

The Essential Aspects of Parity: A Training Tool for Policymakers



SAMHSA
Substance Abuse and Mental Health
Services Administration

THE ESSENTIAL ASPECTS OF PARITY: A TRAINING TOOL FOR POLICYMAKERS

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Disclaimer

This document is a joint product of the Departments of the Treasury (Treasury), Labor (DOL), and HHS, (collectively the Departments). It is intended to give a basic understanding of certain requirements related to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and claims and appeals procedures under the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (the Code). The statute, regulations, and other guidance issued by the Departments should be consulted.

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Purpose

This document provides an overview of essential information necessary for understanding mental health and substance use disorder parity (parity) and how to implement and comply with federal parity laws. This guide applies to the application of parity laws to employer-sponsored health plans and group and individual health insurance. While some of the material in this guide refers to the application of parity to Medicaid and the Children's Health Insurance Program (CHIP), this guide does not provide detail on this subject. For more information on the application of parity to Medicaid and CHIP, please contact the lead Medicaid agency in your state or the Center for Medicaid and CHIP Services (CMCS) at the Centers for Medicare & Medicaid Services (CMS).

The U.S. Department of Health and Human Services (HHS), U.S. Department of Labor (DOL), and U.S. Department of Treasury (the Treasury) (collectively the Departments) have produced numerous detailed materials¹ regarding the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) in conjunction with other federal laws.

In 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) hosted a Commercial Parity Policy Academy. Participants from agencies in various states indicated that in addition to conducting education for consumers and other outside stakeholders, they also need to conduct education and training for state staff working on parity. Due to staff turnover and, in some cases, limited state budgets and resources, they need readily accessible resources to use in this type of education and training.

This document serves as a targeted reference document for state insurance regulators and behavioral health staff to develop a better understanding of parity and undertake efforts to improve compliance with parity laws.

Disclaimer: This document is not meant to be considered legal advice and does not represent the official position of the Departments of HHS, DOL, and the Treasury. This document is intended to provide a basic understanding of certain requirements related to MHPAEA and claims and appeals requirements under the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act (ERISA), and the Internal Revenue Code (the Code). This document, and links included, should not be used as a substitute for reading and understanding the statute, regulations, and guidance for MHPAEA and related laws. The applicable statutes, regulations, and other guidance issued by the Departments should be consulted. Further information is available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

INTRODUCTION TO PARITY

This section:

- introduces the concept of mental health and substance use disorder parity;
- explains what parity laws do and do not cover;
- reviews the legal background and types of plans and insurance to which parity requirements apply;
- and provides an overview of compliance and enforcement responsibilities.

Definition of Parity Under Federal Laws and Regulations

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) supplemented the Mental Health Parity Act of 1996 (MHPA), which ensured that annual and lifetime dollar limits on mental health benefits were no more restrictive than those imposed on medical/surgical (also known as physical health) benefits. Generally, MHPAEA requires that the financial requirements (such as deductibles, copayments, or coinsurance) and treatment limitations imposed 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. Treatment limitations include quantitative treatment limitations (QTLs), such as annual or lifetime day or visit limits, which are numeric. Treatment limitations also may be nonquantitative (nonquantitative treatment limitations (NQTLs)); examples include preauthorization requirements and medical necessity reviews, which may restrict the scope and duration of benefits for treatment.

Types of Benefit Limitations Barred or Restricted by Parity Laws and Regulations

Federal laws and regulations generally categorize benefits limitations into four categories: financial requirements, dollar limits, QTLs, and NQTLs. The regulations (Final Rules) implementing MHPAEA and the Patient Protection and Affordable Care Act (ACA) provide the following examples:

CATEGORY	EXAMPLES (NON-EXHAUSTIVE LIST)
Financial requirements	Deductibles, co-payments, coinsurance, and out-of-pocket maximums ²
Dollar limits	Aggregate lifetime dollar limits and annual dollar limits ³
Quantitative treatment limitations	Limits on the frequency of treatment, number of visits, days of coverage, and days in a waiting period, including annual, episode, and lifetime day and visit limits ⁴
Non-quantitative treatment limitations	Formulary design for prescription drugs; network tier design; standards for provider admission to participate in a network, including reimbursement rates; and fail-first policies ⁵

Dollar limits are defined as limitations on the total amount of benefits paid by a plan for either a year or the entire time a person is covered by the plan. Financial requirements and dollar limits also differ in that financial requirements refer to cost-sharing by the insured, while dollar limits refer to spending by the plan or insurer. As the Final Rules make clear, “Financial requirements do not include aggregate lifetime or annual dollar limits,”⁶ because these two terms are excluded from the meaning of financial requirements. QTLs and NQTLs both refer to mechanisms by which plans or insurers limit access to services. However, QTLs set numerical limits on frequency, duration, or quantity, while NQTLs limit treatment in other ways, such as requiring further review or approval for certain services, service providers, medications, etc., or encouraging use of certain items and services over others.

Further, with respect to NQTLs, parity requirements refer to processes and standards, not results. Disparate results alone, the Final Rules make clear, are not conclusive evidence of non-compliance.⁷ For example, provider reimbursement rates for behavioral health providers may be lower than those for medical surgical providers, based on factors “such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers,” so long as the factors are applied to mental health and substance use disorder

services are “applied comparably to and no more stringently than those applied with respect to medical/surgical services.”⁸ However, plans cannot impose an NQTL on mental health or substance use disorder services without a comparable NQTL on medical/surgical services in the same classification.⁹ An unconditional exclusion of all benefits for a condition or disorder is not an NQTL but any exclusions applying to mental health or substance use disorder benefits must be comparable to those existing for other conditions.¹⁰

Federal parity protections also include “disclosure provisions requiring that the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment under a group health plan (or health insurance coverage) with respect to mental health or substance use disorder benefits be made available upon request in certain circumstances.”¹¹ These disclosure provisions are also described in detail below.

