Navigating the latest mental health parity rules

Preparing for 2025 and 2026 with new data evaluation requirements on the horizon

Katie Matthews, FSA, MAAA
T.J. Gray, FSA, MAAA
Stoddard Davenport, MPH

Milliman

While the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) has been the law of the land for over 16 years, its implementing rules and regulations have continued to evolve.[1] New rules were finalized in September 2024, with some requirements taking effect at the beginning of 2025, and others delayed until 2026.[2] While the latest requirements may not be as disruptive as some had initially expected, there are still meaningful changes to compliance requirements that health plans and plan sponsors should prepare for as 2025 begins.

Background

MHPAEA is a federal law designed to ensure parity in access to benefits for mental health and substance use disorders (MH/SUD) compared to benefits for medical/surgical (M/S) conditions. The law defines a treatment limitation as anything that potentially limits the scope or duration of benefits under the plan, and outlines separate rules for quantitative treatment limitations (such as cost-sharing requirements like deductibles, copays, and coinsurance, along with day or visit limits, etc.) and nonquantitative treatment limitations (such as medical management criteria like prior authorization and concurrent review, standards for provider admission to a network, provider reimbursement rates, network adequacy standards, step therapy requirements, formulary design for prescription drugs, and many other aspects of benefit design and administration).

The rules for financial requirements and quantitative treatment limitations (often referred to as QTLs) include relatively straightforward mathematical tests to determine the types and levels of such limitations that are permissible for MH/SUD benefits. The rules for nonquantitative treatment limitations (NQTLs) are comparatively more subjective and involve consideration of the processes, strategies, evidentiary standards, and other factors used in the design and application of NQTLs.

Initially, much of the focus in MHPAEA compliance and enforcement was on QTLs, but in recent years NQTLs have taken center stage. In 2018, the U.S. Department of Labor (DOL) published an MHPAEA self-compliance tool for employers that outlined a stepwise comparative analysis for documenting MHPAEA compliance.[3] At the time, this approach was considered best practice but was not explicitly required. Later, the Consolidated Appropriations Act of 2021 (CAA) was passed

This paper provides an overview of key changes to MHPAEA compliance requirements that take effect in January 2025 and January 2026 and describes how health plans and plan sponsors can prepare to meet the new requirements.

Each of these topics are explored in more depth throughout this paper, but for many plans and plan sponsors, the most noteworthy changes may include:

- New requirements to collect and evaluate data on access to MH/SUD benefits compared to medical/surgical benefits.
- New requirements for health plan fiduciaries to certify that they have engaged in a prudent process to ensure compliance.
- Increased pressure on benefit administration vendors (such as third-party administrators, networks, medical management providers, pharmacy benefit managers, etc.) to support health plan sponsors with ensuring compliance.
- Numerous technical clarifications and updates regarding how compliance should be demonstrated and documented.

1. The full text of the legislation is available at https://www.congress.gov/bill/110th-congress/house-bill/1424/text.
2. The full text of the Final Rules is available at https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.
3. DOL. Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). Retrieved January 31, 2025, from https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mental-health-parity-compliance-tool.pdf.

and included a section that created a new requirement for health plans and plan sponsors to document a comparative analysis for each NQTL they apply to MH/SUD benefits and make it available to regulators upon request. The required format of the analysis was largely similar to the format outlined in the 2018 DOL self-compliance tool. This signaled the first major shift in the standards that health plans and plan sponsors were held to regarding NQTLs and coincided with a substantial increase in federal audits and inquiries related to NQTL compliance.

Most recently, Final Rules containing requirements related to MHPAEA were published to the Federal Register on September 23, 2024.[4] This represents the finalization of rules originally proposed on August 2, 2023.[5] The Final Rules include a mix of areas where the rules were finalized as originally proposed, areas where the rules were finalized with significant changes, and other areas where the proposed rules were dropped entirely in response to public comments.

The Final Rules aim to improve access to mental health and substance use disorder treatment and include language reiterating MHPAEA's fundamental purpose of ensuring that no greater burden to access is placed on mental health and substance use disorder care than on medical/surgical care. This new language provides an overarching lens through which plans should interpret the Final Rules. Although the overarching focus of these rules is consistent with prior iterations, requirements have been added that provide plans with more clarity on how they can directly approach compliance with MHPAEA rules, especially those for NQTLs in a practical manner.

