and how they were used in the comparative analyses. This often happened when a comparative analysis was drafted on behalf of a plan by a third party, such as a consultant, that was not familiar with plan operations or how limitations were designed and applied. Such unexplained changes and inability to provide details are examples of insufficiencies in comparative analyses submitted by plans and issuers.

Over the Reporting Period, EBSA issued initial determination letters citing 33 violations for deficient comparative analyses. In each of these instances, EBSA provided notice of the specific deficiencies beforehand through a written insufficiency letter. EBSA gave multiple opportunities for plans and issuers to address identified deficiencies prior to issuing an initial or final determination of noncompliance.

3. EBSA's Conclusions Regarding Compliance with Disclosure Requirements

When EBSA requested a comparative analysis and plans or issuers provided enough information to identify a violation, the agency issued an initial determination of noncompliance. The only exceptions to this practice during the Reporting Period were situations where plans or issuers promptly corrected NQTL problems after receiving a comparative analysis request (i.e., before providing EBSA with the information necessary to determine whether to issue an initial determination of noncompliance). These plans and issuers were willing to take steps to correct a deficiency after EBSA pointed out a compliance concern or began asking focused questions about possible NQTLs. In these instances, EBSA did not issue an initial determination of noncompliance or a voluntary compliance letter because the plan or issuer fully corrected problems early in the process.

If a plan or issuer corrected a problem before EBSA issued an initial determination of noncompliance, EBSA usually cited the NQTL concern in a letter noting the corrective actions taken and closing the investigation. Over the Reporting Period, EBSA closed 89 investigations that involved a review of NQTLs in this manner.

During the Reporting Period, EBSA issued 25 initial determination letters (16 to plans and 9 to issuers) citing MHPAEA violations in connection with 43 limitations. The following table shows the types of limitations for which EBSA issued an initial determination of noncompliance.

Type of Limitation	Number of Initial Determinations of Noncompliance Issued
Preauthorization	10
Provider network admission standards	10
Out-of-network provider reimbursement	4

Type of Limitation	Number of Initial Determinations of Noncompliance Issued
Other Exclusion[23]	3
Concurrent Care Review	3
Exclusion of speech or occupational therapy	2
Other NQTL	2
Exclusion of prescription drugs for mental health conditions	1
Restrictions based on geographic location, facility type, etc.	1
Exclusion of Medication Assisted Treatment	1
Exclusion of residential care or partial hospitalization	1
Telehealth exclusion	1
Treatment plan requirement	1
Fail first policies	1
Other limitation on therapy: ABA, rehab, IBI, IBEI, etc.	1
Requirement to engage with mental health service administrator as gatekeeper to mental health services	1
Total	**43**

Plans and issuers who received such a determination were generally responsive with a corrective action plan (CAP) to address the violations. During the Reporting Period, EBSA received CAPs from 26 plans and issuers in response to initial determination letters that addressed 41 MHPAEA limitations.[24] Some of these corrections have been finalized (which means that the plan has submitted satisfactory confirmation of the corrective action), while EBSA is still waiting on confirmation of completion for others.

As noted earlier, EBSA's MHPAEA NQTL enforcement resulted in corrections affecting more than 18 million participants across more than 39,000 group health plans during the Reporting Period. Examples are detailed in Section I.

4. EBSA's Specifications Regarding Sufficiency of Responses

EBSA issued 14 insufficiency letters covering 32 NQTLs during the Reporting Period. This is a marked decrease in insufficiency letters, as the agency previously issued between 45 and 80 insufficiency letters per reporting period. EBSA attributes this decrease to multiple factors, including an increased level of detail from some plans and issuers and EBSA's focus on benefit exclusions that plans and issuers voluntarily fix prior to receiving an insufficiency letter.

[23] *See* Footnote 15 above.
[24] Many, but not all, of these CAPs related to NQTLs that EBSA cited as violations or flagged for plans in the Reporting Period.

NQTL investigations are resource intensive necessitating a redeployment of remaining agency investigative resources to focus on bringing existing NQTL cases to resolution. In many of its existing NQTL cases opened in prior reporting periods, EBSA had already issued insufficiency letters and reported on them.

Many plans and issuers provided deficient comparative analyses, but they ultimately did not receive an insufficiency letter or initial determination of noncompliance because those plans and issuers took action to ensure compliance. A common reason why EBSA did not issue an insufficiency letter or initial determination of noncompliance is the removal of a MHPAEA limitation, especially an exclusion or a limitation that applied only to MH/SUD benefits and not to any M/S benefits in a classification, before EBSA sent any finding as to whether the comparative analysis was insufficient and/or noncompliant.

For plans and issuers that received insufficiency letters, common deficiencies were the lack of any comparative analysis for a given NQTL or the absence of key information that the statute[25] requires to accompany a comparative analysis. During the Reporting Period, EBSA continued to see comparative analyses that were deficient for the same reasons as highlighted in prior MHPAEA Reports to Congress.[26]

Several insufficiency letters were issued to plans whose plan sponsors mistakenly believed that a service provider's claims review processes or template coverage products were compliant with MHPAEA. Some self-funded plans were surprised to find that responsibility for MHPAEA compliance lies with the plan, not their service provider. Many plans also mistakenly assumed their service provider had a comparative analysis or would prepare one for them, even in instances where the responsibility to prepare a comparative analysis was not a term specified in their contract. Some service providers refused to provide a comparative analysis or were unable to give the information needed for a plan to assess its own MHPAEA compliance.[27]

5. EBSA's Specifications Regarding Compliance

EBSA issued five final determinations of noncompliance that were based on the adequacy of the comparative analyses during the Reporting Period. EBSA attributes the low number of final determinations of noncompliance, as compared to the number of corrections EBSA obtained before issuing an initial determination of noncompliance, to the motivation of plans and issuers to come into compliance by correcting cited violations. EBSA closely monitored the status of remedial efforts by recipients of initial determination letters and did not make a final determination of noncompliance if a plan or issuer showed a good faith effort to

[25] ERISA Section 712(a)(8)(A)(i) –(v).
[26] *See* pages 54–55 of the 2024 MHPAEA Report to Congress, pages 50–53 of the 2023 MHPAEA Report to Congress, and pages 13–18 of the 2022 MHPAEA Report to Congress (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity/reports-to-congress).
[27] This concern arose especially often when plans had different service providers handling MH/SUD and M/S benefits. Plans with these carveout arrangements rarely obtained a complete comparative analysis from either service provider, especially where the service providers were not communicating with each other or aware of the processes, strategies, evidentiary standards, or other factors used by the other. Plans with carveout arrangements should closely review the information provided by their service providers to ensure there is a meaningful comparison of information provided by each service provider.

correct the cited violations. In at least one investigation, a plan that received an initial determination of noncompliance provided additional information that contributed to EBSA revisiting whether a violation was present. This resulted in EBSA deciding not to pursue corrective action or issue a final determination of noncompliance.