Applicability of Parity Requirements Under Federal Laws and Regulations

It is important to understand which group health plans and health insurance issuers are covered under parity laws and regulations. Some states have their own parity laws, which are not covered in this document.

The following table¹² provides a historical overview of federal parity laws and regulations. The laws described below have amended the PHS Act, ERISA, and the Code, and it should be noted that descriptions refer to historical events, rather than the current state of the law. Further, the ACA extended MHPAEA’s parity requirements. DOL, HHS, and the Treasury have issued regulations relating to these laws. The Centers for Medicare and Medicaid Services (CMS) within HHS, the Employee Benefits Security Administration (EBSA) within DOL, and the Internal Revenue Service (IRS) within the Treasury are involved in implementing parity.

HISTORICAL OVERVIEW OF FEDERAL PARITY LAWS AND REGULATIONS

TIME	POLICY	APPLICABILITY	DESCRIPTION
1996	Mental Health Parity Act (MHPA)	Large employer- sponsored group health plans and their health insurance issuers	MHPA is enacted, requiring comparable annual and lifetime dollar limits on mental health and medical coverage in large employer- sponsored group health plans and their health insurance issuers (small employers with 50 or fewer employees are exempted).
1999	Direction by President Clinton	Federal Employees Health Benefits Program (FEHBP)	President Clinton directs the Office of Personnel Management to implement parity in FEHBP following White House Conference on Mental Health” (https://www.chcoc.gov/content/mental-health-and-substance-abuse-parity-implementation-federal-employees-health-benefits).
2008	MHPAEA	Large employer- sponsored plans and their health insurance issuers	MHPAEA is signed into law and applies to large employer-sponsored plans (exempting small employers with 50 or fewer employees) and their health insurance issuers. It is effective for most plans and issuers starting in 2010 and includes parity with respect to substance use disorders for the first time.
2008	Medicare Improvements for Patients and Providers Act (MIPPA)	Medicare Part B	MIPPA is enacted, including a provision to phase out a statutory provision requiring a higher co-pay for outpatient mental health and substance use disorder services in Medicare Part B.
2009	Children’s Health Insurance Program (CHIP) Reauthorization Act	CHIP	CHIP Reauthorization Act is enacted, requiring parity in CHIP plans.
2009	State Health Official letter	CHIP	CMS releases State Health Official letter to provide additional guidance on MHPAEA application to CHIP.
2010	MHPAEA Interim Final Rules		Interim final rules are issued to implement MHPAEA, applicable for group health plans and health insurance issuers for plan years beginning on or after July 1, 2010.

2010	ACA	Individual health insurance coverage including qualified health plans offered through exchanges; small group health insurance coverage	ACA extends parity protections to individual health insurance, including qualified health plans offered through exchanges. In addition, the law requires coverage of mental health and substance use disorder treatment services as a category of Essential Health Benefits, guaranteeing coverage for consumers enrolled in individual and small group market plans.
2013	MHPAEA Final Rules	Group health plans and group and individual health insurance issuers	Final rules are issued to implement MHPAEA, applicable for group health plans and group and individual health insurance issuers for plan years beginning on or after July 1, 2014.
2014	Final Rules on Essential Health Benefits (EHBs)	Individual and non-grandfathered small- group health insurance plans	Final rules on EHBs are issued, implementing mental health and substance use disorder services as a category of EHB and extending MHPAEA requirements to non-grandfathered small group insurance plans starting in January 2014. (Grandfathered insurance plans are group health plans that existed at the time ACA was enacted and may make only those changes allowed under federal regulations.)
2014	Final Rules on Alternative Benefit Plans	Medicaid Alternative Benefit Plans (ABPs)	Final rules on ABPs are issued providing further guidance regarding MHPAEA's application to EHBs in this Medicaid program.
2013	Medicaid State Health Officials letter	Medicaid managed care organizations, CHIP	Medicaid State Health Officials letter is published providing guidance on the application of MHPAEA to Medicaid managed care organizations, Medicaid ABPs, and CHIP.
2016	TRICARE Final Rule	TRICARE	TRICARE issues a proposed and a final rule that requires equivalent cost-sharing between medical-surgical and behavioral health care and eliminates treatment limits for mental health and substance use disorder care. Tricare is a health program for uniformed services members, retirees and family members. https://www.tricare.mil/About
2016	Final Regulations	Medicaid managed care organizations, ABPs, and CHIP	Final regulations are issued on parity in Medicaid managed care organizations, Medicaid ABPs, and CHIP, with an October 2, 2017, compliance deadline.
2016	21st Century Cures Act (Public Law 114-255)	Medicaid programs	The Act creates an Assistant Secretary for Mental Health and Substance Use, creates opportunities for Medicaid-sponsored community demonstration projects to improve care for mental illness for adults and children, and creates a coordinating committee to evaluate federal programs related to serious mental illness (SMI) and provide recommendations to better coordinate mental health services for people with SMI. The Act also required DOL, HHS and the Treasury to provide additional guidance on parity and report on their enforcement efforts.
2020	Consolidated Appropriations Act (CAA)	Health plans	The CAA requires group health plans and health insurance issuers to perform and document a comparative analysis of the design and application of NQTLs. The comparative analysis must be made available to state and federal authorities upon request. The Departments must request the analysis for potential violations of or complaints about the NQTL requirements of MHPAEA and in any case at least 20 Comparative analyses per year. The CAA also requires the Departments to annually report to Congress and the public findings regarding compliance of the analyses that they have requested and reviewed.

The following table, adapted from DOL's 2016 mental health and substance use disorder report to Congress,¹³ summarizes the impact of the laws and regulations described above on various types of individual and group health insurance plans.

