

2022 MHPAEA Report to Congress

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Realizing Parity, Reducing Stigma, and Raising Awareness:

Increasing Access to Mental Health and Substance Use Disorder Coverage

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PREFACE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires the Secretary of Labor to submit a report to the appropriate committees of Congress on compliance by group health plans (and health insurance coverage offered in connection with such plans) with MHPAEA's requirements. The first such report was due by January 2012, and additional reports have been delivered every two years since.

The Department of Labor's (DOL) 2012 and 2014 Reports to Congress provided an overview of the interim final rules, final rules, and related guidance that implement MHPAEA. The 2012 and 2014 Reports also described DOL's general strategy of working with plans, issuers, consumers, providers, states, and other stakeholders to help the regulated community comply with the law and help families and individuals understand the law and benefit from it, as Congress intended.

In addition to summarizing recent guidance issued by DOL, the 2016 Report to Congress detailed DOL's significant enforcement efforts and provided numerous examples of situations in which DOL was able to intervene on behalf of participants and beneficiaries to ensure that they received coverage for the health care to which they were entitled.

DOL's 2018 Report to Congress supplemented the 2016 submission by further highlighting DOL's continued parity implementation efforts. It also outlined DOL's strategy for continuing to identify and correct MHPAEA non-compliance and minimize the likelihood of future violations through effective outreach, compliance assistance, and interpretive guidance. The 2020 Report to Congress summarized DOL's activities to further parity implementation since the 2018 Report to Congress, including DOL's partnership efforts across the Administration, as well as with plans, issuers, consumers, providers, states, and other stakeholders. The 2020 Report detailed DOL's intent to use the information gathered from these partnerships to develop a roadmap to compliance for the regulated community so that health plan participants and beneficiaries are able to realize the full benefits of MHPAEA.

Following the inauguration of President Biden and Vice President Harris, the DOL, along with the Departments of Health and Human Services (HHS) and the Treasury (collectively, the Departments) have made an unprecedented commitment to build on their longstanding efforts to advance mental health parity by making MHPAEA enforcement a top priority. Although compliance assistance efforts remain an important part of the Departments' MHPAEA efforts, feedback from stakeholders makes it clear that compliance assistance alone is not sufficient, and a greater emphasis on proactive enforcement is required.

Responding to similar feedback, in the Consolidated Appropriations Act, 2021 (CAA), Congress furnished the Departments with an important new enforcement tool by amending MHPAEA to require plans and issuers to provide comparative analyses of their non-quantitative treatment limitations (NQTLs) to the Secretary of the Treasury, the Secretary of Labor, and the Secretary of HHS (collectively, the Secretaries) upon request and to authorize the Secretaries to determine whether those NQTLs comply with MHPAEA.

This 2022 MHPAEA Report to Congress (2022 Report) highlights the Secretaries' recent emphasis on greater MHPAEA enforcement and discusses the significant resources dedicated to supporting these efforts. As the first report since the enactment of the CAA, the 2022 Report also details the efforts by the Departments to interpret, implement, and enforce the amendments to MHPAEA made by the CAA. This 2022 Report also provides information to follow up upon the fiscal year (FY) 2020 Mental Health and Substance Use Disorder (MH/SUD) Enforcement Evaluation Program outlined in the 2020 Report. This

2022 Report is intended to satisfy both the requirement under section 712(f) of the Employee Retirement Income Security Act (ERISA) that DOL provide a biennial report to Congress on MHPAEA compliance, and the requirement under section 203 of title II of Division BB of the CAA that the Departments provide an annual report to Congress on the NQTL comparative analyses. The MHPAEA enforcement fact sheet, attached as an appendix, is intended to fulfill the Departments' reporting requirements under section 13003 of the 21st Century Cures Act, as amended by section 7182 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Support Act).¹

CAA Enforcement Results Fast Facts:

The following is an overview of the key enforcement results under section 203 of Title II of Division BB of the CAA, which are explained more fully in Section II.B below:

- The Employee Benefits Security Administration (EBSA) has issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs across 86 investigations.²
- The Centers for Medicare & Medicaid Services (CMS) issued 15 letters between May and November 2021 to issuers in states where CMS has direct enforcement authority over MHPAEA (Texas, Missouri, and Wyoming) and to non-Federal governmental plan sponsors in those and other states.
- None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt. EBSA observed several common themes in deficiencies:
 - Failure to document comparative analysis before designing and applying the NQTL;
 - Conclusory assertions lacking specific supporting evidence or detailed explanation;
 - Lack of meaningful comparison or meaningful analysis;
 - Non-responsive comparative analysis;
 - Documents provided without adequate explanation;
 - Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification/s affected by an NQTL;
 - Limiting scope of analysis to only a portion of the NQTL at issue;
 - Failure to identify all factors;
 - Lack of sufficient detail about identified factors;
 - Failure to demonstrate the application of identified factors in the design of an NQTL; and
 - Failure to demonstrate compliance of an NQTL as applied.