The following is a summary of each final determination of noncompliance, including the reason EBSA determined the plan was not in compliance and the corrective action required to come into compliance.

a. MDA Health Plan Trust (EIN/Plan Number 38-1300483/501)

On July 29, 2021, EBSA's Cincinnati Regional Office requested that this self-funded plan, which covered over 2,000 participants, provide its comparative analyses for prior authorization in the outpatient and inpatient benefit classifications. The comparative analyses did not:

- Define the factors used to determine whether the NQTL applied to MH/SUD and M/S benefits;
- Explain how each factor was applied in practice to determine which benefits were subject to prior authorization requirements; or
- Provide sufficient evidence demonstrating application of the factors in practice.

EBSA issued insufficiency letters to the plan noting the deficiencies in the comparative analyses on September 24, 2021, and November 12, 2021.

Afterward, EBSA investigators tried to obtain information from the plan necessary to cure the prior authorization comparative analysis deficiencies, but were unsuccessful. EBSA also worked with the plan and its service provider to examine and address MHPAEA compliance for other NQTLs.[28]

On May 18, 2022, the Department made an initial determination citing the plan for failure to produce a compliant comparative analysis for the prior authorization NQTL. The initial determination letter required the plan to provide a comparative analysis demonstrating compliance if it sought to continue to impose its current prior authorization requirements.

Within 45 calendar days of the initial determination, the plan responded showing it revised its comparative analysis by reorganizing the information and adding more detail on definitions of previously identified factors. However, the revised comparative analysis still did not demonstrate how the named factors are used to determine whether prior authorization would

[28] Other NQTL compliance concerns included a limitation on telehealth services for mental health conditions and substance use disorders as well as a requirement that participants be evaluated using a specific, named diagnostic tool before ABA therapy could be granted. The diagnostic evaluation tool, the Autism Diagnostic Observation Schedule 2 (ADOS-2), is one of many available tools to diagnose ASD. The plan ultimately worked with both EBSA and its service provider to resolve these other NQTL concerns by clarifying that other diagnostic tests could be used and removing the telehealth limitation.

apply or not for a given service. The plan's response also indicated that it hired an expert consultant to recommend best practices for compliance.

EBSA pointed out the continued deficiency and gave additional time for submission of supplemental information after the initial determination. Because the plan was making efforts to correct other NQTLs and due to delays in work by the plan's consultant, EBSA provided extra time before making a final determination.

EBSA ultimately issued a final determination of noncompliance on June 28, 2024, citing the plan for failing to comply with ERISA section 712(a)(8). On July 5, 2024, the plan provided the statutorily required notice to participants and beneficiaries. The investigation is now closed. In general, in order to come into compliance, the plan must provide a comparative analysis that contains the information required by statute. Going forward, the plan must demonstrate, through a MHPAEA-compliant comparative analysis, that any prior authorization NQTL complies with MHPAEA's requirements.

b. Sheridan Community Hospital Welfare Benefit Plan (EIN/Plan Number 38-1369796/501) and Priority Health (EIN 38-2715520)

On August 16, 2021, EBSA's Cincinnati Regional Office requested that the Sheridan Community Hospital Welfare Benefit Plan provide its comparative analysis for prior authorization in the outpatient benefit classifications. At the time of the request, this self-funded plan covered approximately 68 participants. In response, on August 30, 2021, the plan provided its comparative analysis. EBSA found the response was deficient and sent an insufficiency letter to the plan on October 4, 2021. The plan subsequently notified EBSA that it had switched from a self-funded design to fully-insured products offered by Priority Health.

On May 24, 2022, EBSA requested a new comparative analysis on the prior authorization NQTL from the plan's issuer, Priority Health, and suggested the plan work with them to ensure the response addressed the concerns raised in the October 2021 insufficiency letter.

The plan and Priority Health submitted a new comparative analysis prepared by Priority Health that contained similar deficiencies to the plan's original comparative analysis. For example, the new comparative analysis failed to demonstrate how the named factor of "clinical efficacy and appropriateness" and corresponding evidentiary standards were applied in practice to determine which services are subject to the prior authorization NQTL. EBSA issued two additional insufficiency letters on July 20 and September 7, 2022, to both the plan and Priority Health noting the deficiencies.

Over the next 18 months, EBSA unsuccessfully sought information from the plan and Priority Health to cure the noted deficiencies. However, the agency successfully worked with the issuer to address a different limitation imposed across multiple ERISA plans served by Priority Health.

On June 10, 2024, EBSA issued separate initial determination letters to the plan and to Priority Health citing a violation for failure to produce a compliant comparative analysis for the prior authorization NQTL.[29]

In response to the initial determination letter, the plan and Priority Health submitted a revised comparative analysis on November 8, 2024. The revised comparative analysis did not cure the deficiencies cited in the initial determination letter. It included a list of updated factors and the services to which those factors applied, but failed to demonstrate how the revised factors used to apply prior authorization to MH/SUD benefits were comparable to and applied no more stringently than those used to apply prior authorization to M/S benefits within the respective benefits classification.

For instance, the comparative analysis identified "provider discretion" as a factor applicable to both ABA therapy and cardiac diagnostic benefits. However, the comparative analysis did not demonstrate how this factor was used to determine that prior authorization applied to specific services and why this factor was applied only to these services and no other services in the benefit classification. In addition, the revised comparative analysis provided a list of "guiding principles" used to assess whether a service would be subject to prior authorization but did not explain how those principles interacted with the factors used to design and apply prior authorization to each service.[30]

EBSA issued final determinations of noncompliance to both the plan and Priority Health on April 25, 2025, citing violations of ERISA section 712(a)(8). On April 30, 2025, Priority Health on behalf of the plan provided the statutorily required violation notice to participants and beneficiaries enrolled in the fully-insured Priority Health coverage options[31] offered by the plan.

