Understanding Your Plan's Mental Health Benefits

A Plan Sponsor's Q&A Guide to Understanding and Implementing the Mental Health Parity and Addiction Equity Act (MHPAEA)

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THE BALDWIN REGULATORY COMPLIANCE COLLABORATIVE

Table of Contents

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What is MHPAEA and what does it have to do with employee benefit plans?

Many Americans struggle to find and afford the care they need. Of the 21% of adults who had any mental illness in 2020, less than half received mental health care; fewer than one in ten with a substance use disorder received treatment. Research shows that people with private health coverage have a hard time finding a mental health provider in their health plan's network, or, if they do find a practitioner in their insurance network, they often find that in-network providers weren't accepting new patients or have months long waiting lists.

Despite the repeated bipartisan efforts aimed at assuring mental health parity, insurers may make it difficult to access mental health treatment, causing millions of consumers to seek care out-of-network at significantly higher costs and pay out of pocket, or defer care altogether. One study shows that insured people are well more than twice as likely to be forced to go out-of-network and pay higher fees for mental health care than for physical health care. And the problem is getting worse: in recent years, the gap between usage of out-of-network care for mental health and substance use disorder benefits versus physical health benefits increased 85 percent. As a result, millions of people are paying for out of network care for mental health services they need.

The Mental Health Parity and Addiction Equity Act (also known as "MHPAEA") requires parity (as in a lateral relationship) between a group health plan's medical/surgical ("M/S") benefits and its mental health/substance use disorder ("MH/SUD") benefits (collectively, "behavioral health benefits").

Final rules published by the Department of Labor from 2013 specify that MHPAEA's parity requirements apply to:

- Financial requirements, such as deductibles, copayments and coinsurance.
- Quantitative treatment limitations (or "QTL's"), such as day or visit limits.
- Non-quantitative treatment limitations (or "NQTL's"), which generally limit the scope or duration of benefits, such as prior authorization requirements, step therapy requirements and standards for provider admission to participate in a network.

The Consolidated Appropriations Act of 2021 (the "CAA") amended the requirements of MHPAEA to require health plans and health insurance issuers to conduct comparative analyses of the NQTLs they apply to medical/surgical benefits compared to those that they apply to behavioral health benefits. These analyses must contain a detailed, written, and reasoned explanation of the specific plan terms and practices underlying the limitations and include the basis for the plan's or issuer's conclusion that the NQTLs comply with the requirements of MHPAEA.

Plans and issuers must make their comparative analyses available upon request to the certain federal regulatory agencies (the "Departments" referring to the US Department of Labor, the Internal Revenue Service, and the US Department of Health and Human Services) and, where applicable, to applicable state agencies. If the Departments find that a plan or issuer is not in compliance with MHPAEA's substantive requirements, they may specify corrective actions that must be implemented within 45 days of the insurer or plan sponsor receiving notice of same. If the plan or issuer then remains noncompliant after such 45 days have lapsed, the insurer or plan sponsor must notify all enrollees of the determination of noncompliance within seven (7) days.

Are all group health plans subject to MHPAEA's parity requirements?

MHPAEA applies to plans sponsored by employers with more than 50 employees, including self-insured plans and fully insured arrangements. MHPAEA does not require large group health plans and their health insurance issuers to cover behavioral health benefits. MHPAEA's requirements apply only to large group health plans and their health insurance issuers who voluntarily elect to include behavioral health benefits in their benefit packages. However, other state and federal laws may nevertheless require a plan to provide behavioral health benefits for their participants.

The Patient Protection and Affordable Care Act (also known as the "ACA") builds on MHPAEA and requires some plans to cover behavioral health services as an essential health benefit. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include behavioral health services), as well as comply with the federal parity law requirements, beginning in 2014.

While MHPAEA applies to most employment-based group health coverage, there are a few important exceptions. Specifically, MHPAEA does not apply to small employers who have fewer than 51 employees. There is also an increased cost exception available to plans that follow guidance issued by the Departments. Additionally, plans for state and local government employees that are self-insured may opt out of MHPAEA's requirements if certain administrative steps are taken (such as sending notice to enrollees). Finally, MHPAEA does not apply to retiree-only plans.

In general, what must a health plan assure to be in compliance with MHPAEA'S requirements?

Group health plans and issuers may still apply financial requirements and treatment limitations with respect to behavioral health benefits; however, they must do so in accordance with the requirements under MHPAEA.