¹ Pub. L. 115-271 (Oct. 24, 2018).

² This count of "unique" NQTLs only includes limitations that the Department has identified under a plan or health coverage that the plan or issuer has defined using different factors or evidentiary standards than other NQTLs, regardless of whether it is applied to different classifications, or to different plans (in cases where a request was made to a health insurance issuer). Counting each NQTL separately by benefit classification, plan, and product, the number of NQTLs for which EBSA requested a comparative analysis would be 1,112.

- EBSA has issued 80 insufficiency letters for over 170 NQTLs, requesting additional information and identifying specific deficiencies.
- CMS has issued 19 insufficiency letters identifying deficiencies in the comparative analyses and requested additional information to address these deficiencies.
- EBSA has so far issued 30 initial determination letters finding 48 NQTLs imposed on MH/SUD benefits lacking parity with medical/surgical benefits (36 unique NQTLs).
- CMS has so far issued 15 initial determination letters to plans and issuers finding 16 NQTLs out of parity with medical/surgical benefits. Two NQTLs were found to be impermissible separate treatment limitations in effect and 14 comparative analyses remained insufficient.
- EBSA received corrective action plans from 19 plans in response to initial determination letters. These corrective action plans address 36 NQTLs (30 unique NQTLs).
- CMS received corrective action plans from 6 plans and issuers in response to initial determination letters. These corrective action plans address 13 NQTLs.
- 26 plans and issuers so far have agreed to make prospective changes to their plans.

I. INTRODUCTION

Mental health is a vital component of overall health and wellbeing, and ensuring that individuals have access to MH/SUD care is essential. The COVID-19 pandemic has not only drawn a new focus on the importance of attending to MH/SUD health, but it also has exacerbated existing barriers to and health disparities in accessing treatment. During the 12-month period ending in April 2021, over 100,000 Americans died of overdose, a figure that represents a nearly 30 percent year-over-year increase.³ The impact of COVID-19 on overdose rates has been especially prominent in communities of color that are also experiencing disproportionately high rates of COVID-19 cases and deaths.⁴ Black and Hispanic adults were more likely than White adults to report symptoms of anxiety or depressive disorder during the COVID-19 pandemic.⁵ Black, Hispanic, and Asian-American communities are also more likely to report fear of contracting the virus itself as a source of stress.⁶ Moreover, from 2019 to 2020, Black individuals had a 48.8 percent increase in overdose deaths while White individuals experienced a 26.3 percent increase. In 2020, overdose death rates among Black individuals climbed to 36.8 per 100,000, a rate 16.3 percent higher than that for White individuals during that period. American Indian and Alaska Native communities have been hardest hit by incidences of overdose during the pandemic, experiencing an overdose mortality rate of 41.4 per 100,000.⁷ The COVID-19 pandemic exacerbated preexisting inequities that affect these communities of color, which in turn influenced a broad array of health and quality-of-life outcomes and risks, including those related to MH/SUD.⁸ As these statistics demonstrate, it is essential that the health coverage that Americans have access to includes coverage for treatment of MH/SUD.

For far too long, people with MH/SUD conditions and their loved ones have faced stigma, discrimination, and other barriers inside and outside of the health care system.⁹ These biases and discriminatory practices can often operate as an impediment to even seeking MH/SUD treatment in the first place. And once individuals attempt to seek care, they often find that treatment for their mental health condition or substance use disorder operates in a separate, and often very disparate, system than treatment for medical and surgical care, even under the same health coverage.

Even before the onset of the COVID-19 pandemic, mental illness was widespread; in 2019, nearly 52 million adults in the United States experienced some form of mental illness.¹⁰ And, in 2020, an estimated

³ Centers for Disease Control and Prevention. (2021). Vital Statistics Rapid Release: Provisional Drug Overdose Death Counts. Retrieve December 12, 2021 at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

⁴ Substance Abuse and Mental Health Services Administration (April 15, 2021). Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. <https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf>.

⁵ Kaiser Family Foundation (October 2020). Race, Health, and COVID-19: The Views and Experiences of Black Americans. <https://files.kff.org/attachment/Report-Race-Health-and-COVID-19-The-Views-and-Experiences-of-Black-Americans.pdf>.

⁶ American Psychological Association (May 2020). Stress in America: Stress in the Time of COVID-19, Volume One. <https://www.apa.org/news/press/releases/stress/2020/stress-in-america-covid.pdf>.

⁷ Friedman, J., & Hansen, H. (2021). Black and Native Overdose Mortality Overtook that of White Individuals During the COVID-19 Pandemic. *medRxiv*, 2021.2011.2002.21265668. doi:10.1101/2021.11.02.21265668

⁸ See *supra* note 4.

⁹ Van Boekel, L. C., Brouwers, E. P., van Weeghel, J., & Garretsen, H. F. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. *Drug and Alcohol Dependence*, 131(1-2), 23–35. <https://doi.org/10.1016/j.drugalcdep.2013.02.018>.

