

Proposed Updates to 2020 MHPAEA Self-Compliance Tool:

Request for Comments

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally requires that the financial requirements and treatment limitations imposed by a group health plan or health insurance issuer on mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical and surgical benefits. The MHPAEA Self-Compliance Tool is published by the Department of Labor (DOL) to help group health plans' sponsors and administrators, group and individual market health insurance issuers, State regulators, and other stakeholders determine whether a group health plan or health insurance issuer is in compliance with MHPAEA and its implementing regulations.

Section 13001(a) of the 21st Century Cures Act added section 2726(a)(6) of the Public Health Service Act, which directs DOL, the Department of Health and Human Services (HHS), and the Department of the Treasury (the Departments) to provide a publicly available compliance program guidance document which is updated every two years. DOL last updated the MHPAEA self-compliance tool in April 2018.

I. Revisions Included in the Proposed 2020 MHPAEA Self-Compliance Tool

Since the tool's 2018 update, DOL issued additional guidance on MHPAEA, hosted a roundtable discussion with stakeholders on MHPAEA compliance, and continued its enforcement efforts. In addition, DOL frequently coordinated with other Federal and State agencies and State insurance regulators to ensure consistent interpretation of MHPAEA, provision of education, and improved enforcement of parity requirements. In coordination with the Departments of HHS and the Treasury, DOL is proposing to issue this updated 2020 MHPAEA Self-Compliance Tool with certain amendments. The amendments, highlighted in yellow throughout the document, generally fall into four main categories:

1. *Integration of Recent Guidance*: Since 2018, the Departments have published Final Frequently Asked Questions (FAQs) part 39 on the implementation of MHPAEA. Including the relevant guidance from these FAQs will help to better ensure the regulated community is aware of their content.
2. *Revising Compliance Examples*: The 21st Century Cures Act emphasizes the need for more examples of how to comply with the law. To meet this need, the proposed 2020 update revises examples of non-compliance in the 2018 version of the tool to add an explanation of how plans and issuers could correct these violations, and also includes an appendix with additional examples of compliance.
3. *Best Practices for Establishing an Internal Compliance Plan*: Although not required by MHPAEA, an internal compliance strategy that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans may differ, but many successful compliance plans share similar characteristics which are noted in the proposed 2020 update. The

updated tool also includes examples of the types of records that a plan or issuer should be prepared to provide in the event of a DOL investigation.

4. *Warning Signs*: DOL has previously issued guidance, based on previous investigations, on “warning signs.” These are not determinative of a MHPAEA violation but may serve as red flags to possible impermissible treatment limitations, warranting further review. In the 2020 proposed update, DOL has incorporated additional examples of treatment limitations encountered in recent Federal and State enforcement efforts that may be warning signs of a potential violation.

II. Request for Comments

DOL requests comments on these updates, marked in yellow, to the proposed 2020 MHPAEA Self-Compliance Tool. DOL is not requesting comments on other sections of the MHPAEA Self-Compliance Tool at this time. Public comments should be submitted by July 24, 2020, to ehpsca-MHPAEA-SCT-2020@dol.gov. After considering the feedback received through this solicitation, DOL will issue a Final 2020 MHPAEA Self-Compliance Tool with any necessary clarifications in response to comments.

Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)

About This Tool.....	4
Introduction.....	5
Definitions.....	6
SECTION A. APPLICABILITY.....	8
SECTION B. COVERAGE IN ALL CLASSIFICATIONS.....	10
SECTION C. LIFETIME AND ANNUAL LIMITS.....	15
SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS.....	16
SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.....	20
SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS.....	21
SECTION G. DISCLOSURE REQUIREMENTS.....	30
SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN.....	34
APPENDIX I: ADDITIONAL ILLUSTRATIONS.....	36
APPENDIX II: TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE.....	39

About This Tool

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, State regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a Federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many States have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should check with their State regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are also included in the Appendix.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Report at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity>.

Introduction

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for mental health or substance use disorder benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over non-Federal governmental group health plans, such as those sponsored by State and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers in States that have notified HHS's Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the State is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which includes, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provide MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

Definitions

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but not including mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

NOTE: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of medical/surgical treatments in the same classification). See *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q1*, available at

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

SECTION A. APPLICABILITY

Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).

Comments:

If a group health plan or group or individual health insurance coverage provides either mental health or substance use disorder benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-Federal governmental plans that have elected to exempt the plan from MHPAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (*Note*: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e)*).