IMPACT OF LAW AND REGULATIONS ON HEALTH INSURANCE PLANS

MARKET	DO MHPAEA AND/OR ERISA REQUIREMENTS APPLY
1. ERISA-governed self-insured health benefit plans	Yes, MHPAEA and ERISA requirements apply; cost exemptions may apply; and size exemptions would apply in the case of small ERISA plans (fewer than 50 employees) that self-insure.
2. ERISA-governed fully-insured group health benefit plans	Yes, MHPAEA, state law, or PHS Act (in the case of federal fallback) apply to the insurer, and ERISA requirements apply to the plan; employer size and cost exemptions may apply (but see #3).
3. State-regulated small group and individual insurance	Yes, MHPAEA standards extend to both the small group and individual health insurance markets through ACA provisions and EHB requirements.
4. Medicaid fee-for-service (FFS)	No, CMS Medicaid standards apply (for Medicaid beneficiaries served only under FFS plans). ¹⁴
5. Medicaid managed care	Yes, CMS Medicaid managed care standards apply.
6. Medicaid benchmark plans	Yes, CMS benchmark standards apply.
7. Separately administered CHIP plans	Yes, MHPAEA standards apply regardless of delivery system.
8. Medicare FFS market	No, CMS Medicare standards apply.
9. Medicare Advantage	No, CMS Medicare standards apply.
10. Issuers participating in state health insurance exchanges	Yes, MHPAEA standards apply.
11. FEHBP	Carriers in the FEHBP Program must comply with MHPAEA.
12. TRICARE	No, but TRICARE parity standards apply.
13. Church plans	Yes, although church plans are exempt from ERISA requirements, PHS Act standards would apply to insured products unless churches have a state exemption.
14. Self-insured and fully insured Non-federal public employee health benefit plans	Yes, covered by the MHPAEA's PHS Act provisions, but plan sponsors of self-insured plans may opt out.

The following exemptions from parity requirements apply:

EXEMPTION	DESCRIPTION
Self-insured state and local government employee plans that opt out. ¹⁵	Plans for state and local government employees that are self-insured may opt out of MHPAEA's requirements if certain administrative steps are taken.
Self-insured small employers with 50 or fewer employees ¹⁶	MHPAEA does not apply to self-insured small private employers.
Retiree-only plans ¹⁷	MHPAEA does not apply to retiree-only plans.
Plans experiencing increased costs and claiming exemption ¹⁸	MHPAEA contains an increased-cost exemption available to plans that meet the requirements for the exemption. The final rules establish standards and procedures for claiming an increased-cost exemption under MHPAEA.

Note that group plans and issuers that are exempt from some parity requirements may nevertheless be required to disclose information related to the denial of mental health or substance use disorder claims.¹⁹

Compliance and Enforcement

States and the federal government share enforcement authority, depending on the type of plan. As described below, HHS, DOL, the IRS, and state insurance commissioners may have primary or secondary authority.

Types of Plan

Individual Plans, and Fully Insured Small Group and Large Group Plans

State insurance commissioners oversee individual and employer-sponsored, fully insured insurance coverage. (Under a ‘fully insured’ plan, enrollees or employers pay premiums to an insurance company that must pay for the cost of covered health care services.) HHS has secondary authority. However, the following states have determined that their insurance commissioner lacks the authority under their current state laws to enforce MHPAEA: Missouri, Oklahoma, Texas, and Wyoming. In these states, HHS exercises enforcement authority.²⁰

Self-Funded Plans

As a fact sheet produced by DOL’s EBSA notes: “DOL and the IRS generally have enforcement authority over [self-funded] private sector employment-based plans that are subject to ERISA.”²¹ “A ‘self-funded’ or ‘self-insured’ plan is one where the employer sets aside funds to pay for the full cost of employees’ health care. These plans typically hire an insurance company or third-party administrator to perform claims processing.”²²

Non-Federal Governmental Plans

The law treats group plans maintained by local and state government differently from plans maintained by other employers: “HHS has direct enforcement authority with respect to non-Federal governmental plans.”²³

Obtaining Assistance

Employees (or their dependents) of private employers with questions about the MHPAEA or complaints about compliance by their employment-based group health plans are encouraged to contact the DOL. However, inquiries can be directed to DOL, HHS, or the IRS. The Departments work together and, to the extent an insurer is involved, will work with the states, as appropriate, to ensure parity violations are corrected.²⁴ Individuals can also contact state insurance departments about insurance plans over which states have enforcement authority. Some state laws provide even stronger consumer protections than the federal parity requirements. In those cases, MHPAEA permits the state to enforce the law’s stricter requirements, generally through the state’s insurance commissioner.²⁵

Importance of Compliance Activities

HHS, DOL, and the IRS have described the positive consequences of ensuring that group health plans and health insurance issuers comply with parity laws and regulations. The Final Rules implementing MHPAEA state that these consequences include prevention of bankruptcies, prevention of disability, and improvement of productivity:

Improving coverage in the small group and individual markets will also expand financial protection for a significant segment of those covered and soon to be covered by private health insurance. One indicator of the consequences of unprotected financial risk is bankruptcies. The literature on bankruptcies identifies mental health care as a source of high spending that is less protected than other areas of health care. One estimate is that about 17 percent of bankruptcies are due to health care bills. Another estimate using the same data is that about ten percent of medical bankruptcies are attributable to high mental health care costs, and an additional two to three percent of bankruptcies are attributable to drug and alcohol abuse. Improvements in coverage of mental health and substance use disorder services since MHPAEA has reduced some of the financial risk and also yielded successful treatment for people with mental health or substance use disorder problems.

Earlier entry into treatment may have a salutary impact on entry into disability programs. Of the 8.6 million disabled workers receiving Social Security Disability Insurance benefits, 28 percent are identified as having a disability related to mental disorders, not including intellectual disability. Mental disorders are the second largest diagnostic category among awards to disabled workers, after conditions associated with the musculoskeletal system and connective tissue (29 percent) but ahead of those related to the circulatory system (8.5 percent).