¹⁰ National Institute of Mental Health: Mental Illness, available at <https://www.nimh.nih.gov/health/statistics/mental-illness>.

40.3 million people aged 12 or older (or 14.5 percent of this population) had a substance use disorder.¹¹ The prevalence of mental health conditions, substance use disorders, and overdose deaths has only increased with the COVID-19 pandemic. Recent data from the Centers for Disease Control and Prevention indicate that between August 2020 and February 2021, the percentage of adults exhibiting symptoms of an anxiety or a depressive disorder increased significantly, from 36.4 percent to 41.5 percent.¹² Similarly, the overdose and substance use disorder epidemic has taken a heartbreaking toll on far too many American families. Since 2015, overdose death numbers have risen, reaching a historic high of 70,630 deaths in 2019, and surging to an estimated 100,306 drug overdose deaths in the United States during the 12-month period ending in April 2021.¹³ The COVID-19 pandemic has also exacerbated disparities in the opioid epidemic. While Black and Latino communities have similar rates of opioid misuse as the general population, in recent years Black communities have experienced the greatest increase in non-methadone synthetic opioids overdose deaths.¹⁴

MHPAEA promotes equal access to treatment for MH/SUDs by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than for medical/surgical benefits. Such limitations include higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews, as compared to other medical treatments covered by a plan. Under the Biden-Harris Administration, EBSA and CMS have committed to making MH/SUD parity a top enforcement priority. EBSA's enforcement jurisdiction has a broad reach. Specifically, EBSA has primary enforcement jurisdiction over MHPAEA for approximately 2 million group health plans covering roughly 136.5 million Americans. In furtherance of this commitment, EBSA is taking unprecedented steps to enforce the law and to ensure that the agency is using its full authority to facilitate access to MH/SUD treatment. Similarly, CMS has increased its enforcement activities of MHPAEA requirements in the individual and fully-insured group markets in states where it has enforcement authority¹⁵ and over non-Federal governmental group health plans in all states (e.g. plans sponsored by state and local governments for their employees).

Given the rapidly escalating challenges MH/SUD conditions have posed during the COVID-19 pandemic, greater enforcement of MHPAEA is essential to integrating treatment for MH/SUD with health care for physical health. Effective February 2021, as part of the CAA, Congress provided the Departments with an important new MHPAEA enforcement tool, as well as additional funding to implement it. Before the CAA, although group health plans and health insurance issuers were prohibited from imposing limits on MH/SUD coverage that did not comply with parity requirements, MHPAEA did not explicitly state how plans or issuers were to demonstrate and document that they were ensuring compliance with the rules regarding NQTLs. For EBSA, CMS, other regulators, and individuals attempting to either enforce

¹¹ Substance Abuse and Mental Health Services Administration (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

¹² Vahratian A, Blumberg SJ, Terlizzi EP, Schiller JS. Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:490–494. DOI: <http://dx.doi.org/10.15585/mmwr.mm7013e2external>.

¹³ Hedegaard, H., Miniño, A.M., Wagner, M. (2020). Drug Overdose Deaths in the United States, 1999-2019. NCHS Data Brief No. 304 (December 2020) <https://www.cdc.gov/nchs/data/databriefs/db394-H.pdf>; Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2021, available at <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

¹⁴ See *supra* note 4.

¹⁵ HHS currently enforces MHPAEA with respect to issuers in Missouri, Texas, and Wyoming.

MHPAEA or assert their rights under MHPAEA, this served as a major roadblock to obtaining compliance and ensuring that individuals received the MH/SUD benefits to which they were entitled.

MHPAEA, as amended by the CAA, specifies how group health plans and health insurance issuers to whom MHPAEA applies must perform and document comparative analyses of the NQTLs they impose on MH/SUD coverage to demonstrate parity, and provide those analyses to the Secretaries or applicable state authorities upon request. This new enforcement authority is the cornerstone of the Departments' heightened enforcement efforts. Leveraging this new authority, EBSA has redesigned its NQTL enforcement strategy and committed significant new resources to its MHPAEA enforcement efforts as a first step in furtherance of its heightened commitment to MHPAEA enforcement. Similarly, CMS has dedicated a team of analysts focused on conducting NQTL comparative analysis reviews as part of its efforts to use this new authority to enhance its enforcement of MHPAEA requirements and advance mental health parity.

As detailed in Section II below, these efforts have already borne results, and the Departments will continue to devote greater resources to enforcement so as to take full advantage of these new and existing tools that Congress has provided to the Departments, as well as traditional enforcement methods.