Quantitative Treatment Limitations (QTL)
There is a test for determining whether a financial requirement or treatment limitation, known as QTL, for MH/SUD benefits is permissible. The general rule is that a plan 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 quantitative limitation of that type applied to substantially all medical/surgical benefits in the same classification.

MHPAEA contains the following parity requirements:

- The financial requirements (such as deductibles, copayments, coinsurance, and out-of-pocket limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements.

Non-quantitative Treatment Limitations (NQTL)
In addition, MHPAEA imposes parity requirements on the NQTLs that plans may place on behavioral health benefits. Under MHPAEA, a plan may not impose a NQTL with respect to MH/SUD benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to behavioral health benefits in the classification are comparable to and 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.

NQTLs include: *Please note that the below is illustrative, rather than an exhaustive list.*

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- 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 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 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.

Is there a specific testing methodology I am required to utilize?

Federal regulations implementing MHPAEA's behavioral health parity requirements provides for the substantively complex analysis of multiple aspects of employee benefit plan operation and administration.

Quantitative Treatment Limitations (QTL)
To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification, e.g., self-only, family, or employee plus spouse. If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits the predominant level is determined separately for each coverage unit.

- **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. Any reasonable method can be used for this calculation.*

- **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. 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.*

Non-quantitative Treatment Limitations (NQTL)
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.

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.

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.

NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA. 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.

Step two: Identify the factors considered in the design of the NQTL.

Examples of factors include but are not limited to the following:

- 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
- Current and projected demand for services

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

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

- Internal claims analysis
- Medical expert reviews
- State and federal requirements
- National accreditation standards
- Internal market and competitive analysis
- Medicare physician fee schedules
- 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 to employ a particular source or evidentiary standard), if 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 its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices.

If the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and 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.

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.

<u>You may also wish to consider the following:</u>

What data, if any, are used to determine if the benefit is "high cost"?

How, if at all, is the amount that is to be considered "high cost" or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified? Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:

- 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?

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 to MH/SUD services and medical/surgical services.

These are 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 regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.
- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

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. 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 benefits.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent 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.

Are there specific NQTLS that the departments intend to focus on when requesting comparative analyses from plans and issuers for purposes of review in accordance with the requirements of the CAA?

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. For example, if a complaint is received regarding prior authorization requirements for coverage of buprenorphine for the treatment of opioid use disorder, the Departments may request an NQTL comparative analysis for prior authorization requirements placed on prescription drugs. Additionally, the CAA provides that the Departments may also request NQTL comparative analyses in any other instance deemed appropriate.

In the near term, DOL expects to focus on the following NQTLs in its enforcement efforts:

- Prior authorization requirements for in-network and out-of-network inpatient services
- Concurrent review for in-network and out-of-network inpatient and outpatient services
- Standards for provider admission to participate in a network, including reimbursement rates
- Out-of-network reimbursement rates (plan methods for determining usual, customary and reasonable charges)

Plans and issuers should also be prepared to make available a list of all other NQTLs for which they have prepared a comparative analysis and a general description of any documentation that exists regarding each analysis. In the context of these reviews, plans and issuers may be required to submit analyses for these additional NQTLs. Furthermore, an initial focus on the above four NQTLs by DOL does not in any way limit the Departments' or an applicable State authority's ability to request or review different or additional NQTL analyses for MHPAEA compliance. The CAA requires plans and issuers to perform and document comparative analyses for all NQTLs imposed.

How do I show my benefit plan meets the requirements of MHPAEA?

Plans and issuers should complete comparative analyses that are 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 and applied no more stringently to behavioral health benefits than to medical/surgical benefits, as described further below. To that end, a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet this statutory requirement.

The DOL's MHPAEA Self-Compliance Tool details robust agency guidance detailing the requirements for NQTLs and outlines a process for analyzing whether a particular NQTL meets such requirements. It also includes numerous examples and compliance tips that may be helpful to plans and issuers regarding how to conduct comparative analyses of NQTLs, along with potential warning signs that may be indicative of noncompliance and warrant further review.