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1)*. However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3)*; *See also ACA Implementation FAQs Part XVII, Q6, available at: <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf>*. In practice, this means that individuals in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market will have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g)*.

Sponsors of self-funded, non-Federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a “HIPAA opt-out.” The HIPAA opt-out election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). **The procedures and requirements for**

non-Federal governmental plans to opt out may be found at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Self-Funded%20Non-Federal%20Governmental%20Plans>.

Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?

Comments:

Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS

Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?

Comments:

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications* of benefits are:

- 1) inpatient, in-network;
- 2) inpatient, out-of-network;
- 3) outpatient, in-network;
- 4) outpatient, out-of-network;
- 5) emergency care; and
- 6) prescription drugs.

See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

**See special rules related to the classifications discussed below.*

NOTE: If a plan or coverage excludes all other benefits for a particular mental health condition or substance use disorder, but nevertheless covers formulary prescription drugs for that condition or disorder, the plan would be covering mental health or substance use benefits in one classification (prescription drugs). Therefore, the plan would be required to provide mental health or substance use benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits.

ILLUSTRATION: A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

NOTE: If a plan covers room and board for inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, both of which the plan classifies as inpatient care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction based on facility type - a treatment limitation - only on MH/SUD benefits and therefore violates MHPAEA.¹ The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

Medication Assisted Treatment (MAT) is subject to MHPAEA

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that medication for the treatment of opioid use disorder be contingent upon availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally be not be permissible in the absence of a comparable process to determine limitations for the treatment of medical/surgical conditions.

ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs, and developed medical-necessity criteria that mirrors Federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment

¹ See 29 CFR 2590.712(c)(iii) Ex. 9.

improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards are comparable for both MH/SUD and medical/surgical conditions.

Treatment for eating disorders is subject to MHPAEA

Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. See *ACA Implementation FAQs Part 38, Q1*, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf>. Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with the requirements under MHPAEA. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside a hospital setting for eating disorders would generally not be permissible if the plan did not impose a similar limitation on treatment outside hospital settings for medical/surgical benefits. See *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.

Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. See *26 CFR 54.9812-1(c)(2)(ii)(C)*, *29 CFR 2590.712(c)(2)(ii)(C)*, *45 CFR 146.136(c)(2)(ii)(C) Example 1*.
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

***NOTE: Special rules related to classifications**

1. Special rule for outpatient sub-classifications:

- For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii); 29 CFR 2590.712(c)(3)(iii) 45 CFR 146.136(c)(3)(iii).*
- After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (i.e., office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), and 45 CFR 146.136(c)(3)(iii).*
- Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

2. Special rule for prescription drug benefits:

- There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

3. Special rule for multiple network tiers:

- There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD

benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/ surgical benefits in the tier.

NOTE: As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

SECTION C. LIFETIME AND ANNUAL LIMITS

Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

Comments:

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

ILLUSTRATION: Plan Z limits outpatient substance use disorder treatments to a maximum of \$1,000,000 per calendar year. With the exception of a \$500,000 per year limit on chiropractic services, (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

Compliance Tip

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6**. A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

NOTE: These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits only apply to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2020 the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is \$8,150 for self-only coverage and \$16,300 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4), this updated amount is detailed each year in regulations issued by the Department of Health and Human Services.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

Comments:

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
 - Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
 - Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

Compliance Tips

- Ensure that the plan or issuer does not impose cost-sharing requirements or QTLs that are applicable only to mental health/substance use disorder benefits.
- Identify all benefit packages and health insurance coverage to which parity applies.

Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a \$15 copayment for self-only and a \$20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE (“substantially all” test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.
 - Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*
- **STEP TWO (“predominant” test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (*Note:* If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)
 - Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Compliance Tip: Book of Business

- When performing the “substantially all” and “predominant” tests for financial requirements and QTLs, basing the analysis on an issuer’s entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. See *ACA Implementation FAQs Part 34, Q3*, available at <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>.

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification.**

Based on its prior claims experience, Plan Z expects \$1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and \$700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is \$700,000, is at least 2/3 of the \$1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.

2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

In the outpatient, in-network classification where \$1 million in medical/surgical benefits is expected to be paid, \$700,000 of those benefits are expected to be subject to copayments. Out of the \$700,000, Plan Z expects that 25% will be subject to a \$15 copayment and 75% will be subject to a \$30 copayment. Since 75% is more than half, the \$30 copayment is the predominant level.

CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than \$30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification, but applies a specialist copayment only for certain

medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review.

Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. See *26 CFR 54.9812-1(c)(3)*, *29 CFR 2590.712(c)(3)*.

SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

Comments:

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual \$250 deductible on medical/surgical benefits in a classification and a separate \$250 deductible on MH/SUD benefits in the same classification.
- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*
- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

ILLUSTRATION: A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. **The plan could come into compliance by removing the day and visit limits for mental health services.**

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

Comments:

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as “fail-first” policies or “step therapy” protocols);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see *Warning Signs*, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii)*. Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

NOTE – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, and market need or availability (demand) must be applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

NOTE - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and to ensure reasonable patient wait times for appointments by adjusting provider admission standards through increased reimbursement rates and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with the requirements of MHPAEA, plans and issuers must take measures that are comparable and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network *See FAQs Part 39, Q6 and Q7, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.*

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or around Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE in Appendix II.
2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:

Step One:

- Identify the NQTL.

Comments:

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

Compliance Tips

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (e.g., outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (e.g., prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

Step Two:

- Identify the factors considered in the design of the NQTL.

Comments:

Examples of factors include but are not limited to:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for services.

Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, **including the specific data used in the determination (if any).**

Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments:

Examples of sources of factors include, but are not limited to:

- Internal claims analysis;
- Medical expert reviews;
- State and Federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

NOTE: Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and has legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices due to high cost and legitimate safety concerns to impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should describe the experts' qualifications and whether the expert evaluations in setting recommendations for both MH/SUD and medical/surgical conditions are comparable.

NOTE: When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider:

- What data are used to determine the benefit is “high cost?”
- How, if at all, is the amount that is to be considered “high cost” different for MH/SUD benefit as compared to medical/surgical benefits, and what is used to justify this difference?

Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent

of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Step Four:

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Comments:

Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently on MH/SUD services and medical/surgical services.

Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

Examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are comparable.

- Summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits.

Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.
- Check sample claims to see how an NQTL operates in practice. A plan may have written processes that are compliant, yet not follow these processes in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance. For example, if a plan has a 34% denial rate on concurrent reviews of psychiatric hospital stays in a 12 month period and a 5% denial rate on concurrent review for medical hospital stays in that same 12 month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

Warning Signs: The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder:* A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.
2. *Denying all drug screening tests for those with SUD:* A plan or issuer denies all claims for drug screening tests for participants and beneficiaries with a sole diagnosis of addiction because they are treated as not medically necessary. However, the plan or issuer covers drug screening tests when the diagnosis is a medical/surgical condition.

3. *Different medical necessity review requirements:* A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical care.

Compliance Tip

- **Do not focus on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits?

SECTION G. DISCLOSURE REQUIREMENTS

Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?

Comments:

- The plan administrator (or the health insurance issuer) must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

- Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including mental health/substance use disorder) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representative) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*
- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*
- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to \$110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

Compliance Tips

- The reason for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

Make Showing Compliance Simple

Documents or Plan Instruments Participants and Beneficiaries or DOL may request:

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA and copies must be furnished within 30 days of request. This may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL is in compliance with MHPAEA. For example, participants and beneficiaries may ask for:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year in a classification or its basis for calculating claims expected to be subject to a certain type of QTL in the current plan year in a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests.
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (in- or out-of-network, in- or outpatient). These might include references to specific plan documents, for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the Plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;
- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Pull a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf>). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.
- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with parity, therefore vendors and carve out providers should provide documentation of the necessary information to the plan to ensure that all combination of benefits comport with parity.

NOTE: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision or other applicable Federal or State law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan may be complying with MHPAEA, but failing to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with the plan documents. *Cf. Wit v. United Behavioral Health*, No. C-14-2346 JCS (N.D. Cal. Feb. 28, 2019). Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

ERISA-covered plans must provide an SPD that describes provisions related to the use of network providers, and the composition of the provider network. The list of providers may be distributed as a separate document and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). 29 CFR 2520.102-3; See also *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10*, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.

SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

- 1. Conducting effective training and education.** Successful compliance programs provide training and education to the individuals responsible for ensuring parity compliance, including those who are responsible for making decisions related to MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be given to participants and beneficiaries to inform them of their rights under MHPAEA.²
- 2. Ensuring retention of records and information systems.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.
- 3. Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor and conduct an internal review for potential non-compliance and identification of problem areas with MHPAEA and audit samples of adverse benefit determinations, to assess the application of medical necessity criteria, the level of detail provided to claimants, and correctness of determinations. Plans and issuers may wish to initiate an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and elevating their complaints of noncompliance.
- 4. Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct these violations promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at 866-444-3272.