Improving coverage of mental health and substance use disorder treatment could also more generally improve productivity and improve earnings among those with these conditions. Studies have shown the high prevalence of depression causes \$31 billion to \$51 billion annually in lost productivity in the United States. More days of work loss and work impairment are caused by mental illness than by various other chronic conditions, including diabetes and lower back pain. A recent meta-analysis of randomized studies that examined the impact of treating depression on labor market outcomes showed that while the labor supply effects were smaller than the impact on clinical symptoms,

there were consistently significant and positive effects of treatment on labor supply. Although the expected impact of MHPAEA on labor supply is likely modest for large employers, it is probably considerably larger for small group and individual plans where pre-MHPAEA coverage was more limited than in the large group market.²⁶

Interaction With State Law

The Final Rules state: “MHPAEA requirements are not to be ‘construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement’ of MHPAEA and other applicable provisions. To the extent the State law mandates that an issuer provide some coverage for any mental health condition or substance use disorder, benefits for that condition or disorder must be provided in parity with medical/surgical benefits under MHPAEA.”²⁷ In other words, state laws can strengthen parity protections but not weaken them.

Excluding coverage for a specific disorder (such as gambling addiction) or categories of disorders (such as eating disorders) is not specifically prohibited by MHPAEA. However, as the Final Rules explain, “Other Federal and State laws may prohibit the exclusion of particular disorders from coverage where applicable, such as the Americans with Disabilities Act. Other Federal and State laws may also require coverage of mental health or substance use disorder benefits, including the EHB requirements under section 2707 of the PHS Act and section 1302(a) of the Affordable Care Act.”²⁸

IMPORTANT CONCEPTS

Ensuring that group health plans and health insurance issuers comply with parity requirements requires a thorough understanding of fundamental concepts that include:

- benefits classifications and sub-classifications;
- types of parity requirements;
- relevant tests for determining compliance; and
- disclosure provisions and when they apply.

Benefits Classifications and Sub-Classifications

Evaluating compliance with MHPAEA requires performing separate analyses within six benefits classifications established by the regulations. Plans or insurers may choose to establish a limited number of sub-classifications or tiers as defined in the regulation (i.e., office visits or non-office visits), to which separate parity analyses are applied instead of to the entire classification.

The Six Benefits Classifications

As noted earlier, the MHPAEA regulations divide benefits into six classifications, listed in the table below. If a plan or health insurance coverage includes mental health or substance use disorder benefits, these benefits must be provided in all classifications in which medical/surgical benefits are provided.

Per the Final Rules, mental health and substance use disorder benefits are “defined under the terms of the plan and in accordance with applicable Federal and State law,” and “must be consistent with generally recognized 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 International Classification of Diseases (ICD), or State guidelines.)”²⁹ Plans and issuers, both private and Medicaid, must assign all covered services to one of these six benefits classifications, even if they do not fit neatly into one of these classifications, such as long-term residential programs. The Final Rules state: “Plans and issuers must assign covered **intermediate mental health and substance use disorder benefits** to the existing six benefit classifications in the same way that they assign comparable intermediate medical/surgical benefits to these classifications. For example, if a plan or issuer classifies care in skilled nursing facilities or rehabilitation hospitals as inpatient benefits, then the plan or issuer must likewise treat any covered care in residential treatment facilities for mental health or substance user disorders as an inpatient benefit. In addition, if a plan or issuer treats home health care

BENEFITS CLASSIFICATIONS

CLASSIFICATIONS	DEFINITION ³⁰	PERMISSIBLE SUB-CLASSIFICATIONS
Inpatient, in-network	Benefits furnished on an inpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.	• Network tiers
Inpatient, out-of-network	Benefits furnished on an inpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes inpatient benefits under a plan (or health insurance coverage) that has no network of providers.	N/A
Outpatient, in-network	Benefits furnished on an outpatient basis and within a network of providers established or recognized under a plan or health insurance coverage.	• Network tiers • Office visits • All outpatient services other than office visits
Outpatient, out-of-network	Benefits furnished on an outpatient basis and outside any network of providers established or recognized under a plan or health insurance coverage. This classification includes outpatient benefits under a plan (or health insurance coverage) that has no network of providers.	• Office visits • All outpatient services other than office visits
Emergency care	Benefits for emergency care	N/A
Prescription drugs	Benefits for prescription drugs	• Multi-tiered prescription drug benefits

as an outpatient benefit, then any covered intensive outpatient mental health or substance use disorder services and partial hospitalization must be considered outpatient benefits as well.”³¹

Sub-Classifications

Under the MHPAEA Final Rules, a plan or insurer may choose to divide certain benefits classifications into sub-classifications for parity. Sub-classifications permitted under the rule are:

- sub-classification of office visits and all other outpatient services, under either out-patient, in-network or out-patient, out-of-network;
- establishment of network tiers or preferred providers;
- establishment of tiers of prescription drug benefits (e.g., with varying co-pays or other financial requirements).

The Final Rules state: “After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification”³²

Plans and issuers are permitted to sub-classify **office visits** and **all other outpatient services**, as stated above. For example, some plans require a co-payment for office visits and coinsurance for outpatient surgical procedures.

Network tiers are permissible sub-classifications if the tiers meet the following two conditions:

- the tiers are designed “without regard to whether a provider provides services with respect to medical/ surgical benefits or mental health or substance use disorder benefits”; and
- the tiers are “based on reasonable factors,” which may include “quality, performance, and market standards.”³³

Multi-tiered prescription drug benefits are permissible sub-classifications if the tiers meet the following two conditions:

- the tiers are designed “without regard to whether a drug is generally prescribed with respect to medical/ surgical benefits or with respect to mental health or substance use disorder benefits”; and
- the tiers are “based on reasonable factors,” which may include “cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.”³⁴

As noted earlier, parity laws and regulations do not necessarily guarantee equal results. The question, for example, is not whether too few mental health and substance use disorder providers or drugs are in the tiers with lower cost sharing, but whether the tiers meet the applicable conditions.