The investigation is now closed. In general, in order to come into compliance, the plan must provide a comparative analysis that contains the information required by statute. Going forward, the plan must demonstrate, through a MHPAEA-complaint comparative analysis, that any prior authorization NQTL complies with MHPAEA's requirements.

c. Local 103 I.B.E.W. Health Benefit Plan EIN/Plan Number 04-6063733/501

On April 9, 2021, EBSA's Boston Regional Office requested that this self-funded plan, which at the time of the request covered approximately 8,000 participants, provide comparative analyses for eight NQTLs, including:

- preauthorization for in-network and out-of-network outpatient services and prescription drugs;
- concurrent review for in-network inpatient, in-network outpatient, out-of-network outpatient, and out-of-network inpatient services;

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[e] On July 31, 2024, plan representatives confirmed that it would adopt Priority Health's response to the initial determination letter. On November 8, 2024, Priority Health provided its response to the June 10, 2024, initial determination letter.

[30] "Guiding principles" is not a term used in MHPAEA or its implementing regulations.

[31] The plan's affected coverage options were the HMO Traditional (Tiered Copay) and HMO HSA (Traditional Copay) fully-insured options through Priority Health.

- standards for provider admission to participate in a network, including reimbursement rates, for inpatient and outpatient services; and
- out-of-network reimbursement rates (including plan methods for determining usual, customary, and reasonable charges), for inpatient services and outpatient services.

The plan's comparative analyses contained information generated separately by its M/S claims processor and by its MH/SUD claims processor, which were unrelated entities. Each claims processor identified factors used in the design of the above-listed NQTLs for M/S claims that were different than those used in the design of the NQTLs for MH/SUD claims. The comparative analyses from one claims processor did not compare or contrast the factors, strategies, evidentiary standards, and processes described by the other claims processor.

EBSA investigators communicated with the plan multiple times, to have the plan to reconcile the different information it had collected from its service providers. On December 4, 2024, the Department issued an initial determination of noncompliance citing the plan for failure to produce compliant comparative analyses for two NQTLs: the standards for provider admission to participate in a network and the out-of-network reimbursement rates.

On December 20, 2024, the Department issued a second initial determination letter citing the plan for failure to produce compliant comparative analyses for the remaining two NQTLs: preauthorization and concurrent review.

Within 45 calendar days of the initial determination letters, the plan submitted responses indicating that it had retained a third party to prepare revised comparative analyses that would be produced in 8 weeks.

On April 7, 2025, the plan provided comparative analyses from the third party. However, those comparative analyses failed to define the factors or identify evidentiary standards, sources and evidence relied upon. They also did not demonstrate a comparable application of the processes, strategies, evidentiary and other factors used to apply the NQTLs to MH/SUD benefits and M/S benefits in the relevant classifications.

For example, for both the standards for provider admission to participate in a network NQTL and the out-of-network reimbursement rates NQTL, the updated comparative analyses included "usual and customary rates" as a factor. This factor provided no further detail, such as the methodologies used to determine it, the parameters around the negotiation process, the basis for the variation in rates, and the specific criteria used when making determinations. Accordingly, the plan failed to demonstrate comparable application of the factor, and the plan's conclusions about compliance were unsupported.

EBSA issued two final determination letters on May 6, 2025, each covering two of the four NQTLs identified above, citing the plan for failing to comply with ERISA section 712(a)(8). The plan provided the statutorily required violation notice to participants and beneficiaries on May 15, 2025. The investigation is now closed. In general, in order to come into compliance, the plan must provide a comparative analysis that contains the information required by statute. Going forward, the plan must demonstrate, through a MHPAEA-complaint comparative analysis, that any prior authorization NQTL complies with MHPAEA's requirements.

II. CMS' MHPAEA NQTL Enforcement Work

During the Reporting Period, CMS issued:

- **43 initial letters** requesting comparative analyses for **43 NQTLs**,
- **62 insufficiency letters** covering **43**[32] **NQTLs**,
- **9 initial determination letters** finding that plans and issuers had violated MHPAEA's requirements for **9 NQTLs**, and
- **10 final determinations of noncompliance** finding a plan or issuer violated MHPAEA's requirements for **10 NQTLs.**

Examples of CMS' enforcement results include:

- After an initial determination of noncompliance, a non-federal governmental plan removed an impermissible 6-month limit on ABA therapy prior authorization approvals.[33] The plan removed all prior authorization requirements for outpatient, in-network MH/SUD benefits, including for ABA therapy, and re-adjudicated claims resulting in approval of benefits for 29 individuals, totaling $91,789.10.

- After an initial determination of noncompliance, a non-federal governmental plan removed exclusions for methadone treatment for OUD and Spravato for individuals with substance use disorders.[34]

- After an initial determination of noncompliance, a non-federal governmental plan standardized prior authorization approval timeframes for elective M/S services and MH/SUD services, to ensure that approvals of elective MH/SUD services were not shorter than approvals for elective M/S services.[35]

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[32] As the 62 insufficiency letters include initial and secondary letters, some plans and issuers received more than one letter for the same NQTL review. Therefore, there are fewer NQTLs covered by these letters than total letters sent.

[33] A non-federal governmental plan was found to have a prior authorization requirement for ABA therapy, a mental health service, that was more stringent than the prior authorization requirement for M/S services. Whereas the plan limited the length of prior authorization approval for ABA therapy to a six-month time period, there was no such limitation for M/S benefits in the classification. CMS directed the plan to conduct a claims audit to identify individuals affected by the NQTL. The plan re-adjudicated claims for individuals who were adversely affected by application of the NQTL, resulting in approval of benefits for 29 individuals totaling $91,789.10.

[34] A non-federal governmental plan excluded methadone treatment for OUD, a substance use disorder but did not impose any comparable exclusions of prescription drugs for M/S conditions. The plan also applied a factor for determining whether to cover a prescription drug, "Safety, e.g., Adverse effects of drugs; Contraindications; and Drug interactions," that was not comparable and was applied more stringently to MH/SUD prescription drugs compared to M/S prescription drugs. This resulted in the exclusion of a prescription drug, Spravato, for individuals diagnosed with a substance use disorder. As a result of the investigation, the plan began covering methadone treatment for OUD and eliminated the exclusion of Spravato for individuals with substance use disorders. The plan reviewed claims and authorization requests to determine whether members were denied coverage because of these exclusions and found no associated denied claims or authorization requests.

[35] In its initial submission, the plan provided its precertification policy and procedure document that stated precertification approvals for elective M/S services were valid for up to six months. In contrast, elective MH/SUD precertification approvals were only valid for specific dates of the approved services, resulting in approvals for elective MH/SUD benefits potentially being of shorter duration than approvals for elective M/S benefits.