EBSA quickly began to use the new enforcement tool in the CAA to enhance its existing MHPAEA enforcement efforts. In the short period of time from February 10, 2021 to October 31, 2021, EBSA has issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs across 86 investigations. This count of "unique" NQTLs includes only NQTLs that DOL has identified under a plan or health coverage, such that an NQTL that applies to more than one benefit classification within a plan or product is counted as one NQTL, and an NQTL that applies to different plans or products by the same health insurance issuer or service provider is counted as one NQTL. Counting each NQTL separately by benefit classification, plan, and product, the number of distinct NQTLs for which EBSA requested a comparative analysis would be 1,112.¹⁶

Similarly, HHS quickly initiated reviews under the authority granted by the CAA. Since the enactment of the CAA, CMS has issued 15 letters between May and November 2021 to issuers in states where CMS has direct enforcement authority over MHPAEA (Texas, Missouri, and Wyoming) and to non-Federal governmental health plan sponsors in those and other states. CMS requested 21 distinct NQTL comparative analyses in 2021. Additionally, CMS developed two webinars with training materials for health insurance issuers and for plan sponsors of non-Federal governmental health plans. The webinars were designed to educate plans and issuers about the new NQTL comparative analysis requirements under the CAA. These materials were distributed to non-Federal governmental health plans and issuers and are posted on the CMS website.

Despite the CAA's February 2021 deadline for plans to perform and document their comparative analyses, many plans and issuers stated that they were unprepared to respond to the Departments' requests and had not started preparing their comparative analyses by the February 2021 deadline. None of the comparative analyses EBSA or CMS have initially reviewed to date contained sufficient information upon initial receipt. EBSA has issued 80 insufficiency letters addressing over 170 NQTLs, identifying specific deficiencies in the comparative analyses and requesting additional information to remediate those deficiencies. In addition, to date, EBSA has issued 30 initial determination letters, finding 48 NQTLs

¹⁶ Throughout this 2022 Report, NQTLs (not designated "unique NQTLs") are counted separately by DOL if they apply to different plans, options, issuers, or products. However, the same NQTL imposed by a plan or issuer is not counted separately for each benefit classification, if imposed across more than one benefit classification within the same plan or product.

imposed on MH/SUD benefits violated MHPAEA's parity requirements. In several instances, EBSA has used the process outlined in section 203 of title II of Division BB of the CAA as a method to engage with service providers (such as third-party administrators (TPAs) and managed behavioral health organizations) to obtain wider-scope corrections affecting many plans at once. Similarly, CMS has issued 19 insufficiency letters identifying deficiencies in the comparative analyses and requested additional information to address these deficiencies. After review of supplemental responses submitted by plans and issuers, 14 comparative analyses remained insufficient and two plans and issuers were found to have impermissible separate treatment limitations in effect, resulting in initial determinations of non-compliance for 15 reviews. The Departments continue to assess the remaining responses received to date from plans and issuers. The 2022 Report also describes the lack of sufficient comparative analyses for plans and issuers and provides some examples of how the CAA's provisions have allowed the Departments to supplement existing MHPAEA enforcement programs, resulting in participants and beneficiaries gaining increased access to MH/SUD benefits.

In addition to using its enforcement authority under MHPAEA to help ensure access to MH/SUD treatment, DOL has undertaken efforts to reduce the stigmatization and discrimination that have long plagued individuals with mental health conditions and/or substance use disorders, and to raise awareness among American workers, their families, employers, and other stakeholders so that these individuals can receive the treatment that they need and to which they are entitled. Secretary of Labor Martin J. Walsh has embarked on a campaign to engage stakeholders to raise awareness and reduce stigma across the country. Following his lead, EBSA has made a concerted effort to engage stakeholders that include consumer advocacy groups, other federal and state regulators, employer associations, health care organizations, and provider groups to inform its MHPAEA efforts. Section III below covers these outreach and education efforts intended to help change attitudes and eliminate bias.

As part of the ongoing dialogue with stakeholders, and in line with its efforts to promote education, EBSA also maintains a program to provide interpretive guidance and technical assistance to stakeholders. EBSA shares interpretive jurisdiction of MHPAEA with the Departments of HHS and the Treasury. Working together, the Departments have provided robust guidance and technical assistance to stakeholders, including state regulators, to help promote compliance and ensure consistent interpretation of the law. Section IV below includes notable actions taken as part of this program.

The Departments are committed to using their full statutory authority to support the Administration's response to address the nation's MH/SUD epidemics. Moreover, in supporting this response, the Departments have learned through their efforts in implementing and enforcing the law, as well as by engaging with stakeholders. Based on what the Departments have learned, the Departments are of the view that, with additional tools, the ability to facilitate greater access to MH/SUD treatment will be greatly augmented. Accordingly, Section V below sets forth recommendations to strengthen MHPAEA's consumer protections and better position the Departments to enforce MHPAEA. Additionally, in light of the lessons learned by the Departments, the Departments intend to issue additional rulemaking to further clarify MHPAEA's protections for individuals and the obligations it imposes on plans and issuers.