In particular, the Self-Compliance Tool outlines four steps that plans and issuers should take to assess their compliance with MHPAEA for NQTLs. For each step, the Self-Compliance Tool also identifies certain information to support the analysis and the conclusions reached about whether the plan or coverage complies with MHPAEA. This information closely aligns with the information outlined in the next paragraph, that plans and issuers must include as part of their comparative analyses. Therefore, plans and issuers that have carefully applied the guidance in the Self-Compliance Tool should be in a strong position to comply with the CAA's requirement to submit comparative analyses upon request.

Under the CAA, plans and issuers must now be prepared to submit their comparative analysis with respect to each NQTL imposed when requested by any of the Departments or by an applicable State authority. For an analysis to be treated as sufficient under the CAA, it must contain a detailed, written, and reasoned explanation of the specific plan terms and practices at issue and include the bases for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA.

At a minimum, a sufficient written analysis must include a robust discussion of certain elements, as detailed below:

- A clear description of the specific NQTL, plan terms and policies at issue.
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
- Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
- The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
- A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with the requirements of MHPAEA.
- The date of the analysis and the name, title, and position of the person or persons who performed or participated in the preparation of the comparative analysis.

What are examples of reasons why the departments might conclude that documentation of comparative analyses of NQTLS is insufficiently specific and detailed?

A general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, standards, or other factors is insufficient and will not pass muster. Comparative analyses that consist of conclusory or generalized statements without specific supporting evidence and detailed explanations, or those that offer a mere production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analyses, will be deemed insufficient.

Rather, a sufficient analysis should include all the elements set forth in the response to the question above.

In past investigations of suspect NQTLs, the Departments have observed the following practices and procedures, which plans and issuers should avoid in responding to requests for comparative analyses because they are insufficient:

- Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
- Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
- Identification of processes, strategies, sources and factors without the required or clear and detailed comparative analysis;
- Identification of factors, evidentiary standards and strategies without a clear explanation of how they were defined and applied in practice;
- Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

In addition to documentation of the comparative analyses, what types of documents should I be prepared to make available to the departments?

As specified in the CAA, plans and issuers should be prepared to make available documents that support the analysis and conclusions of their NQTL comparative analyses, including any documents and other information relevant to the factors used to determine the application of an NQTL and the evidentiary standards used to define the factors identified. In its most recent update of the MHPAEA Self-Compliance Tool, DOL highlighted the following types of documents and relevant information that a plan or issuer should have available to support its NQTL comparative analyses.

- Records documenting NQTL processes and detailing 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, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law.
- Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to behavioral health benefits than 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 its rationale.
- Samples of covered and denied behavioral health and medical/surgical benefit claims.
- Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all behavioral health benefits to another entity), which may include studies, testing, claims data, reports, or documents related to other considerations in defining or applying factors (such as meeting minutes or reports showing how those considerations were applied).

The precise information needed to support an NQTL analysis will vary depending on the type of NQTL and the processes, strategies, evidentiary standards, and other factors used by the plan or issuer.

What information must be made available to the members of the plan?

Under the CAA, plans and issuers must make their comparative analyses available to the US Department of Labor, as well as certain state-level insurance authorities upon a request from same. The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or an official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service (PHS) Act for the State involved with respect to the issuer.

Furthermore, as stated in previous guidance, participants and beneficiaries (or their authorized representatives) in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits, as well as behavioral health benefits, detailing the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and behavioral health benefits under the plan. The types of documents contemplated in previous guidance would include any analyses performed by the plan as to how the NQTL complies with the requirements of MHPAEA.

Therefore, for plans subject to ERISA, plans and issuers must make the comparative analyses and other applicable information required by the CAA available to participants, beneficiaries, and the plan's enrollees, upon a written request. If a provider or another individual is acting as a patient's authorized representative, the provider or other representative may request such documents.

In addition, insurance claimants (or their authorized representative(s)) have a right upon appeal of an adverse benefit determination (or upon a final internal adverse benefit determination) 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 right includes access to documents with information on medical necessity criteria for both medical/surgical benefits and behavioral health benefits. Necessarily, this also includes documents reflecting the processes, strategies, evidentiary standards, and other factors used to apply an underlying NQTL with respect to behavioral health and medical/surgical benefits under the plan.

These documents would include any analyses performed by the plan or issuer as to how the NQTL complies with the requirements of MHPAEA.

Are there any penalties associated with failing to achieve MHPAEA's substantive compliance requirements?

If the Departments conclude a plan or issuer has provided insufficient information to conduct a reasonable analysis of the plan, the CAA provides that the Departments shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request.