Familiar seas: Subtle changes to comparative analysis requirements

Consistent with prior guidance under Section 203 of the CAA, the Final Rules confirm that plans must provide comparative analyses that illustrate how any NQTLs imposed by the plan on MH/SUD benefits are comparable to and applied no more stringently than those that apply to medical/surgical benefits, both as written and in operation.[6] The required elements of the comparative analysis are similar to those outlined in the CAA and a prior version of the DOL's self-compliance tool.[7] However, the comparative analysis as codified in the Final Rules includes six steps rather than five, as illustrated in Figure 1.

Note that a comparative analysis must be prepared for each NQTL that applies to MH/SUD benefits and should address each benefit classification separately (in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency, and prescription drug benefits) unless the NQTL is applied uniformly across all classifications.

FIGURE 1: COMPARATIVE ANALYSIS FRAMEWORK, 2024 FINAL RULES[8]

1. Description of the NQTL

Each NQTL applicable to mental health and substance use disorder benefits must be clearly identified and described. This includes outlining the specific terms of the plan and relevant policies or guidelines that govern the NQTLs.

2. Identification and definition of factors and evidentiary standards used to design or apply the NQTL

Plans must identify and define all factors considered in designing the NQTL. This includes detailing the evidentiary standards used to apply each factor and the sources from which these standards are derived. Each factor's definition should also be provided to ensure clarity.

3. Description of how factors are used in the design and application of the NQTL

The analysis must explain how each identified factor is utilized in determining which MH/SUD benefits and medical/surgical (M/S) benefits are subject to the NQTL. This includes outlining decision-making processes, timing, the roles of decision-makers, and how various factors interrelate in the application of the NQTL.

4. Demonstration of comparability and stringency as written

Plans are required to evaluate whether the processes and strategies used for NQTLs in MH/SUD benefits are comparable to those for M/S benefits in the written terms of the plan. This includes documentation of factors applied, quantitative analyses, and specific provisions in guidelines or procedures.

5. Demonstration of comparability and stringency in operation

The comparative analysis must assess how NQTLs operate in practice, ensuring that the application of these limitations to MH/SUD benefits is no more stringent than for M/S benefits. Plans must provide a comprehensive explanation of operational methodologies, data collected, and outcomes observed from applying the NQTL.

6. Findings and conclusions

The analysis must conclude with findings regarding compliance with MHPAEA requirements, detailing any areas of concern or noncompliance. It should include a reasoned discussion of findings, citations for supporting information, and the qualifications of individuals involved in the analysis, along with the date of completion.

4. See https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.
5. See https://www.federalregister.gov/documents/2023/08/03/2023-15945/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.
6. See https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf.
7. DOL, Self-Compliance Tool for MHPAEA, op cit.
8. See the Final Rules at https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.

Compared to the five-step process laid out by the CAA, the six-step process required under the Final Rules combines identification of the factors (step 2 under the CAA) and evidentiary standards (step 3 under the CAA) into a single step (step 2 under the Final Rules), but more explicitly requires a discussion of how those factors and standards are used in the design and application of NQTLs as its own step (step 3 under the Final Rules). The Final Rules now also require that the demonstration of comparability and stringency previously addressed in a single step (step 4 under the CAA) be broken into separate steps for comparability as written (step 4 under the Final Rules) and in operation (step 5 under the Final Rules).

Changing waters: New requirements for collection and measurement of outcomes data

The Final Rules continue to require that plans may not impose nonquantitative treatment limitations (NQTLs) on mental health or substance use disorder benefits in any classification, "unless, under the terms of the plan, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the limitation with respect to medical/surgical benefits in the classification." This is referred to as the *no more restrictive* requirement. However, there are several material changes to how this statement is assessed. To demonstrate NQTL compliance under the Final Rules, plans must satisfy three sets of requirements, as illustrated in Figure 2.

Note that, as originally described in the proposed rules, the no more restrictive requirement included a four-pronged test that would have created mathematical tests for NQTLs similar to those currently in use for QTLs. The four-pronged test was not finalized, and instead the no more restrictive requirement is described as a general standard for NQTL compliance that can be satisfied by meeting the *design and application* and *relevant data evaluation* requirements.