II. MHPAEA ENFORCEMENT EFFORTS

A. Overview of Section 203 of Title II of Division BB of the CAA

The CAA amended MHPAEA to strengthen the enforcement of parity requirements in the application of NQTLs to medical/surgical and MH/SUD benefits. MHPAEA's pre-CAA implementing regulations¹⁷ made clear that the parity requirements apply both to quantitative treatment limitations (QTLs) that are expressed numerically (such as deductibles, copays, and caps on the number of office visits), and to NQTLs, which are generally non-numerical requirements that limit the scope or duration of benefits (such as prior authorization requirements, step therapy, and provider reimbursement rules). Because of their nature, the approach to identifying NQTLs and evaluating whether they are more stringently applied to MH/SUD benefits differs from the approach used to identify and evaluate QTLs. Specifically, to comply with MHPAEA's implementing regulations, plans and issuers must ensure that the processes, strategies, evidentiary standards, and other factors used when applying an NQTL to MH/SUD benefits are, both in writing and in operation, 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 same benefits classifications.

To strengthen compliance with that requirement, the CAA amended MHPAEA to require plans and issuers to perform and document comparative analyses of the design and application of each NQTL imposed under a plan or coverage and to make these analyses available to the Secretaries or applicable state authorities upon request. These analyses must include the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and medical/surgical benefits to which each such term applies in each benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical/surgical benefits;
3. The evidentiary standards used to develop the identified factors, 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/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 MHPAEA's requirements.

The CAA provides a mechanism by which the Departments request NQTL comparative analyses to examine whether the plans or issuers are in compliance with MHPAEA's NQTL requirements. Plans and issuers determined not to be in compliance must specify the corrective actions they will take to come into

¹⁷ 78 FR 68239 (Nov. 13, 2013).

compliance and provide additional comparative analyses that demonstrate compliance not later than 45 days after the initial non-compliance determination. Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer still is not in compliance, the plan or issuer must notify all enrolled individuals of the non-compliance no later than seven days after a final determination. As described in further detail below, on April 2, 2021, the Departments issued *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45* (FAQs Part 45) to provide guidance on the amendments to MHPAEA made by the CAA.

B. EBSA's MHPAEA Enforcement Activity under the CAA

Under the Biden-Harris Administration, and in response to the enactment of the CAA, EBSA began implementing a framework to enforce the new requirements. EBSA formed a MHPAEA NQTL Task Force (Task Force) composed of experienced investigators, health policy experts, technical experts from EBSA's regional and national offices, and attorneys from the Office of the Solicitor of Labor. The Task Force worked closely with agency leadership as well as the regional offices (who are the agency's frontline enforcers) to implement the new provisions. As detailed in the FAQs Part 45, EBSA selected the following four NQTLs to focus on in FY2021: (1) preauthorization for inpatient services; (2) concurrent care review for inpatient and outpatient services; (3) out-of-network provider reimbursement rates; and (4) provider network admission and participation criteria, including reimbursement rates.¹⁸ The Task Force evaluated existing investigations to identify NQTLs for comparative analysis requests pursuant to the CAA. As detailed below, the responses to many initial requests involved potential violations related to FY2021's four focus NQTLs.

Under this initiative, EBSA issued 156 letters to plans and issuers requesting comparative analyses for 216 unique¹⁹ NQTLs across 86 investigations. All 156 plans and issuers have responded. After analyzing the responses received, EBSA issued 80 insufficiency letters covering more than 170 NQTLs. EBSA has also issued 30 initial determination letters that identified 48 impermissible NQTLs, as described below. EBSA continues to assess the remaining responses received to date from plans and issuers. While EBSA has not yet made final determinations regarding these requests and responses, this first report under the CAA outlines the agency's impressions of compliance with the new provisions as well as EBSA's efforts to enforce the law.

¹⁸ 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-ebbsa/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>.

¹⁹ In this report, DOL distinguishes between NQTLs and "unique" NQTLs to better gauge how many NQTLs it is addressing. In general, a "unique" NQTL is a limitation that the Department has identified under a plan or health coverage. However, where many NQTLs might be replicated in multiple benefit classifications in that plan, those additional NQTLs are not included as "unique" NQTLs where the NQTLs are otherwise identical. Similarly, NQTLs might be replicated across multiple plan options, especially where the plan options differ by the level of co-insurance or copays, etc. Also, in those instances, those identical NQTLs are not counted as "unique" NQTLs because they are otherwise identical within the same plan. As one example, an NQTL imposed by a plan/issuer might affect more than one benefit classification; it might be imposed on the following classifications: (1) in-patient, in-network, (2) in patient out-of-network, (3) out-patient in-network, and (4) out-patient out-of-network. In this case, unless EBSA receives a parity analysis that is materially different for each benefit classification, then this NQTL is counted as one unique NQTL instead of four. Likewise, if an issuer or service provider applies the same NQTL across 100 plans, EBSA counted this as one NQTL instead of 100, even if EBSA issued more than one request for a comparative analysis relating to that NQTL. If EBSA were to count each NQTL separately by benefit classification, plan, and product, then the number of NQTLs for which EBSA requested a comparative analysis would be 1,112.