- As a result of a final determination of noncompliance, an issuer performed a self-audit to identify individuals affected by a prior authorization requirement on MH/SUD services. The self-audit covered plan years 2021, 2022, and 2023. The issuer's self-audit identified 236 claims for 69 unique members. These claims were re-adjudicated, resulting in approval of benefits for 69 individuals, totaling $224,701.08.[36]

- As a result of a final determination of noncompliance, an issuer removed a prior authorization requirement for outpatient, in-network MH/SUD services effective January 1, 2024. A self-audit by the issuer of claims that were affected by the prior authorization requirement identified 48 claims for 22 members. These claims were re-adjudicated, resulting in approval of benefits for 22 members, totaling $58,758.03.[37]

A. CMS' Statutory Reporting Requirements

1. CMS' Summary of Requested Comparative Analyses and Identification of Noncompliant Plans and Issuers

Over the Reporting Period, CMS issued 43 letters requesting comparative analyses, 33 letters to plans and 10 letters to issuers across 43 investigations. These letters requested comparative analyses for a total of 43 NQTLs, as detailed in the table below.

Type of Limitation Covered by New Requests in the Reporting Period	Number of Comparative Analyses Requested
Prior Authorization	**10**
Prior authorization treatment limitations for outpatient, in-network services	7
Prior authorization treatment limitations for inpatient, in-network services	3
Precertification	**6**
Precertification treatment limitations for outpatient, in-network services	4
Precertification treatment limitations for inpatient, in-network services	2
Medical Necessity	**10**
Medical necessity treatment limitations for outpatient, in-network services	8
Medical necessity treatment limitations for inpatient, in-network services	2
Concurrent Review	**5**

[36] Further details about this review can be found on pages 28–29; *see* Cigna Health and Life Insurance Company (Missouri) – Prior authorization requirements for outpatient, in-network services.
[37] Further details about this review can be found on pages 31–32; *see* Medica – Prior authorization for outpatient, in-network services.

Type of Limitation Covered by New Requests in the Reporting Period	Number of Comparative Analyses Requested
Concurrent review treatment limitations for outpatient, in-network services	4
Concurrent review treatment limitations for inpatient, in-network services	1
Retrospective Review	**2**
Retrospective review treatment limitations for outpatient, in-network services	1
Retrospective review treatment limitations for inpatient, in-network services	1
Post service Review	**2**
Post service review treatment limitations for outpatient, in-network services	1
Post service review treatment limitations for inpatient, in-network services	1
Medical Management Standards for Experimental/Investigational Treatments	**3**
Medical management standards limiting or excluding benefits based on whether the treatment is experimental or investigative for outpatient, in-network services	2
Medical management standards limiting or excluding benefits based on whether the treatment is experimental or investigative for inpatient, in-network services	1
Provider Network Admission	**2**
Network participation/admission requirements for outpatient, in-network services	1
Network participation/admission requirements for inpatient, in-network services	1
Provider Reimbursement	**2**
Provider reimbursement treatment limitations for outpatient, in-network services	1
Provider reimbursement treatment limitations for outpatient, out-of-network services	1
Treatment Limitations and Exclusions	**1**
Limitations on, and exclusions of, court-ordered treatments for inpatient, in-network services	1
Total	**43**

During the Reporting Period, CMS issued ten final determinations of noncompliance, which are described in more detail in Section II.A.5 below, to the following plans and issuers:

Plan/Issuer	NQTL(s)	Plan Year	Date of Final Determination
Aetna Life Insurance Company – Missouri	• Concurrent review for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.	2022	01/14/2025
Aetna Life Insurance Company – Wyoming	• Concurrent review for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.	2022	01/14/2025
Cigna Health and Life Insurance Company – Missouri	• Concurrent review requirements for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.	2021	02/05/2024
East Side Union High School – California	• Concurrent review for outpatient, in-network services.	2022	01/14/2025
Medica Insurance Company – Missouri	• Prior authorization for outpatient, in-network services.	2022	04/03/2024
State of Nebraska's WellNebraska Plans – Nebraska	• Prior authorization for inpatient, in-network services; and • Prior authorization for inpatient, out-of-network services.	2022	08/23/2024

2. CMS' Conclusions Regarding Sufficiency of Responses

As described in prior Reports to Congress, CMS continues to see comparative analyses that are not sufficient when initially submitted. During the Reporting Period, CMS observed a continued trend of zero comparative analyses that were sufficient at first submission. After reviewing initial comparative analysis submissions, CMS sent plans and issuers requests for additional information needed to complete the reviews. CMS provided up to two opportunities

for the submission of additional information before making an initial compliance determination. During the Reporting Period, CMS requested and received 62 supplemental responses for comparative analysis reviews. CMS continues to review plans' and issuers' initial and supplemental submissions.[38]

Over the Reporting Period, CMS issued initial determination letters citing 6 plans and issuers for violations for insufficient comparative analyses. In each of these instances, CMS provided notice of the specific deficiencies beforehand through a written insufficiency letter. CMS gave multiple opportunities for plans and issuers to address identified deficiencies prior to issuing an initial or final determination of noncompliance.

3. CMS' Conclusions Regarding Compliance with Disclosure Requirements

For any instances of noncompliance found during the Reporting Period, CMS sent an initial determination letter to the plan or issuer describing each instance of noncompliance. Since February 2021, CMS has obtained sufficient information resulting in 43 initial determinations of noncompliance for 24 plans and issuers in connection with 43 NQTLs (14 distinct types of NQTLs). Nine of those were issued during the Reporting Period in connection with 9 NQTLs (7 distinct types of NQTLs). These initial determination letters involved the NQTLs listed in the chart below.

Type of Limitation Covered by CMS' Requests	**Number of Comparative Analyses Requested**	
	Total Issued Since February 2021	**Issued During the Reporting Period**
Prior authorization for outpatient, in-network services	9	1
Prior authorization for inpatient, in-network services	4	-
Prior authorization for outpatient, out-of-network services	3	1
Prior authorization for inpatient, out-of-network services	1	-
Concurrent review for outpatient, in-network services	11	2
Concurrent review for outpatient, out-of-network services	2	1
Concurrent review for inpatient, out-of-network services	1	-
Treatment certification requirements for inpatient, in-network services	1	-
Credentialing standards to qualify as an inpatient, in-network provider	3	-
Credentialing standards to qualify as an outpatient, in-network provider	3	-
Prescription drug exclusions of specific treatments for certain conditions	1	-

[38] Of reviews called during the Reporting Period, 14 comparative analysis submissions were still undergoing analysis for sufficiency at the time of drafting this Report. Determinations of the sufficiency of these comparative analyses will be summarized in subsequent reports.