The relevant data evaluation requirement represents a substantial change from prior iterations of compliance demonstration under MHPAEA. Although outcomes data could be included as part of a comparative analysis in the past, differences in outcomes were not considered (in and of themselves) to be determinative of compliance with the parity rules.[9] Instead, outcomes were viewed as potential warning signs for areas that warranted further investigation.[10]

FIGURE 2: NQTL COMPLIANCE REQUIREMENTS, 2024 FINAL RULES[11]

* The terms "predominant" and "substantially all" as used in the Final Rules with regard to NQTLs are not defined using mathematical tests as they are for QTLs. Instead, if the plan or issuer does not satisfy the design and application requirements or the relevant data evaluation requirements, then the NQTL is considered to be more restrictive than the predominant NQTL that applies to substantially all medical/surgical benefits in the classification.

9. DOL, Self-Compliance Tool for MHPAEA, op cit.

10. Ibid.

11. Ibid.

Under the new rules, relevant outcomes data must be collected and evaluated "in a manner reasonably designed to assess the impact of the NQTL on outcomes as they impact access to MH/SUD and M/S benefits."[12] Differences in relevant outcomes data may not be disregarded, and reasonable action must be taken to address material differences in outcomes between MH/SUD and medical/surgical benefits.

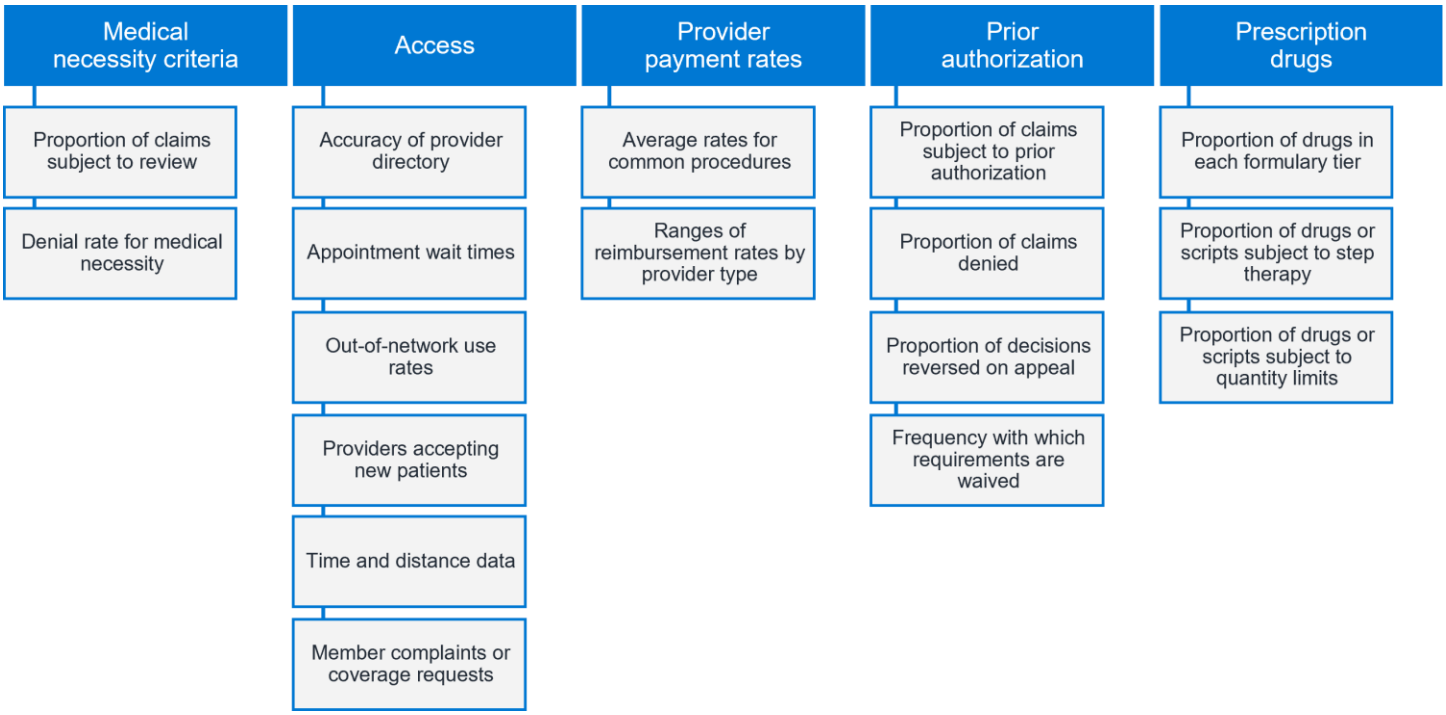
When disparate outcomes are identified, the plan or plan sponsor must first identify whether it considers such differences to be material. If the differences are considered material, then the plan or plan sponsor must determine whether those differences are related to the application of an NQTL. If the differences are found to be related to the application of an NQTL, then the plan or plan sponsor must determine whether those differences are the result of differences in the comparability or stringency with which the NQTL is applied. If so, the plan or plan sponsor must take reasonable action to resolve the differences.