Parity Requirements

Plans and issuers covered by MHPAEA and related laws and regulations must implement parity with respect to financial requirements, dollar limits, QTLs, and NQTLs. This section provides further guidance on each of these four requirements, as well as the relevant tests for determining compliance.

Financial Requirements and Quantitative Treatment Limitations

Financial requirements and QTLs are two separate categories of provisions regulated by MHPAEA. However, the two-part test to determine whether they comply with MHPAEA is the same. (Additional rules apply to cumulative financial requirements and QTLs, which refer to accumulated quantities, such as annual or lifetime visit limits or deductibles.)

Financial Requirements Defined

“**Financial requirements** include deductibles, co-payments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.”³⁵ An easy way to remember this is that financial requirements—deductibles, co-payments, coinsurance, or out-of-pocket maximums—all refer to an amount or percentage that is **financially required** of the person receiving services. [Note: Medicaid managed care (p.18436), ABPs (p. 18439) and CHIP (p. 18442) adopted the same definitions for financial requirements <https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf>].

Quantitative Treatment Limitations Defined

QTLs are one of two types of treatment limitations. Unlike dollar limits, which typically place overall limitations on what a plan will pay, treatment limitations typically apply to specific benefits. The following definitions are found in the Final Rules: “**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. ... A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. ... **Quantitative treatment limitations** ... are expressed numerically (such as 50 outpatient visits per year).”³⁶ The example provided illustrates a limit on the number of visits. Other examples of QTLs might include the following:

TYPE OF TREATMENT LIMITATION	EXAMPLE
Frequency of treatment	No more than five outpatient visits per provider per month
Days of coverage	No more than 30 days of residential treatment per year
Other limits on scope or duration	No more than 21 consecutive days of residential treatment

The Two-Part Test

The test to determine financial requirements' and QTLs' compliance with MHPAEA within a classification (or sub-classification when permissible) is sometimes called "The Two-Part Test."³⁷ The Final Rules state: "A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/ surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the **predominant** financial requirement or treatment limitation of that type that is applied to **substantially all** medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to **substantially all** medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation."³⁸

The Final Rules state a mathematical standard for **substantially all** and **predominant**:

- Substantially all means at least two-thirds: "A type of financial requirement [e.g., co-pay] or quantitative treatment limitation [e.g., cap on length of stay] is considered to apply to substantially all medical/surgical benefits in a classification of benefits if it applies to at least two-thirds of all medical/surgical benefits in that classification."³⁹
- Predominant means more than one-half: "If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all medical/surgical benefits in a classification ... the level of the financial requirement [e.g., \$10 co-pay] or quantitative treatment limitation [e.g., 21 day stay in residential treatment] that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of medical/ surgical benefits in that classification subject to the financial requirement or quantitative treatment limitation."⁴⁰

The portion of medical/surgical benefits in a classification of benefits subject to a type of financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year (or for the portion of the plan year after a [relevant] change in plan benefits). The portion of medical/surgical benefits in a classification of benefits subject to a level of financial requirement or quantitative treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification that are subject to that financial requirement or quantitative treatment limitation expected to be paid under the plan for the plan year (or for the portion of the plan year after a [relevant] change in plan benefits).

So, if 67 percent of medical/surgical emergency care (a benefits classification) is subject to a co-pay (a type of financial requirement), then a co-pay applies to substantially all medical/surgical emergency care. This percentage refers to the dollar amount that the plan pays during the plan year, not the percentage of emergency department visits.

In such cases, the Final Rules call for evaluating the predominant level of the financial requirement: Continuing the example, if 51 percent of medical/surgical emergency care that is subject to a co-pay is subject to a \$100 co-pay, then the \$100 co-pay is the predominant financial requirement.

Of course, there may be circumstances in which no specific level of a financial requirement or quantitative treatment limitation applies to more than half of medical/surgical benefits within a benefits classification that are subject to the relevant financial requirement or quantitative treatment limitation. The Final Rules state: "The plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification."⁴¹ The rules explain further: "For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation."⁴²

The same Two-Part Test that applies to financial requirements also applies to QTLs. So, if 67 percent of inpatient, out-of-network medical/surgical care (a benefits classification) is subject to a limit on consecutive days of coverage (a type of QTL), then a limit on consecutive days of coverage applies to substantially all inpatient, out-of-network medical/surgical care. Thus, the predominant level of consecutive days of coverage for inpatient, out-of-network medical/surgical care must be identified. If 51 percent of such services that are subject to a limit on consecutive days of coverage are subject to a 21-day maximum, then 21 days is the predominant level of this QTL, and a more restrictive QTL may not be placed on mental health or substance use disorder benefits in the classification. Remember, these percentages refer to the dollar amount that the plan pays during the plan year, not the percentage of emergency department visits. The Final Rules contain other illustrations of how the two-part test is applied.

TESTS TO DETERMINE MHPAEA COMPLIANCE

TEST	MATHEMATICAL STANDARD	APPLIES TO	BASED ON
Substantially all	At least two-thirds of medical/surgical benefits within a classification	Type of financial requirement (e.g., co-pay) or quantitative treatment limitation (e.g., stay limit)	Dollar amount of all medical/surgical benefits within a classification
Predominant	More than one-half of medical/surgical benefits within a classification that are subject to the financial requirement or quantitative treatment limitation	Level of financial requirement (e.g., \$10 co-pay) or quantitative treatment limitation (e.g., 21-day maximum stay)	Dollar amount of benefits subject to the financial requirement or treatment limitation within a classification

Special Rules for Cumulative Financial Requirements and Cumulative QTLs

Cumulative financial requirements or QTLs (such as an annual deductible or lifetime cap on days of treatment) should not be confused with annual or aggregate dollar limits. The Final Rules explain, “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. (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.)”⁴³ 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.”⁴⁴

The following special rule applies to cumulative financial requirements and cumulative QTLs: “A group health plan (or health insurance coverage offered in connection with a group health plan) may not apply any cumulative financial requirement or cumulative quantitative treatment limitation for mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.”⁴⁵ In other words, a covered plan cannot have, for example, one deductible that applies to medical/surgical office visits and another that applies to mental health and substance use disorder office visits.