Type of Limitation Covered by CMS' Requests	Number of Comparative Analyses Requested	
	Total Issued Since February 2021	Issued During the Reporting Period
Provider reimbursement for outpatient, in-network services	2	2
Formulary design for prescription drugs	1	1
Prior authorization requirements, step therapy, quantity limits for prescription drugs	1	1
Total	**43**	**9**

The initial determination letters directed the plan or issuer to submit a CAP within 45 calendar days of the date of the letter.[39] CMS requested that the CAP include actions taken or in progress to correct the instances of noncompliance described in the letter, a timeline for completion, evidence of corrective action implementation or completion, and an additional NQTL comparative analysis demonstrating compliance based on the corrective actions identified in the CAP. Plans and issuers who received such an initial determination letter were generally responsive with a CAP to address the violations.

During the Reporting Period, CMS received 14 CAPs from 7 plans and issuers in response to initial determination letters that addressed 14 NQTLs. Some of these corrective actions have been finalized (which means that the plan has submitted satisfactory confirmation of the corrective action), while CMS is still waiting on confirmation of completion for others.

4. CMS' Specifications Regarding Sufficiency of Responses

In its fourth and fifth years, 2024 and 2025, respectively, of implementing the CAA amendments to MHPAEA, CMS has not seen a marked improvement in the sufficiency of initial NQTL comparative analyses provided by plans and issuers. However, a few plans and issuers provided more detailed comparative analyses upon initial request, and a growing number provided relevant data and more detailed explanations in response to insufficiency letters and initial determinations of noncompliance. Deficiencies and trends identified during this Reporting Period are consistent with those noted in previous reports.[40] For plans and issuers that received insufficiency letters, common deficiencies were the lack of any comparative analysis for a given NQTL or the absence of key information that the statute[41] requires to accompany a comparative analysis.

[39] Section 2726(a)(8)(B)(iii)(I)(aa) of the PHS Act. [40] *See* pages 70–73 of the 2024 MHPAEA Report to Congress, pages 67-69 of the 2023 MHPAEA Report to Congress, and pages 28–30 of the 2022 MHPAEA Report to Congress (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity/reports-to-congress).

[40] *See* pages 70–73 of the 2024 MHPAEA Report to Congress, pages 67-69 of the 2023 MHPAEA Report to Congress, and pages 28–30 of the 2022 MHPAEA Report to Congress (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity/reports-to-congress).

[41] PHS Act § 2726(a)(8)(A)(i)–(v).

During the Reporting Period, CMS determined that 32 comparative analyses were insufficient upon initial review. In 2023, CMS added a secondary Insufficient Data Request step to the review process to allow for more guidance to plans and issuers to improve sufficiency of NQTL comparative analyses prior to issuing initial determinations. During the Reporting Period, CMS issued 30 secondary Insufficient Data Requests. The sufficiency determination for the remaining reviews is in progress. Plans and issuers are working with CMS to provide additional information about identified NQTLs, complete CAPs, and provide additional comparative analyses. CMS will also include these sufficiency determination findings in future reports to Congress.

Several insufficiency letters were issued to plans whose plan sponsors were surprised to find that responsibility for MHPAEA compliance lies with the plan, not their service provider. Many plans also assumed their service provider had a comparative analysis or would prepare one for them. As noted by EBSA, CMS similarly observed that some service providers refused to provide a comparative analysis or were unable to give the information needed for a plan to assess its own MHPAEA compliance.[42]

5. CMS' Specifications Regarding Compliance[43]

CMS is required to identify in this report the non-federal governmental plans and health insurance issuers that were issued a final determination of noncompliance.[44] Additionally, CMS posts all final determination letters to its website at https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement. CMS determined that the plans and issuers listed below were not in compliance with MHPAEA based on reviews of comparative analyses of ten NQTLs:

Plan/Issuer	NQTL(s)
Aetna Life Insurance Company – Missouri	• Concurrent review for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.
Aetna Life Insurance Company – Wyoming	• Concurrent review for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.

[42] CMS also observed that this concern arose often when plans had different service providers handling MH/SUD and M/S benefits. Plans with these carveout arrangements rarely obtained a complete comparative analysis from either service provider. Plans with carveout arrangements should closely review the information provided by their service providers to ensure there is a meaningful comparison of information provided by each service provider.
[43] This summary complies with the Secretary's reporting obligations under section 2726(a)(8)(B)(iv)(V) of the PHS Act—the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance.
[44] Section 2726(a)(8)(B)(iv)(I) of the PHS Act.

Plan/Issuer	NQTL(s)
Cigna Health and Life Insurance Company – Missouri	• Concurrent review requirements for outpatient, in-network services; and • Prior authorization requirements for outpatient, in-network services.
East Side Union High School – California	• Concurrent review for outpatient, in-network services.
Medica Insurance Company – Missouri	• Prior authorization for outpatient, in-network services.
State of Nebraska's WellNebraska Plans – Nebraska	• Prior authorization for inpatient, in-network services; and • Prior authorization for inpatient, out-of-network services.

All plans and issuers that received a final determination of noncompliance were required, within 7 days of the date of the final determination letter, to notify all individuals enrolled under the impacted plans and coverage that such plan or coverage was determined to be out of compliance with MHPAEA.[45] All plans and issuers subject to this requirement fulfilled this obligation in a timely manner. CMS also requires plans and issuers that receive a final determination of noncompliance to verify that they have completed their stated corrective actions. As of the end of the Reporting Period, three of the plans and issuers had completed the required corrective actions, while the corrective actions for the other three plans and issuers remained in progress.

CMS identified instances of noncompliance with MHPAEA due to impermissible separate treatment limitations. CMS also issued final determinations of noncompliance due to factors used by an issuer in applying an NQTL to MH/SUD benefits, in operation, that were not comparable to those used to apply the NQTL to M/S benefits in the same benefit classification. Additionally, in all cases in which a plan or issuer received a final determination of noncompliance, the plan or issuer did not provide sufficient information and supporting documentation in its comparative analysis. Without sufficient information and supporting documentation, CMS was unable to validate whether the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to M/S benefits, as written and in operation.