The Final Rules also require consideration of the aggregate impact of all NQTLs related to network composition on access to MH/SUD benefits, rather than evaluating relevant data separately by NQTL, as is generally required for other NQTLs. Differences in access related to network composition are not automatically deemed to be a violation of MHPAEA but are viewed as a strong indicator of a violation.

If a plan or plan sponsor believes that any observed differences are not the result of an NQTL (or differences in the application of an NQTL), they must provide a reasoned justification for how they have reached this conclusion. Federal regulators may be skeptical of justifications that ascribe differences to broad market phenomena in the absence of evidence that the plan or plan sponsor has taken steps to rule out other possible factors that may be within their control.

Plans are likely collecting some outcomes data already. However, there may be other data for which plans will need to develop new data collection and/or tracking processes to satisfy the requirements. Specifically, the Final Rules emphasize data around network composition and reimbursement as components of the relevant data evaluation requirement. Specific examples of outcomes data that can reasonably be collected may include data elements listed in Figure 3.

FIGURE 3: ILLUSTRATIVE EXAMPLES OF RELEVANT OUTCOMES DATA



12. See the Final Rules at https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.

Changing waters: Broadened responsibilities and new certification requirements for fiduciaries

While most health plans and plan sponsors fall under the jurisdiction of both state and federal regulators, in practice MHPAEA enforcement has generally been handled by federal regulators (such as the DOL) for self-funded plans, and by state regulators (typically departments of insurance) for fully insured plans. Health insurance carriers generally take the lead on ensuring parity compliance for their fully insured books of business, but employer plan sponsors (that carry the responsibility of ensuring compliance for self-funded plans) may have mixed results when seeking support with MHPAEA compliance from their third-party administrators (TPAs) or other benefit administration vendors. Some vendors have taken a "hands-off" approach in order to manage their own legal liabilities, but employers often find themselves unsure how to proceed with meeting documentation requirements for processes that are not in their direct control.

The DOL expressed an understanding of this predicament in a Tri-Agency 2022 MHPAEA Report to Congress.[13] The DOL described its position that it could "greatly augment its efforts in achieving meaningful parity" if it were authorized to "pursue all appropriate actors when it encounters a violation," and recommended that Congress amend ERISA to "expressly provide the agency with the authority to directly pursue parity violations by entities that provide administrative services to ERISA plans and TPAs."[14]

FIDUCIARY RESPONSIBILITIES OF BENEFIT ADMINISTRATION VENDORS

The recent Final Rules included language describing that any fiduciary to a plan must work with plan sponsors and issuers to ensure compliance.[15] The Final Rules also clarify that TPAs (or any other service providers to a plan) that exercise "discretionary authority or discretionary responsibility" in the administration of benefits are considered to be fiduciaries.[16] Further, the Final Rules clarify that any plan sponsors that are not receiving the support that they need from their benefit administration vendors should notify the DOL directly.

Altogether, these developments have created an environment where it's less feasible for benefit administration vendors to leave employer plan sponsors on their own for ensuring parity compliance. In our experience, employer plan sponsors have been able to obtain more complete, and often better, support with evaluating their plans for compliance in recent years than was the case directly after the publication of the CAA and in earlier years. We anticipate that this trend will likely continue as the DOL acts on the broad interpretation of fiduciary responsibility outlined in the Final Rules.