Dollar Limits

Unlike financial requirements, which set an amount that a plan member or insured person pays, dollar limits set a maximum amount that the plan would pay over the course of a year, or for the time that a person is covered by the plan. The ACA prohibits most annual or lifetime dollar limits, with the following two exceptions:

- services that are not considered essential health benefits, and “grandfathered” individual plans may impose annual dollar limits (but not lifetime dollar limits) that are not subject to many of the ACA requirements.

However, the parity provisions may apply to two types of dollar limits even when an exception applies:

- “**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 offered in connection with such a plan) 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 offered in connection with such a plan) for any coverage unit.”⁴⁶

The test for evaluating both types of dollar limits examines whether the limits apply to:

1. **less than one-third of all** medical/surgical benefits;
2. **at least one-third but less than two-thirds** of all medical/surgical benefits; or
3. **at least two-thirds of all** medical/surgical benefits.

The standards are as follows:

STANDARDS BASED ON PORTION OF MEDICAL/SURGICAL BENEFITS SUBJECT TO DOLLAR LIMITS

PORTION	LANGUAGE FROM FINAL RULES ⁴⁷
No dollar limits, or applicable to less than one-third of medical/surgical benefits	“If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/ surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.”
Applicable to at least one-third but less than two-thirds of medical/surgical benefits	“A group health plan (or health insurance coverage) that [includes] ... aggregate lifetime or annual dollar limits on [at least one-third but less than two-thirds of] medical/ surgical benefits, must either— (A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or (B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits.”
Applicable to at least two-thirds of medical/surgical benefits	“If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either— (i) Apply the aggregate lifetime or annual dollar limit both to the medical/ surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/ surgical benefits and mental health or substance use disorder benefits; or (ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.”

Non-Quantitative Treatment Limitations

Unlike QTLs, which contain a numerical restriction, NQTLs “otherwise limit the scope or duration of benefits for treatment under a plan or coverage.”⁴⁸ The general requirement for NQTLs is as follows:

A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation 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 applying the limitation with respect to medical/surgical benefits in the classification.⁴⁹

EXAMPLES IN FINAL RULES ⁵⁰	ILLUSTRATIONS ⁵¹
Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative	<ul style="list-style-type: none"> • Preauthorization requirements • Post-admission notification required • Concurrent care review every 10 days • Medical necessity review
Formulary design for prescription drugs	
Formulary design for prescription drugs	
Standards for provider admission to participate in a network, including reimbursement rates	
Plan 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	<ul style="list-style-type: none"> • Progress requirements

Probability of improvement as a result of treatment	<ul style="list-style-type: none"> • Requirements that a treatment will result in measurable and substantial improvement in mental health status within 90 days.
Exclusions based on failure to complete treatment	<ul style="list-style-type: none"> • Patient noncompliance
Restrictions based on geography, facility, specialty, and criteria that limit scope or duration of benefits for services provided under the plan or coverage	<ul style="list-style-type: none"> • Limits on residential treatment • Licensure requirements for treatment facilities
Requirements for a written treatment plan	<ul style="list-style-type: none"> • Written plan required at beginning of treatment • Written treatment plan required at intervals

Though not an exhaustive list, the following table provides some illustrations of NQTLs:

Some of the illustrations in the table above are taken from a document issued by the Departments, entitled *Warning Signs—Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*.⁵² That document lists numerous examples of policy language and plan or insurer conduct that could signal non-compliance with MHPAEA. However, a full analysis, including requesting additional information, may be necessary to determine non-compliance:

Language contained in [such] provisions (absent similar restrictions on medical/surgical benefits) can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL. Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both MH/SUD and medical/surgical benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance.⁵³

CMS suggests the following inquiries for each NQTL in each classification.⁵⁴ The inquiries would be performed with respect to medical/surgical services and mental health/substance use disorder services. (Although CMS suggests these inquiries in conjunction with Medicaid and CHIP, the relevant regulations use the same comparable to/applied no more stringently than language as those applying to commercial plans.)

Strategy

- What is the rationale for determining which benefits in this classification should be subject to the limit?

Process

- What is the process for implementing the limit? (For example, are prior authorizations performed by the direct treatment provider, or does the plan require secondary assessment to complete the authorization?)
- Are there exceptions to the application of the limit in certain circumstances? List the situations when exceptions are granted.
- Are there any time restrictions? (For example, what is the maximum amount of time allowed to issue a determination on a prior authorization request?)
- If there is any change to policies or procedures for this limit, does the plan update providers about the change? How often do these updates occur?

Evidentiary Standards

- What evidence was relied upon to make determinations about which benefits meet the criteria to apply the limit?
- If the processes used to apply the limit are different for MH/SUD than for medical/surgical benefits, what evidence was relied upon to determine that these differences are appropriate?

The Final Rules make clear that the illustrations provided are not exhaustive, and “all NQTLs imposed on mental health and substance use disorder benefits by plans and issuers subject to MHPAEA are required to be applied in accordance with these [comparable to/applied no more stringently than] requirements.”⁵⁵

Disclosure Provisions

MHPAEA and related laws require the disclosure of three types of information:

- information about medical necessity criteria used to determine coverage; and
- specific information about why a claim was denied;
- comparative analyses for NQTLs imposed on a plan.