If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

- 1. Plan materials related to the plan's compliance with MHPAEA, including;**
 - a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.**
 - b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law. Such records may also be helpful to plans and issuers in**

² See <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>

responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.

- c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer relied upon as the basis for its compliance with the requirement that any NQTL applicable to MH/SUD benefits was comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits and medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.
- d) A sample of covered and denied mental health and substance use disorder benefit claims, as well as medical/surgical claims.
- e) Any applicable mental health parity testing completed by the plan or the issuer for financial requirements or quantitative treatment limitations applied to MH/SUD benefits.

The National Association of Insurance Commissioners (NAIC) has developed a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart, to assist issuers in listing and comparing MH/SUD NQTLs to medical/surgical NQTLs. Plans and issuers may wish to use this chart to collect information on the NQTLs imposed on medical/surgical and MH/SUD benefits and to identify some basic information on their factors, sources, and comparability. This chart may allow plans and issuers to focus further review on NQTLs where potentially noncompliant disparities appear. The chart is available at https://www.naic.org/meetings1904/d_cmte.pdf (see page 14 of the pdf).

APPENDIX I: ADDITIONAL ILLUSTRATIONS

ILLUSTRATION 1: A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to, the conditions for which testing is covered and those for which it is excluded.

ILLUSTRATION 2: A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

Conclusion: In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

ILLUSTRATION 3: A Plan classifies care in skilled nursing facilities or rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

Conclusion: In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

ILLUSTRATION 4: Master's degree training and state licensing requirements often vary among provider types. The Plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable State related to supervised clinical experience requirements in order to participate in the network. Therefore, the Plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

Conclusion: The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose State licensing does not require this experience.

ILLUSTRATION 5: A patient with chronic depression has not responded to five different anti-depressant medications and therefore, was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment for either medical or behavioral conditions to be covered by the plan. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

Conclusion: The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

ILLUSTRATION 6: A plan imposes prior authorization on both MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization on the basis of findings that physical therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and

authorization determinations are provided verbally and in writing consistent with federal and state timeline requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with Jones and Smith Guidelines. Denial determinations are made by physicians with consultation from a licensed physical therapist.

Psychological testing requires prior authorization. Psychological testing was selected for prior authorization on the basis of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found psychological testing claims often were in error because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided in writing consistent with federal and state timeline requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested, and range from 2 to 5 hours for an average evaluation (on the basis of the average number of hours for evaluation conducted nationally for the last 3 years). Denial determinations are made by licensed psychologists with at least 5 years of experience in psychological testing.

Conclusion: In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

APPENDIX II: TOOL FOR COMPARING PLAN REIMBURSEMENT RATES TO MEDICARE

Specialty	CPT Code	Plan rate for [insert locality]	Comments	Medicare rate for [insert locality]	Percentage of Medicare
Orthopedic Surgery	99203 99213	\$ xx.xx \$		\$ xx.xx \$	xx.x%
Cardiologists	99203 99213	\$ \$		\$ \$	
Internists MD	99203 99213	\$ \$		\$ \$	
Endocrinologists	99203 99213	\$ \$		\$ \$	
Gastroenterologist	99203 99213	\$ \$		\$ \$	
Neurologists	99203 99213	\$ \$		\$ \$	
Pediatrician	99203 99213	\$ \$		\$ \$	
Dermatologists	99203 99213	\$ \$		\$ \$	
Psychiatrists	99203 99213	\$ \$		\$ \$	
Psychologists	90832 90791	\$ \$	Based on 1 hour Based on ½ hour	\$ \$	
LCSW	90832 90791	\$ \$	Based on 1 hour Based on ½ hour	\$ \$	
Podiatrists	99203 99213	\$ \$		\$ \$	
Chiropractor	99203 99213	\$ \$		\$ \$	
Occupational Therapy	97003 97004	\$ \$		\$ \$	
Physical Therapy	97001 97002	\$ \$		\$ \$	

Specialty	CPT Code	Plan rate for [insert locality]	Comments	Medicare rate for [insert locality]	Percentage of Medicare
Speech Therapy			Initial Office Visit Codes do not exist. Codes for ST each represent a very specific type of test or follow up to rehab.		