The following summaries provide specific examples:

Aetna Life Insurance Company (Missouri) – Concurrent review for outpatient, in-network services

1. *The Issuer imposed reevaluation and validated assessment requirements for concurrent review determinations for ABA, a MH/SUD service, but did not impose such requirements for any M/S service in the same benefit classification.*

[45] Section 2726(a)(8)(B)(iii)(I)(bb) of the PHS Act.

2. *The Issuer did not provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL.*

The Issuer provided a coverage policy used to make concurrent review determinations for ABA services that required members receiving ABA services to be reevaluated every six months to assess the need for continued coverage. The Issuer did not require the reevaluation of treatment plans every six months for any M/S services in the same benefit classification. Coverage policies for the M/S services cited by the Issuer did not clearly mandate reevaluations in order to continue to receive coverage for the service. In addition, the coverage policy for ABA services required that specific validated assessments be performed to demonstrate response to treatment. The Issuer did not require validated assessments to demonstrate response to treatment for any M/S services in the same benefit classification. In its CAP submission, the Issuer asserted that the M/S evaluations were effectively the same as the ABA assessment requirements. However, the coverage policy for ABA services clearly distinguished between evaluations and validated assessments, as it required both an evaluation and an assessment as part of the concurrent review approval process.

The coverage policies for M/S services did not require reevaluations and validated assessments for concurrent review determinations as required for ABA services. Therefore, the concurrent review NQTL for outpatient, in-network services, functioned as an impermissible separate treatment limitation applied only to certain MH/SUD benefits and not to M/S benefits in the same benefit classification.

The Issuer identified return on investment (ROI) as a factor used to determine whether the concurrent review NQTL will continue to apply to a service. The Issuer also identified the use of "extenuating factors" to apply the NQTL to MH/SUD services and M/S services that did not meet the ROI threshold. In its CAP submission, the Issuer did not provide sufficient information on the formula and associated inputs used to calculate ROI for MH/SUD services and M/S services. The Issuer also did not provide sufficient information regarding the extenuating factors used.

As a result of CMS' final determination of noncompliance, CMS specified that the Issuer must remove concurrent review NQTL for outpatient, in-network MH/SUD services from plans beginning with the 2022 plan year and for subsequent plan years, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations. Additionally, CMS required the Issuer to provide to CMS an updated policy and procedure document that reflects the removal of concurrent review requirements for outpatient, in-network MH/SUD services beginning with the 2022 plan year and for subsequent plan years and to update its medical management system to reflect the removal of concurrent review requirements for outpatient, in-network MH/SUD services. CMS also directed the Issuer to identify and provide to CMS a list of any applicable MH/SUD claims that were adversely affected by application of the concurrent review requirement to MH/SUD services. As of the end of the Reporting Period, the corrective actions were in progress.[46]

[46] These corrective actions were received as of December 10, 2025. CMS is reviewing the completeness of the corrective actions and future reports to Congress will include the results of these corrective actions.

Aetna Life Insurance Company (Missouri) – Prior authorization requirements for outpatient, in-network services

1. *The Issuer did not provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL.*

The Issuer did not make available a sufficient comparative analysis including the factors used to determine that the NQTL will apply to MH/SUD and M/S benefits and the evidentiary standards used for the factors identified. The Issuer identified ROI as a factor used to determine whether the prior authorization NQTL will continue to apply to a service. The Issuer also identified the use of "extenuating factors" to apply the NQTL to MH/SUD services and M/S services that did not meet the ROI threshold. In its CAP submission, the Issuer did not provide sufficient information on the formula and associated inputs used to calculate ROI for MH/SUD services and M/S services. The Issuer also did not provide sufficient information regarding the extenuating factors used.

As a result of CMS' final determination of noncompliance, CMS specified that the Issuer must submit an updated comparative analysis that described the process, calculations, formula inputs, and any evidentiary standards used by the Issuer to calculate ROI for MH/SUD services and M/S services; and provide an exhaustive list of all extenuating factors considered when determining whether to impose a prior authorization requirement on a MH/SUD service or M/S service that does not meet the ROI threshold. As of the end of the Reporting Period, the corrective actions were in progress.[47]

Aetna Life Insurance Company (Wyoming) – Concurrent review for outpatient, in-network services

The findings of this review were substantially similar to the findings of Aetna Life Insurance Company (Missouri) – Concurrent review for outpatient, in-network services, summarized on pages 24–25. Additionally, CMS identified the following violation:

1. *The Issuer did not provide sufficient information and supporting documentation regarding the processes used to apply the NQTL.*

The Issuer provided a policy that detailed the timeliness standards for concurrent review determinations. However, the policy did not clearly establish the standard used by the Issuer for non-urgent concurrent review requests. In its CAP submission, the Issuer indicated that non-urgent concurrent review requests would be subject to the same decision timeliness standard as non-urgent prior authorization requests. However, this conflicted with the provided policy which stated that either the urgent or non-urgent prior authorization timeframe may be used for outpatient non-urgent concurrent review requests. The Issuer did not explain the considerations used to determine whether a non-urgent concurrent review request would be subject to the urgent or non-urgent prior authorization decision timeliness standard. The Issuer also did not explain whether the process for determining the timeliness standard differed between MH/SUD benefits and M/S benefits. Without this information, CMS was unable to determine whether the processes

[47] These corrective actions had not been received as of July 31, 2025. Future reports to Congress will include the results of these corrective actions.

used to apply the NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to M/S benefits.

CMS specified that the Issuer must remove the concurrent review NQTL for outpatient, in-network MH/SUD services from plans beginning with the 2022 plan year and for subsequent plan years, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations. Additionally, CMS required the Issuer to provide an updated policy and procedure document that reflects the removal of concurrent review requirements for outpatient, in-network MH/SUD services beginning with the 2022 plan year and for subsequent plan years and to update its medical management system to reflect the removal of concurrent review requirements for outpatient, in-network MH/SUD services. CMS also directed the Issuer to identify and provide to CMS a list of any applicable MH/SUD claims that were adversely affected by application of the concurrent review requirement to MH/SUD services. As of the end of the Reporting Period, the corrective actions were in progress.[48]

Aetna Life Insurance Company (Wyoming) – Prior authorization requirements for outpatient, in-network services

The findings of this review were the same as those in Aetna Life Insurance Company (Missouri) – Prior authorization requirements for outpatient, in-network services, summarized on page 25. Please refer to that summary for a description of identified violations and required corrective actions. As of the end of the Reporting Period, the corrective actions were in progress.[49]

Cigna Health and Life Insurance Company (Missouri) – Prior authorization requirements for outpatient, in-network services