As mentioned above, EBSA identified the recipients of the majority of its initial comparative analysis requests by conducting a comprehensive review of its existing inventory of open investigations, although EBSA opened some new cases specifically to request comparative analyses. EBSA chose to request the majority of the comparative analyses in relation to NQTLs where EBSA had previously developed specific investigative leads, indicating a possible violation of Title I of ERISA, as a part of its standard investigative process. This approach is consistent with EBSA’s strategy of leveraging its limited investigative resources to target potential violations based on specific leads that, if corrected, will have the greatest impact on the mental health benefits of participants and beneficiaries.

Obtaining sufficient information from plans and issuers to determine whether they are complying with MHPAEA’s NQTL requirements is complex and time-consuming. Historically, this process was even more difficult because plans often did not have a written parity analysis before the CAA imposed the comparative analysis requirement. Gathering and analyzing information needed to make a compliance determination was resource intensive, because key information about the processes, strategies, evidentiary standards, and factors used to apply the NQTL was spread across an array of documents or computer systems and often was in the possession of a variety of different plan representatives across various corporate divisions. The CAA’s new requirements directly address the difficulties, but, as detailed below, challenges remain.

This year, under the Biden-Harris Administration and after the enactment of the CAA, EBSA enhanced its MHPAEA NQTL enforcement program by increasing the investigative resources dedicated to NQTL review and analysis. This included the creation and refinement of tools and techniques to more thoroughly evaluate MHPAEA NQTL compliance and identify parity violations. For example, EBSA developed request templates for NQTL comparative analyses so that investigators could move quickly and, to the extent possible, make uniform requests to plans and issuers.²⁰ EBSA has also significantly expanded staffing, increased staff specialization, developed tools for use in investigations, and retained contractor support for enforcement of MHPAEA’s NQTL provisions. A key component of EBSA’s push for increased enforcement of NQTLs has been training new and existing staff. Between April and September 2021, the Task Force delivered more than 15 training sessions to groups ranging in size from 15 to 500 investigators, managers, benefits advisors, and attorneys from the Office of the Solicitor. At the first large-group training session focusing on NQTLs, Secretary Walsh spoke to all investigative staff to underscore the importance of MHPAEA enforcement and the impacts of timely access to MH/SUD care. EBSA’s regional offices conducted many more NQTL-specific training sessions tailored to staff needs.

1. Summary of Requests and Identification of Non-Compliant Plans and Issuers²¹

Between April 9, 2021 and October 31, 2021, EBSA issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs, across 86 investigations. Of the 156 letters, EBSA issued 141 to plans (7 to plans providing fully-insured coverage and 134 to plans providing self-funded coverage) and 15 to issuers. EBSA’s requests sought information concerning many different kinds of NQTLs. The

²⁰ Complete uniformity is not possible because the range of possible NQTLs imposed by a large health plan or issuer is very broad and the number of possible permutations for each NQTL, as written and in operation, is very large.

²¹ This summary fulfills the Secretary’s reporting obligations under ERISA section 712(a)(8)(B)(iv)(I), 29 U.S.C. § 1185a(a)(8)(B)(iv)(I), which requires the Secretary to submit a yearly “summary of the comparative analyses requested . . . , including the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb)[.]”

following is a list of the most common NQTLs for which EBSA requested a comparative analysis, listed in descending order of frequency.

1.	Preauthorization or precertification requirements
2.	Network provider admission standards
3.	Concurrent care review
4.	Limitations on applied behavior analysis or treatment for autism spectrum disorder
5.	Out-of-network reimbursement rates
6.	Treatment plan requirements
7.	Limitations on medication assisted treatment for opioid use disorder
8.	Provider qualification or billing restrictions
9.	Limitations on residential care or partial hospitalization programs
10.	Nutritional counseling limitations
11.	Speech therapy restrictions
12.	Exclusions based on chronicity or treatability of condition, likelihood of improvement, or functional progress
13.	Virtual or telephonic visit restrictions
14.	Fail-first or step therapy requirements

The report required under section 203 of title II of Division BB of the CAA must include “a summary of the comparative analyses, as well as the identity of each group health plan or health insurance issuer, with respect to certain health insurance coverage, that is determined to be not in compliance after the final determination by the Secretary.” DOL has yet to make a final determination under ERISA section 712(a)(8)(B)(iii)(I)(bb) that a plan or issuer is not in compliance with the section 712 requirements. EBSA is reviewing the comparative analyses, corrective action plans, and other information received, as well as engaging with plans and issuers to obtain additional information in an ongoing effort to assess compliance.

2. EBSA’s Conclusions Regarding Sufficiency of Responses²²

In order to make a determination relating to a plan’s or issuer’s compliance with MHPAEA, EBSA must first assess whether the response provides sufficient information to make a compliance determination. In cases where EBSA determines that additional information is needed, the agency issues an insufficiency letter, which notifies the plan or issuer of the additional information it must submit.²³

Because the plan language, application, and other relevant facts surrounding each NQTL are unique and vary by case and by NQTL, EBSA has implemented a comprehensive review process to ensure a consistent approach across cases and similar NQTLs.