FIDUCIARY CERTIFICATION REQUIREMENTS

In addition to laying out a broader interpretation of who has fiduciary responsibilities for a plan, the Final Rules also create a new requirement for a named fiduciary of the plan to certify that it has engaged in a prudent process to select one or more qualified service providers to perform and document a comparative analysis, and that it has satisfied its duty to monitor those service providers.[17]

The fiduciary certification requirement does not appear to explicitly require that the certification be produced by the employer plan sponsor and may allow for the certification to come from any of the plan's named fiduciaries (which could also include a board of trustees, a benefits committee, or other entities, depending on the plan). Additionally, this requirement does not necessitate that the analysis be completed by an independent third party and allows for analyses to be completed internally by employer plan sponsors, or externally by the plan's benefit administration vendors.

Per the preamble to the September 2024 Final Rules:

"For ERISA-covered group health plans, fiduciaries, including TPAs or other service providers who are acting as fiduciaries, must work with plan sponsors and issuers to ensure that the plans and coverage they help establish and administer comply with the law."

"The DOL also underscores its commitment to holding fiduciaries of ERISA-covered group health plans liable through existing means and working with all relevant entities, including service providers, to effectuate MHPAEA compliance."

13. See the full report at https://www.cms.gov/files/document/2022-mhpaea-report-congress.pdf.
14. Ibid.
15. See the Final Rules at https://www.federalregister.gov/documents/2024/09/23/2024-20612/requirements-related-to-the-mental-health-parity-and-addiction-equity-act.
16. Ibid.
17. Ibid.

Depending on the roles and relationships among the parties involved with the design and administration of a plan's benefits, several different combinations of parties may be able to satisfy the analysis and certification requirements. Plans that purchase relatively "off-the-shelf" benefit plans and services from a carrier that are largely similar to that carrier's fully insured business (in terms of benefit design, administration, medical management standards, network services, etc.) may reasonably expect the carrier to provide substantial support. On the other hand, plans that are self-designed, self-administered, or highly customized may need to carry more of the responsibility to complete the analysis themselves.

We recommend that employer plan sponsors consult with their legal counsel to determine the right individual(s) and/or organization(s) that should be engaged to meet these requirements, in consideration of the various roles and contributions of each party to the administration of the plan.

Other technical updates and clarifications

In addition to setting up clear guidelines around the required reporting and use of outcomes data in determining MHPAEA compliance, as well as the roles and requirements of fiduciaries, the Final Rules provide additional clarity in many other areas as well. Many of these updates or clarifications will chiefly be of interest to those that are tasked with developing or evaluating MHPAEA compliance documentation, but we have highlighted a few particularly noteworthy items in this section.

CONSISTENT DEFINITION OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Historically, health plans and plan sponsors have had leeway to use any reasonable method to define what services are classified as MH/SUD and medical/surgical benefits, provided that these determinations are made in line with generally accepted standards and comply with any relevant state or federal guidance. Although many diagnoses and services are handled consistently by most plans and plan sponsors, some diagnoses or types of services have historically been treated differently across plans (or even by different regulatory agencies).

The Final Rules significantly reduce ambiguity in this area and clarify that, instead of allowing any reasonable method, mental health benefits and substance use disorder benefits should be defined consistently with the mental, behavioral, and neurodevelopmental disorders listed in the most current versions of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). If an updated version of the ICD or DSM is adopted, then the relevant version for MHPAEA compliance is the version that is current on the first day of the plan year beginning at least one year following the publication of the updated version.

Plans using the latest version of the ICD (for example) would need to ensure that they classify conditions such as autism, eating disorders, gender dysphoria, and many developmental disorders, as well as some types of dementia, sleep disorders, or sexual disorders, as MH/SUD conditions for the purposes of evaluating MHPAEA compliance. In our experience, these conditions have been among those with the greatest variability to date in how they have been classified. On the other hand, the latest version of the ICD does not explicitly classify as MH/SUD some diagnoses that many plans have historically included, such as suicidal ideation, intentional self-harm, or poisoning and toxic effects of certain substances. In many cases, there may still be some room for interpretation depending on the clinical characteristics and information coded on insurance claims for each service, as some services involve multiple overlapping or interacting diagnoses that all contribute to the need for treatment.

MEANINGFUL BENEFITS REQUIREMENT

Since its initial passage, MHPAEA has included a requirement that any covered MH/SUD diagnosis must be covered in all the same classifications where medical/surgical diagnoses are covered (sometimes referred to as the "cover one, cover all" rule). This would mean, for example, that a plan with typical comprehensive medical and prescription drug benefits could not cover therapy for a mental health diagnosis but deny coverage of prescription drugs for the same diagnosis, or vice versa. However, the exact scope of services that was required to be covered in each classification has not been clear.