1. *The Issuer's prior authorization decision processes and timeframes were not comparable between MH/SUD benefits and M/S benefits.*
2. *The Issuer provided insufficient information and supporting documentation regarding the ROI factor considered in the design and application of MH/SUD and M/S prior authorization processes.*

The Issuer's CAP submission included a written policy with its "standard" and "urgent" prior authorization processes and decision timeframe standards. This policy indicated that urgent M/S prior authorization requests were decided within 30 minutes of receiving the prior authorization request, whereas urgent MH/SUD prior authorization requests were decided within 36 hours of obtaining all necessary information. CMS determined that the prior authorization decision timeframes were not comparable between MH/SUD benefits and M/S benefits, as written. The Issuer was unable to provide information that would enable CMS to determine that the prior authorization processes as applied to MH/SUD benefits and M/S benefits were

[48] These corrective actions had not been received as of July 31, 2025. Future reports to Congress will include the results of these corrective actions.
[49] These corrective actions had not been received as of July 31, 2025. Future reports to Congress will include the results of these corrective actions.

comparable in operation. Therefore, CMS determined that the Issuer did not demonstrate that the processes for these benefits were comparable in operation.

The Issuer indicated that ROI was the "key factor" in determining the application of prior authorization upon MH/SUD benefits and M/S benefits. The Issuer provided the ROI calculations for each individual M/S procedure/revenue codes but only provided ROI for grouped MH/SUD procedure/revenue codes. Because the Issuer did not provide its calculation of ROI for MH/SUD benefits at the individual code level, CMS could not adequately assess how the Issuer determined that the ROI factor would apply to MH/SUD benefits or whether that determination was comparable with how the factor applies to M/S benefits.

The Issuer also stated in its CAP submission that the estimated cost to perform a coverage review, part of the ROI calculation used in the design and application of the NQTL, is $40 per review for M/S benefits and $100 per review for MH/SUD benefits. This information did not align with prior responses submitted by the Issuer which indicated that the cost for all reviews was $100. It was unclear how the estimated cost to perform a coverage review was determined for both MH/SUD benefit prior authorization ROI calculations and M/S benefit prior authorization ROI calculations, whether the average costs per review for M/S benefits was $40 or $100, or how the average cost per review for both MH/SUD benefits and M/S benefits is used in the ROI calculation.

CMS specified that the Issuer must remove the prior authorization NQTL for outpatient, in-network MH/SUD benefits from plans for the 2021 plan year and future plan years, following the 2021 plan year, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations. Additionally, CMS required the Issuer to provide an updated policy and procedure document that reflects the removal of prior authorization requirements for outpatient, in-network MH/SUD benefits and to update its medical management system.

The Issuer confirmed during the CAP phase, that the plan was no longer in existence as of December 31, 2023, and that it exited the individual market in Missouri effective January 1, 2024. The corrective actions regarding removal of the NQTL and updating policy and procedure documents were no longer relevant given that the plan is no longer active. The Issuer also submitted a list of the participants, beneficiaries, and enrollees who were adversely affected by the application of prior authorization requirements to MH/SUD benefits, along with supporting documentation outlining the Issuer's methodology for identifying the impacted claims and notifying the affected individuals. The Issuer's self-audits included plan years 2021, 2022, and 2023. Approvals for benefits to 69 members, totaling $224,701.08[50] were issued for 236 claims originally processed between January 1, 2021, and December 31, 2023. No further compliance concerns regarding MHPAEA for the coverage under review were identified. Cigna Health and Life Insurance Company (Missouri) completed all required corrective actions for this review and the review has been closed.

[50] This total is a combination of benefits paid for prior authorization and concurrent reviews for plan years 2021, 2022, and 2023 as a result of corrective actions.

Cigna Health and Life Insurance Company (Missouri) – Concurrent review requirements for outpatient, in-network services

1. *The Issuer's concurrent review decision processes and timeframes were not comparable between MH/SUD benefits and M/S benefits.*
2. *The Issuer provided insufficient information and supporting documentation regarding the ROI factor considered in the design and application of MH/SUD and M/S concurrent review processes.*
3. *The Issuer provided insufficient information and supporting documentation to demonstrate the comparability and relative stringency of appeal decisions for concurrent review processes between MH/SUD benefits and M/S benefits.*

The Issuer's CAP submission included a written policy with its concurrent review processes and decision timeframe standards, indicating that if a MH/SUD concurrent review request is received less than 24 hours prior to the end of the current authorization period, the Behavioral Health clinical supervisor may "opt" to follow the procedure for an urgent pre-service request. There was no similar opt in language in the corresponding M/S policy, indicating that M/S concurrent review requests received less than 24 hours prior to the end of the current authorization period would follow the urgent process. CMS determined that the processes for the concurrent review were not comparable between MH/SUD benefits and M/S benefit, as written. The Issuer did not provide information necessary for CMS to determine that the processes used to apply concurrent review to MH/SUD benefits and M/S benefits were comparable in operation.

The Issuer also stated in its CAP submission that the estimated cost to perform a coverage review, part of the ROI calculation used in the design and application of the NQTL, is $40 per review for M/S benefits and $100 per review for MH/SUD benefits. This information did not align with prior responses submitted by the Issuer which indicated that the cost for all reviews was $100. It was unclear how the estimated cost to perform a coverage review was determined for both MH/SUD benefit prior authorization ROI calculations and M/S benefit prior authorization ROI calculations, whether the average costs per review for M/S benefits was $40 or $100, or how the average cost per review for both MH/SUD benefits and M/S benefits is used in the ROI calculation. Therefore, the Issuer therefore did not provide sufficient information to demonstrate the comparability and relative stringency of the application of the ROI factor to MH/SUD benefits as compared to M/S benefits.

Finally, in its CAP submission, the Issuer provided decision overturn rate data for concurrent reviews showing a decision overturn rate of 5.67% for MH/SUD reviews and a decision overturn rate of 0.24% for M/S reviews. CMS requested that the Issuer provide a reasoned discussion concerning the comparability and relative stringency of the processes, strategies, evidentiary standards, and other factors used, which resulted in a higher rate of MH/SUD concurrent review decisions overturned compared to M/S concurrent review decisions overturned. The Issuer's response provided general speculation as to why MH/SUD decisions could have been overturned at a higher rate compared to M/S decisions, as opposed to performing and providing an analysis of the overturn metrics and identifying the processes, strategies, evidentiary standards, and other factors that explain why MH/SUD concurrent review decisions are overturned at a higher rate than M/S concurrent review decisions.