Between April 16, 2021 and October 31, 2021, EBSA received and began a detailed review of the responses from 156 plans and issuers, which addressed over 200 unique NQTLs. None of the comparative

²² This summary fulfills the Secretary’s reporting obligations under ERISA section 712(a)(8)(B)(iv)(II), 29 U.S.C. § 1185a(a)(8)(B)(iv)(II), which requires the Secretary to submit his “conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested... for compliance with this section[.]”

²³ See ERISA section 712(a)(8)(B)(ii), 29 U.S.C. § 1185a(a)(8)(B)(ii).

analyses reviewed to date contained sufficient information upon initial receipt.²⁴ The responses either did not contain a comparative analysis, were missing specific information required under ERISA section 712(a)(8)(A)(i)-(v) or did not include additional information required in order to assess compliance.

As a result of EBSA's ongoing review of these responses, EBSA has issued 80 letters noting deficiencies in the analysis and requesting additional information in connection with over 170 NQTLs. Twelve of the 80 letters were sent to plans or issuers that had already received an insufficiency letter, identifying deficiencies in the analysis and requesting additional information, but had failed to address the deficiencies noted in the first insufficiency letter, failed to provide the information requested, or provided new information that raised additional questions about the plan's comparative analysis. Through receipt of comparative analyses, as well as independent investigation, EBSA ultimately obtained sufficient information to make initial determinations of non-compliance for 30 plans and issuers in connection with 48 NQTLs (36 unique NQTLs).²⁵

Despite not yet having issued any final determinations, EBSA has identified some common issues among the responses received thus far. EBSA is sharing these initial impressions to provide a better sense of the specific challenges it has faced in evaluating compliance in advance of this first reporting deadline and to provide greater specificity and clarity as to what EBSA expects in terms of compliance with the new CAA and MHPAEA requirements.

a. Many Plans/Issuers Were Unprepared

The CAA, enacted on December 27, 2020, amended ERISA²⁶ to require plans and issuers to perform and document comparative analyses of the NQTLs they apply to MH/SUD benefits, and to be prepared to make those analyses available to the Secretary of Labor upon request, as of February 10, 2021.²⁷ EBSA issued its first requests for comparative analyses on April 10, 2021, two months after plans and issuers were required to have their analyses ready for DOL's review. Nevertheless, approximately 40 percent of plans and issuers responded to EBSA's initial request letter with a request for an extension of time to respond. Given this high percentage, EBSA concludes that many plans and issuers were deficient in their statutory obligation to perform and document the necessary analyses.

Specifically, a significant number of plans sought extensions on the grounds that the requested analyses either were not complete, or in some cases not yet begun. It appeared that some plans began the process of considering MHPAEA compliance and complying with the requirements of ERISA section 712(a)(8) only after receiving EBSA's request for a comparative analysis. A number of plans stated that they were unable to comply with EBSA's requests because they erroneously assumed that service providers would prepare a comparative analysis for the plan, or that service providers would have prepared their own comparative analysis upon which the plan could rely. Instead, those plans realized after receiving EBSA's request that the service provider had not prepared a comparative analysis that the plan

²⁴ Not all responses contained comparative analyses. For instance, in response to approximately 35 comparative analysis requests, EBSA received a response containing additional information showing that the limitation was not an NQTL, or that the NQTL had been removed and corrected before the passage of the CAA. These responses were neither deficient nor comparative analyses.

²⁵ This number of 48 NQTLs represents 36 unique NQTLs using the counting approach described in FN19.

²⁶ The CAA amended ERISA, the PHS Act, and the Internal Revenue Code. This section refers only to the amendments to ERISA.

²⁷ See Pub. L. 116-260, Section 203, title II, Division BB.

could use. In other instances, plans requested lengthy extensions because they needed time to find someone to draft a comparative analysis for them.

The requirements of ERISA section 712(a)(8) are essential components of a plan's duty to ensure that it is complying with MHPAEA, and violations of those requirements can put participants and beneficiaries at risk. While the CAA added the new requirement to document NQTL parity analyses, plans and issuers have been required to comply with MHPAEA's parity standards for over a decade, and EBSA has long encouraged plans and issuers to document the steps taken to ensure compliance.²⁸ Accordingly, EBSA has generally required a plan or issuer to demonstrate a legitimate reason for an extension before agreeing to requests to delay submission of their comparative analysis. When plans and issuers requested extensions of time, EBSA used that opportunity to refer plans and service providers to guidance, such as FAQs Part 45 and the MHPAEA Self-Compliance Tool, Enforcement Fact Sheets, and webcasts, to educate plans and issuers about their obligations under MHPAEA and the CAA.²⁹

b. All Comparative Analyses Reviewed by EBSA Were Initially Insufficient

The CAA requires that all comparative analyses contain certain features; EBSA determined that all the comparative analyses it reviewed between April 10, 2021, and October 31, 2021, were initially insufficient regarding these statutory requirements.³⁰ Many plans and issuers could not provide sufficient documentation of their analyses demonstrating parity. This was EBSA's experience with plans and issuers before the enactment of the CAA, and this continues to be true now, despite the CAA's new compliance requirements.