In instances where the Departments have reviewed the comparative analyses and any other materials submitted upon request from a plan or issuer and determined that the plan or issuer is not in compliance with MHPAEA, the CAA requires the plan or issuer to specify to the Departments the specific actions the plan or issuer will take to assure prospective compliance.

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Therefore, for plans subject to ERISA, plans and issuers must make the comparative analyses and other applicable information required by the CAA available to participants, beneficiaries, and the plan's enrollees, upon a written request. If a provider or another individual is acting as a patient's authorized representative, the provider or other representative may request such documents.

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These documents would include any analyses performed by the plan or issuer as to how the NQTL complies with the requirements of MHPAEA.

Are there any penalties associated with failing to achieve MHPAEA's substantive compliance requirements?

If the Departments conclude a plan or issuer has provided insufficient information to conduct a reasonable analysis of the plan, the CAA provides that the Departments shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request.

In instances where the Departments have reviewed the comparative analyses and any other materials submitted upon request from a plan or issuer and determined that the plan or issuer is not in compliance with MHPAEA, the CAA requires the plan or issuer to specify to the Departments the specific actions the plan or issuer will take to assure prospective compliance.

Specifically, the plan or issuer must submit additional comparative analyses that demonstrate compliance no more than 45 days following the initial determination of noncompliance. Subsequently, if the Departments make a final determination that the plan or issuer remains noncompliant, within seven (7) days, the plan or the issuer must notify all individuals enrolled in the plan or coverage that the coverage is determined to be noncompliant with MHPAEA. The Departments will share findings of compliance and noncompliance with the State where the group health plan is located or where the issuer is licensed to do business.

MHPAEA's provisions are included under ERISA. The US Department of Labor and the Internal Revenue Service (IRS) generally have enforcement authority over private sector employment-based plans that are subject to ERISA.

While ERISA does not contain a specific penalty for violations of MHPAEA, plan participants and beneficiaries, as well as the Department of Labor, may use ERISA's civil enforcement provisions to enforce MHPAEA.

Furthermore, when the DOL audits an ERISA-covered health plan, it will investigate the plan's compliance with federal mental health parity requirements. Vigorous enforcement of MHPAEA has been one of the DOL's top enforcement priorities. When the DOL identifies MHPAEA violations in a specific group health plan, the agency will require the underlying plan or issuer to make required modifications such that behavioral health parity is assured. Consequently, the outcome of such review will inevitably prompt the plan or issuer to reprocess any denied benefit claims that arose under any conditions of previously noncompliant coverage.

Furthermore, employer plan sponsors that violate MHPAEA may be subject to an excise tax, as levied by the Internal Revenue Service. Generally, an excise tax of $100 per individual, per day will apply to each MHPAEA violation, unless an exception applies to excuse such conduct. Assessed and/or applicable excise taxes must be reported on IRS Form 8928, "Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code."

What additional resources are available to help me understand my MHPAEA obligations?

There are many helpful resources available to help explain these requirements in additional detail, as well as sources offering examples and hypothetical exercises to assist plan sponsors in achieving their behavioral health parity obligations consistent with the requirements of MHPAEA.

Following, please find several notable sources for learning and information respecting the topic of behavioral health parity by the terms of MHPAEA:

U.S. Department of Labor's Employee Benefits Security Administration (EBSA):

- Call 1-866-444-3272 to speak with an EBSA Benefits Advisor
- Visit the EBSA website

U.S. Department of Health and Human Services:

- Call 1-877-267-2332 ext. 61565
- Visit the HHS mental health parity website

Your state's department of insurance:

- Find your state's contact information on the National Association of Insurance Commissioners website

Substance Abuse and Mental Health Services Administration (SAMHSA):

- Visit SAMHSA's website
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Visit EBSA's mental health parity webpage to view the following publications:

- Top 10 Ways to Make Your Health Benefits Work For You
- Parity of Mental Health and Substance Use Benefits with Other Benefits Using Your Employer-sponsored Health Plan to Cover Services
- FAQs for Employees about the Mental Health Parity and Addiction Equity Act
- Consumer Guide to Disclosure Rights:Making the Most of Your Mental Health and Substance Use Disorder Benefits
- Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008
- Know Your Rights: Parity for MentalHealth and Substance Use Disorder Benefits
- Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine MentalHealth Parity Compliance