The Final Rules clarify that, if a plan provides benefits for a mental health condition or substance use disorder in one classification, then the plan must provide "meaningful benefits" for that condition in all other classifications in which medical/surgical benefits are provided. The Final Rules define meaningful benefits as "benefits for a core treatment for that condition or disorder." This highlights that the scope of covered services is expected to be similar for MH/SUD and M/S benefits when both are covered in a particular classification (e.g., outpatient, out-of-network). The Final Rules illustrate the implementation of the meaningful benefits standard in Example 5, related to autism spectrum disorder (ASD). In this example, a plan covers ASD screenings in the outpatient, out-of-network classification but excludes all other benefits in this classification, including applied behavioral analysis (ABA) therapy. Because the plan covers a range of core outpatient, out-of-network treatments for medical/surgical conditions, the plan must provide core treatments for ASD in this classification, including ABA therapy.

DISCRIMINATORY FACTORS AND EVIDENTIARY STANDARDS

The Final Rules specifically prohibit the use of discriminatory factors and evidentiary standards that are biased or not objective and that result in lower access to MH/SUD benefits. Specifically, "information, evidence, sources, or standards are considered to be biased or not objective. . . if they systematically disfavor access or are specifically designed to disfavor access to mental health and substance use disorder benefits as compared to medical/surgical benefits." Plan data or other information sourced from a period when the plan was either not subject to or not in compliance with parity requirements is also considered discriminatory.

While the Final Rules do not provide extensive examples for this requirement, this requirement could indicate (for example) that:

- Provider to population ratios used for determining network adequacy can't be set to arbitrarily low levels designed just to ensure that a plan meets those standards.
- Historical reimbursement rate data should not be used as a benchmark for evaluating the parity of current provider reimbursement rates without adjustments for historical disparities.
- Factors used in the design of prior authorization requirements that are calibrated specifically to ensure that specific behavioral health services become subject to the requirement would be impermissible.

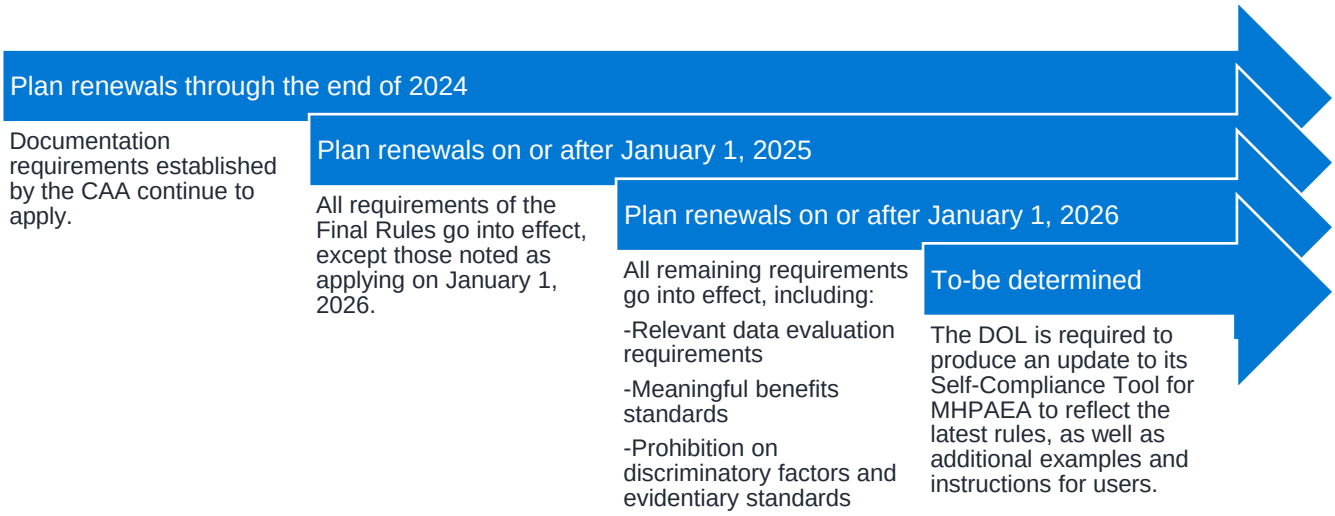
REQUIRED TIMING FOR SUBMISSION OF COMPARATIVE ANALYSES AND SUBSEQUENT RESPONSES

The Final Rules establish required timing for submission of comparative analyses and responses to subsequent requests by the DOL (though the DOL has the authority to modify these timelines). These requirements are broadly consistent with timelines previously required under the CAA.