CMS specified that the Issuer must remove the prior authorization NQTL for outpatient, in-network MH/SUD benefits from plans for the 2021 plan year and future plan years, following the 2021 plan year, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations. Additionally, CMS required the Issuer to provide an updated policy and procedure document that reflects the removal of prior authorization requirements for outpatient, in-network MH/SUD benefits and to update its medical management system.

The Issuer confirmed during the CAP phase, that the plan was no longer in existence as of December 31, 2023, and that it exited the individual market in Missouri effective January 1, 2024. The corrective actions regarding removal of the NQTL and updating policy and procedure documents were no longer relevant given that the plan is no longer active. The Issuer also submitted a list of the participants, beneficiaries, and enrollees who were adversely affected by the application of prior authorization requirements to MH/SUD benefits, along with supporting documentation outlining the Issuer's methodology for identifying the impacted claims and notifying the affected individuals. The Issuer's self-audits included plan years 2021, 2022, and 2023. Approvals for benefits to 69 members, totaling $224,701.08[51] were issued for 236 claims originally processed between January 1, 2021, and December 31, 2023. No further compliance concerns regarding MHPAEA for the coverage under review were identified. Cigna Health and Life Insurance Company (Missouri) completed all required corrective actions for this review and the review has been closed.

East Side Union High School (California) – Concurrent review for outpatient, in-network services

The findings of this review were the same as those in Aetna Life Insurance Company (Wyoming) – Concurrent review for outpatient, in-network services, summarized on pages 25-26. Please refer to that summary for a description of identified violations and required corrective actions. As of the end of the Reporting Period, the corrective actions were in progress.[52]

Medica – Prior authorization for outpatient, in-network services

1. *The Issuer did not provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL.*

CMS found that the use of a factor in the design and application of the prior authorization NQTL was not comparable as applied to MH/SUD outpatient, in-network benefits as compared to M/S outpatient, in-network benefits. The Issuer identified ROI as a factor considered in determining whether to add or retain a prior authorization requirement for MH/SUD services and M/S services. The Issuer's CAP submission included certain decision tools used to determine which MH/SUD services and M/S services should be added, retained, or removed from the list of

[51] This total is a combination of benefits paid for prior authorization and concurrent reviews for plan years 2021, 2022, and 2023 as a result of corrective actions.

[52] These corrective actions have been completed and the review was closed on October 30, 2025. The Plan removed the NQTL for outpatient, in-network MH/SUD services and performed a self-audit. The Plan provided supporting documentation confirming that review of its claims and utilization management reports found no participants, beneficiaries, or enrollees who were adversely affected by the application of the NQTL.

services subject to the NQTL. The tools used for MH/SUD services included specific ROI calculations with associated inputs for each service. However, while the tools provided for M/S services included general utilization management data and references to net savings, specific ROI calculations and the associated inputs were not provided. Specific ROI calculations and associated inputs were used to determine whether the NQTL would apply to MH/SUD services, whereas there was insufficient evidence provided to show that M/S services utilized such ROI calculations or inputs.

As a result of CMS' final determination of noncompliance, CMS required the Issuer to remove the prior authorization NQTL for outpatient, in-network MH/SUD benefits from plans for the 2022 plan year and subsequent plan years, until such time as the Issuer demonstrates to CMS that the NQTL is in compliance with the requirements under MHPAEA and its implementing regulations. Additionally, CMS required the Issuer to provide an updated policy and procedure document that reflects the removal of prior authorization requirements for outpatient, in-network MH/SUD benefits and to update its medical management system to reflect the removal of prior authorization for outpatient, in-network MH/SUD benefits.

The Issuer removed the prior authorization requirement for outpatient, in-network MH/SUD services effective January 1, 2024. The Issuer conducted a self-audit of the MH/SUD members who were adversely affected by the prior authorization requirement and provided CMS with a list of the associated claims including the dates that each claim was re-adjudicated, reprocessed, and paid out to the member for a review period of January 1, 2022, through December 31, 2023. Benefits for 22 members, totaling $58,758.03, were paid under 48 claims. No further compliance concerns regarding MHPAEA for the coverage under review were identified. Medica completed all required corrective actions for this review and the review has been closed.

State of Nebraska's WellNebraska Plans (Nebraska) – Prior authorization for inpatient, in-network services; and Prior authorization for inpatient, out-of-network services

1. *The Plan did not provide sufficient information and supporting documentation regarding the factors considered in the design and application of the NQTL.*
2. *The Plan did not provide sufficient information and supporting documentation regarding the processes used to apply prior authorization.*

The Plan identified "clinical appropriateness" and "value" as factors used in the design and application of the prior authorization NQTL. In its CAP submission, the Plan did not provide sufficient information as to the definitions of the factors and the corresponding evidentiary standards used to design and apply the factors. For the clinical appropriateness factor, the Plan indicated the factor would be triggered if clinical criteria existed for a service. For the value factor, the Plan did not provide sufficient information as to the equation and inputs used to calculate value for MH/SUD services and M/S services. Additionally, the Plan did not provide sufficient supporting documentation, such as policies and procedures, outlining how the factors are evaluated and applied to MH/SUD services and M/S services. The Plan provided incomplete information and documentation as to how the factors are defined, evaluated, and applied to MH/SUD benefits and M/S benefits. The Plan also provided a narrative outlining the process for reviewing prior authorization requests and provided supporting documentation for decision

timeliness standards for non-urgent outpatient services. However, the Plan did not provide supporting policies and procedures for prior authorization decision timeliness standards for non-urgent inpatient MH/SUD services.

As a result of CMS' final determination of noncompliance, CMS specified the Plan must provide additional information and supporting documentation (i.e., a written policy and procedure document) describing how the value factor and clinical appropriateness factor are applied to MH/SUD services and M/S services in the inpatient, in-network classification and inpatient, out-of-network classification; and provide supporting documentation (i.e., a written policy and procedure document) verifying the MH/SUD prior authorization decision timeliness standards and M/S prior authorization decision timeliness standards used for non-urgent inpatient prior authorization decisions.

The Plan provided additional comparative analyses and other supporting documentation showing how the factors are defined, evaluated, and applied to MH/SUD services and M/S services. The Plan also provided an updated policy and procedure document with the prior authorization decision timeliness standards for inpatient services. No further compliance concerns regarding MHPAEA for the coverage under review were identified. State of Nebraska's WellNebraska Plans completed all required corrective actions for this review and the review has been closed.