Depending on the type of plan or coverage, other state and federal laws (such as ERISA) may impose additional disclosure requirements. As the Final Rules note, “compliance with MHPAEA’s disclosure requirements is not determinative of compliance with any other provision of applicable Federal or State law.”⁵⁶

Disclosure Requirement for Medical Necessity Criteria

MHPAEA requires that “Criteria for medical necessity determinations made under a group health plan with respect to mental health or substance use disorder benefits (or health insurance coverage offered in connection with the plan with respect to such benefits) must be made available by the plan administrator (or the health insurance issuer offering such coverage) to any current or potential participant, beneficiary, or contracting provider upon request.”⁵⁷ This disclosure requirement also applies to individual market health insurance issuers, as a result of the ACA’s extension of MHPAEA to such issuers.

Other laws may impose stricter or broader disclosure requirements. For example, employer-sponsored plans subject to ERISA generally must furnish, within 30 days, “documents with information on medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the plan.”⁵⁸

Disclosure Requirement for Denials of Mental Health or Substance Use Disorder Benefits

MHPAEA and ERISA require disclosure of the reason that a claim for mental health or substance use disorder benefits was denied. MHPAEA requires “upon the request of a participant or beneficiary the reason for the claim denial must be provided within a reasonable time and in a reasonable manner.” For plans subject to ERISA, the disclosure requirements are specific, including a maximum of 15 days for pre-service claims and 30 days (with a possible 15-day extension) for post-service claims.⁵⁹ Plans not subject to these requirements must provide a reason for denial “within a reasonable time and in a reasonable manner,” and “a plan that follows the [ERISA] requirements ... for group health plans complies with the requirements.”⁶⁰

In addition, 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, including information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and mental health or substance use disorder benefits.

Comparative Analyses for NQTLs

The Consolidated Appropriations Act, 2021 was enacted on December 27, 2020. Section 203 of Title II of Division BB of the Appropriations Act amended MHPAEA, in part, by expressly requiring group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical benefits and Mental Health/ Substance Use Disorder (MH/SUD) benefits and that impose NQTLs on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs. Further, beginning 45 days after the date of enactment of the Appropriations Act, these plans and issuers must make their comparative analyses and related information available to the Departments or applicable State authorities, upon request. This related information includes:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined,

and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;

4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and

5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.

Comparative analyses should be sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying an NQTL are comparable to and no more stringently applied than those applied to medical/surgical benefits. A general statement of compliance, with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet this statutory requirement.

If sufficient information isn't provided, the Departments will specify the information that must be submitted by the plan or issuer. After reviewing the comparative analysis and other requested materials, if the Departments determine that the plan or issuer is not in compliance with MHPAEA, the plan or issuer has 45 days to specify corrective action that it will take and to submit additional comparative analyses that demonstrate compliance. If the Departments make a final determination of noncompliance, the plan or issuer has 7 days after the determination to notify all enrolled individuals that the coverage has been determined to be noncompliant.

The Departments are required to request analyses if there are potential violations of or complaints about the NQTL requirements of MHPAEA and in any case at least 20 NQTL comparative analyses per year. To the extent that the Departments become aware of potential MHPAEA violations or complaints regarding noncompliance with MHPAEA that concern NQTLs, the Departments may request comparative analyses on the NQTLs that are the subject of the complaint or potential violation. The DOL and HHS will share any findings on compliance and noncompliance with the state where the plan is located or where the issuer is licensed. DOL will also continue to pursue MHPAEA investigations based on leads from other enforcement agencies, feedback from consumer groups, and implementation of advanced case development methods that incorporate various sources and will work with plans' service providers to obtain broad correction, not just for the particular plans investigated, but for other plans that work with the service provider, where noncompliance with MHPAEA is found.

Participants, beneficiaries, or enrollees (or their authorized representative), or state regulator may also request an NQTL analysis. For more information, see FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 part 45, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MHPAEA-FAQs-Part-45.pdf>.

COMPLIANCE AND ENFORCEMENT ACTIVITIES

Compliance and enforcement activities take place on a continuous basis, from the review of proposed plans or proposed changes to existing plans, through regular evaluations of market conduct and response to consumer complaints. This section examines how compliance and enforcement activities can successfully integrate the requirements of MHPAEA and related laws.

In conversations with state insurance officials working in compliance and enforcement, SAMHSA has identified five keys to success. SAMHSA's 2016 report, [*Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from States \(Best Practices\)*](#), lists these principles:

- open channels of communication;

- standardization of materials;
- creation of templates, workbooks and other tools;
- implementation of market conduct exams and network adequacy assessments; and
- collaboration with multiple state and federal agencies, health insurance carriers, and stakeholder groups.⁶¹

The following discussion of compliance and enforcement offers guidance on how to implement these principles.

Initial Review of Plan Documents

Enforcement of the parity provisions in MHPAEA and related laws requires analyzing both how plans and insurance policies are written, as well as implemented. In many cases, a review of plan documents reveals easily identifiable violations.

Some states seek to prevent these types of violations by supporting “standardized language and terms ... [through] templates, workbooks, and other tools designed to ensure parity compliance both in the form filing process and for carriers to use in operations.”⁶²

SAMHSA, in its *Best Practices* report, provides an example of how one state (Rhode Island) improves compliance through its form review process:

An extensive internal review process includes detailed form review instructions with a line-by-line review to target parity issues (e.g., exclusions). This process has resulted in the removal of most behavioral health exclusions from the state’s coverage certificates. Of particular significance for Rhode Island, which is facing an on-going opioid addiction crisis, was the removal of carriers’ discriminatory exclusions for methadone maintenance treatment. The state solicits and considers the parity related comments of in-state and out-of-state advocacy groups and other interested parties, thereby strengthening the form review process. Benefits tools and templates provide a review of coverage documents in real time, and an overall assessment of parity compliance. These activities are conducted in conjunction with a rigorous consumer complaint process and a state-wide all-carrier market conduct examination. This on-going examination involves an extensive review of documents and policies, statistical sampling of behavioral health utilization review cases in high utilization and/or high denial of care categories, and a clinical review of carriers’ medical necessity standard and utilization review decisions.⁶³

Market Conduct Examinations

Of course, not all MHPAEA compliance and enforcement issues are apparent from reviewing forms. Much of complying with parity requirements is implementing the written plan equitably. As discussed above, the two-part test for financial requirements and QTLs requires evaluating the plan or insurers’ spending on medical/surgical benefits in the various classifications and sub-classifications. Also discussed above is the need to evaluate NQTLs based on whether the policies are applied more stringently to mental health and substance use disorder benefits than to medical/surgical benefits.

