Issue brief: Federal parity report once again shows payers' failures

Background

The Consolidated Appropriations Act, 2021 (CAA) amended The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) to require, among other things, that health plans demonstrate that if they provide mental health and substance use disorder benefits (MH/SUD), those benefits must generally be no more restrictive as-written or as-applied than comparable medical/surgical (M/S) benefits. For the third consecutive year, the Departments of Labor, Health and Human Services, and Treasury Report to Congress found that health plans continue to deny and delay MH/SUD care for millions of Americans through the use of impermissible "non-quantitative treatment limitations," (NQTL) which include policies such as prior authorization. One of the key requirements for payers is to document compliance through a "comparative analysis" of NQTLs. A comparative analysis is essentially comparing whether the MH/SUD benefits are comparable to M/S benefits. As detailed in the report and summarized below, patients' ability to access MH/SUD benefits fall far short of M/S benefits.

Key findings

The Report to Congress found:

- **Health plan violations led to delayed or denied care.** It is important to emphasize that every health plan violation found in the course of a parity enforcement action means that there likely was previous harm to a patient because of delayed or denied care. But because parity enforcement actions occur years after-the-fact, the harm already was done. Among the specific types of NQTL violations where the health plan had more stringent or restrictive policies for MH/SUD patients than for M/S patients:
    - Prior authorization, precertification
    - Exclusion of therapy for autism spectrum disorder, cognitive, intensive behavioral, habilitative, or rehabilitative interventions to treat MH/SUD
    - Exclusion of medication-assisted treatment for opioid use disorder
    - Provider billing restrictions
    - Exclusion of nutritional counseling for mental health conditions
    - Exclusion of residential care or partial hospitalization for MH/SUD conditions
    - Exclusion of telehealth/virtual visits
    - Exclusion of speech therapy for mental health conditions
    - Network admission standards, including reimbursement rates and network adequacy
    - Prescription drug exclusions of specific treatments for certain conditions
- **Health plans are not trying very hard.** As in previous years, the 2025 report highlighted that, upon initial submission, every NQTL comparative analysis submitted by health plans that were reviewed was insufficient. The Departments reported throughout the report that plans' explanations were overly generalized, implausible and not convincing.
- **Health plan networks are grossly inadequate.** One of the reasons that tens of millions of Americans cannot find or access timely treatment for MH/SUD care is due to health plans' failures to maintain adequate—or accurate—networks of MH/SUD providers. Secret shopper surveys found that only 8 to 28

percent of patients were able to obtain care from MH/SUD provider networks listed as accepting new patients—compared to 24 to 37 percent of M/S providers surveyed.

- **Health plans do not value MH/SUD providers.** The report found that reimbursement/contract rates for MH/SUD providers were typically much lower than for M/S providers and that health plans routinely took longer to credential MH/SUD providers than M/S providers. Health plans had no reasonable justifications for the violations and instead tried to argue that M/S providers received higher rates because there was greater demand for M/S services but ignored the high demand for MH/SUD services.
- **Health plans know they have the upper hand.** The report showed extensive efforts by the Departments in trying to enforce MHPAEA, but they are greatly outnumbered. The report detailed the considerable resources that targeted enforcement efforts require, but acknowledged that for privately insured plans, there are only 302 investigators for 2.6 million plans covering 136 million Americans; and only 15 investigators for more than 90,000 federal government plans. Even among such overwhelming odds, the successful enforcement efforts led to changes since 2021 helping more than 7.6 million Americans.
- **Health plan failures are the same.** The report said that health plans' "deficiencies and trends" in the 2024 report are the same as in the 2022 and 2023 reports. The report said that health plans' failures were mainly due to "inadequate preparation by plans and issuers, and plans and issuers attempting to justify practices that were adopted without MHPAEA compliance in mind." The repeat violations included:
    - failure to document a comparative analysis before designing and applying the NQTL,
    - conclusory assertions lacking specific supporting evidence or detailed explanation,
    - lack of meaningful comparison or analysis,
    - nonresponsive comparative analysis,
    - documents provided without adequate explanation,
    - failure to identify the specific MH/SUD and M/S benefits or MHPAEA benefit classifications affected by an NQTL, and
    - focusing only on similarities—rather than explaining differences—to show parity.

Conclusion

The AMA greatly appreciates the efforts undertaken by the Departments, including public listening sessions, online resources, and direct enforcement efforts. Health plans, however, continue to show little effort or willingness to try and comply with federal (or state) parity requirements. The AMA continues to strongly urge policymakers to provide regulators with the authority to levy significant financial penalties as well as to implement new federal rules to enforce the MHPAEA.

The AMA urges enforcement by federal regulators of provisions in the new federal rule as well as for state regulators to:

- Adopt the requirement that a plan or issuer must define a mental health condition or substance use disorder by following the most current version of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders.
- Adopt language from the federal rule that if a plan or issuer cannot demonstrate that a "non-quantitative treatment limitation" is no more restrictive than for a medical/surgical condition, the plan or issuer shall be prohibited from using the NQTL until it is compliant.
- Adopt provisions from the federal rule that define and connect "meaningful benefits" and core treatments to recognized standards of medical practice.
- Ensure that state parity laws apply to credentialing standards, as well as to the procedures to join a network. a Furthermore, ensure that state parity laws apply to methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage.

For more information, please see the AMA summary of MHPAEA final rule.