- Plans must submit comparative analyses within 10 business days of a request and respond to subsequent requests for information within 10 business days from that request.
- If a plan is initially found to be noncompliant, it must determine and report actions that will be taken to become compliant and provide an updated comparative analysis showing this compliance within 45 calendar days of the initial determination.
- If a plan is given a final determination of noncompliance, the plan must notify enrollees of the plan within seven business days of the final determination.

Note that the Final Rules lay out detailed requirements for the contents and timing of required notifications if a plan is given a final determination of noncompliance. This includes specific information regarding who should receive such a notification (including any service providers involved), and precise verbiage that must be included prominently on the first page.

FIGURE 4: TIMELINE FOR IMPLEMENTATION OF FINAL RULES



What should plans do next?

Figure 4 illustrates the applicable timing for changes contained in the Final Rules. Because plans have only 10 business days to respond to requests for their comparative analyses—a timeframe that is typically much shorter than required to compile this work—plans should ensure that their comparative analyses and fiduciary certification(s) are completed in the near term. Additionally, while the relevant data evaluation requirements don't take effect until 2026, meeting these requirements may require establishing new processes for data collection and measurement. These processes may take time to develop and implement and should be in place long enough in advance of the requirements taking effect that sufficient data will be available for analysis.

The DOL will be revising and releasing an updated version of the 2020 MHPAEA Self-Compliance Tool, which should be useful to plans in completing the relevant data evaluation requirements.

Of course, plans should also use the legal, actuarial, and operational expertise and resources they have at their disposal to ensure all relevant stakeholders are included in the planning and execution of the comparative analysis requirements and assessment of MHPAEA compliance. We recommend the actions shown in Figure 5.

Plans or plan sponsors that need help developing a game plan or evaluating their readiness for an MHPAEA compliance inquiry should reach out to their benefits consultants, legal counsel, or other qualified service providers with MHPAEA compliance expertise for assistance to reduce the risk of receiving an inquiry before they are prepared to respond.

The DOL has communicated its prioritization of enforcement actions that it anticipates will have broad impacts, but health plans or plan sponsors of any size may find themselves receiving MHPAEA inquiries if members register complaints, or as an additional element when audits, examinations, or inquiries are initiated for other reasons. It has been our experience that regulators have generally been willing to provide technical assistance and flexibility where needed for those that have demonstrated a good faith effort to comply but are not as flexible and for those that are completely unprepared to respond.

FIGURE 5: RECOMMENDED ACTIONS FOR PLANS AND PLAN SPONSORS

1 – ASSESS	2 – DELEGATE	3 – DOCUMENT	4 – CERTIFY	5 – TROUBLESHOOT	6 – LOOK AHEAD
Plans and plan sponsors should ensure that they have a solid understanding of what NQTLs apply to any MH/SUD benefits within their plans.	For each NQTL, plans and plan sponsors should identify the individual(s) or organization(s) responsible for the design and application of the NQTL. This may include other parties that administer various components of the plan benefits.	Plans and plan sponsors should collaborate with those responsible for the design and application of each NQTL to ensure that a comparative analysis is available, and that it has been updated to reflect the latest requirements under the Final Rules.	Plans or plan sponsors should work with their legal counsel to determine what individual(s), organization(s), or combinations thereof should be responsible for ensuring that a prudent process has been followed and for producing the required fiduciary certification.	Plans or plan sponsors that are not receiving adequate support from their benefit administration vendors may consider enlisting the support of their benefit consultants, notifying the DOL, and/or conditioning future contract renewals on the receipt of adequate support.	Plans or plan sponsors should determine what outcomes data will be necessary to fulfill the relevant data evaluation requirements and begin making any operational changes necessary to ensure adequate collection and analysis of the data.

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Katie Matthews
katie.matthews@milliman.com

T.J. Gray
travis.gray@milliman.com

Stoddard Davenport
stoddard.davenport@milliman.com