The mechanism for evaluating whether a plan or insurer is complying with MHPAEA and related laws in the way it implements benefits is defined as a market conduct examination (MCE). As the *Best Practices* report explains:

During MCEs, examiners review a carrier’s policy files, claims files and other internal records to ensure that the carrier is acting in compliance with state laws and regulations. These exams also are used more broadly to assess carrier compliance with parity. A MCE may be either a comprehensive or a targeted examination, depending on what is needed. A comprehensive examination generally involves a full-scope review of all of the carrier’s practices, whereas a targeted exam is conducted when there is evidence of possible noncompliance with parity or consumer complaints. This examination is based on the results of market analysis indicating the need to review additional information (e.g., specific lines of business, specific business practices). Most states use their own insurance department staff to conduct these exams, as well as to perform follow-up visits and analyze findings, although targeted examinations may be conducted by a subcontractor or by an on-site examiner.⁶⁴

Network Adequacy Assessments

Another issue that comes up with evaluating how plans and insurance are implemented (as opposed to written) is whether

consumers can obtain services within their network. In plans with network tiers, access to providers within lower-cost tiers can also be an issue.

As the *Best Practices* report notes:

Network adequacy may be a parity issue if carriers are using more restrictive processes, strategies, standards, or other factors for including behavioral health providers in their networks compared with physical health [i.e., medical/surgical] providers. In other cases, network adequacy problems may stem instead from a shortage of providers in the geographic area covered by the plan. Conducting network adequacy assessments is a critical component of ensuring access to behavioral health services in all geographic areas of a state. Network adequacy has multiple dimensions. Carriers need to keep their materials current with respect to the providers that are included in their networks. Providers themselves often do not know what network tier of coverage they are in; as a result, patients sometimes are seen by providers who are not included in the patient's health plan. Several states discussed efforts to require that carriers keep provider directories up to date and clearly describe in their provider listings how they identify a provider's tier or level of care.⁶⁵

Coverage Data Analysis

Some MHPAEA compliance issues can be identified only by analyzing coverage data. For example, a plan might approve a much smaller percentage of pre-authorization requests for out-of-formulary prescription medications to treat mental health and substance use disorders than it does for medical and surgical reasons. Such a finding might prompt a request for additional information on the standards that the plan or insurer uses for pre- authorizing out-of-formulary prescription medications, and whether those standards are applied fairly and not for discriminatory reasons.

Routine data analysis can prompt such additional inquiries:

Compliance surveys are conducted in some states These surveys (often administered annually) require some or all carriers in a state to review and document that their practices and procedures are compliant with state and federal parity requirements. This process serves as a communication mechanism with carriers that captures information such as differences in services offered for behavioral health care versus medical or surgical care. These compliance surveys often are the first step in identifying specific issues that are then followed by a more targeted investigation, such as a desk audit to review support documents for completeness and to ensure standards are met.⁶⁶

As the *Best Practices* report notes, data analysis can also be used to help investigate consumer complaints: "States reported using complaints to identify potential parity compliance issues. States analyze these complaints, examining trends and identifying issues that necessitated further investigation. States also analyze denials and appeals to identify potential parity issues."⁶⁷

Consumer and Provider Outreach

SAMHSA hosted two state policy academies on parity implementation for state officials in 2017. One of the academies focused on advancing parity compliance in the commercial market, and the other focused on parity in Medicaid and CHIP. Numerous participants stressed the need for creating materials to educate state staff.⁶⁸ I think this is the best practices guide, this document helps to fill that need and may also prove useful in educating plan administrators, insurers, and providers about implementation of parity regulations. Additionally, DOL has sponsored numerous webcasts for consumers and providers. The DOL also maintains a MHPAEA Self-Compliance Tool that is intended to help group health plan sponsors and administrators, health insurance issuers, State regulators, and other stakeholders determine whether a group health plan or health insurance issuer complies with MHPAEA. As described in MHPAEA Frequency Asked Questions (FAQs) 45, "The MHPAEA Self-Compliance Tool includes a section on NQTLs that outlines a process for conducting comparative analyses of NQTLs. The MHPAEA Self-Compliance Tool is updated every two years and was most recently updated in 2020 by the DOL (in coordination with the Department of the Treasury and HHS)." (See <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> and <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf>).

Educated consumers are often the best source of information about potential parity compliance issues. As the *Best Practices* report notes, "Consumer education, which is essential in ensuring that consumers receive the benefits of the law, can be

facilitated through online and printed products, as well as live presentations.”⁶⁹ The following resources are helpful in educating consumers about parity and disclosure requirements:

- Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4971.pdf>
- Consumer Guide to Disclosure Rights: Making the Most of Your Mental Health and Substance Use Disorder Benefits <https://store.samhsa.gov/product/Consumer-Guide-To-Disclosure-Rights-Making-The-Most-Of-Your-Mental-Health-and-Substance-Use-Disorder-Benefits/SMA16-4992> and <https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4992.pdf>
- Employee Benefits Security Administration Seminars and Webcasts <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/seminars-and-webcasts>

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- 10 29 CFR 2590.712(c)(4)(iii), Ex. 9.
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