The comparative analyses reviewed by EBSA were deficient because they:

- Failed to identify the benefits, classifications, or plan terms to which the NQTL applies;
- Failed to describe in sufficient detail how the NQTL was designed or how it is applied in practice to MH/SUD benefits and medical/surgical benefits;
- Failed to identify or define in sufficient detail the factors, sources, and evidentiary standards used in designing and applying the NQTL to MH/SUD and medical/surgical benefits;
- Failed to analyze in sufficient detail the stringency with which factors, sources, and evidentiary standards are applied; and/or
- Failed to demonstrate parity compliance of NQTLs as written and in operation.

EBSA observed several common themes in deficiencies. The following is a list of the most common ways a comparative analysis fell short. Many of these deficiencies were addressed in FAQs Part 45, released by the Departments on April 2, 2021.

²⁸ MHPAEA took effect on January 1, 2010, and its corresponding final regulations took effect for plan years starting on or after July 1, 2014. Pub.L. 110-343 (October 3, 2008); 29 C.F.R. Part 2590.712(i).

²⁹ See Mental Health and Substance Use Disorder Parity, available at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

³⁰ This statement applies to only the comparative analyses received for limitations requiring comparative analyses. Not all of the 156 responses EBSA received required a comparative analysis to determine compliance. Some plans and issuers responded to a request with an explanation of how the plan had already been amended to remove the NQTL in question before enactment of the CAA or the Secretary's request. Other plans or issuers responded to a request with an explanation that led EBSA to conclude that the limitation in question was a separate treatment limitation only applicable to MH/SUD benefits, in violation of ERISA section 712(a)(3), irrespective of a comparative analysis.

- **Failure to document comparative analysis before designing and applying the NQTL.** Too often, plans had not completed or started a comparative analysis until after EBSA requested one. In some cases, the plans had imposed the NQTL for years without analyzing compliance with MHPAEA or preparing a written comparative analysis.
- **Conclusory assertions lacking specific supporting evidence or detailed explanation.** Many deficient comparative analyses were not accompanied by a specific explanation (beyond a conclusory or speculative statement) or evidence addressing the comparability in application between medical/surgical and MH/SUD benefits.
- **Lack of meaningful comparison or meaningful analysis.** Many comparative analyses used a multi-page table format organized into two columns, one for medical/surgical and another for MH/SUD benefits, but then populated the table by merely reciting the same general text in both columns. The general text lacked sufficient detail to draw a meaningful comparison, but instead included a conclusory statement over both columns noting that the plan/issuer is in compliance because the processes, strategies, evidentiary standards, and other factors were “the same.” To the extent that these comparative analyses identified factors and evidentiary standards used to develop or apply the NQTL, they did not provide any specific, detailed comparison of those factors, definitions of those factors and standards, or identification and explanation of their application and any resulting disparities. In some instances, comparative analyses contained broad statements that the plan applied “no NQTLs” to MH/SUD benefits or that factors were applied equally, where plan documents plainly contradicted such statements. Other comparative analyses focused on descriptions of efforts undertaken to review plan compliance generally and the existence of review committees, but without details about what specifically was done or decided, by whom, when, or how it related to specific NQTLs.
- **Non-responsive comparative analysis.** Many plans produced comparative analyses that did not address the specific NQTL requested, were outdated due to the passage of time or change(s) in plan terms, or were generically prepared by a service provider to address an entirely different line of business or product than the plan or coverage at issue.
- **Documents provided without adequate explanation.** Many plans and issuers provided supporting documents for which the relevance and probative value was not readily apparent, and without a specific explanation of how they related to or supported the comparative analysis. For example, in response to a request for an analysis demonstrating and comparing how preauthorization is applied in practice, a plan produced dozens of benefit-specific medical policies without explaining what the policies showed, and without reference to specific provisions in each or how they are applied in practice. In this case, the production of policies did not demonstrate parity.
- **Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification(s) affected by an NQTL.** Some plans and issuers did not clearly indicate how they treated certain benefits for purposes of MHPAEA compliance, such as whether intermediate services are considered inpatient or outpatient, or whether benefits for certain therapies are considered medical/surgical or MH/SUD benefits.

- **Limiting scope of analysis to only a portion of the NQTL at issue.** Some comparative analyses focused on only one narrow aspect of an NQTL. For instance, several comparative analyses for out-of-network reimbursement rates failed to identify or compare all the specific methodologies used within the relevant benefit classifications, including methodologies used by third-party pricing entities.
- **Failure to identify all factors.** Some comparative analyses identified only some factors specifically but noted there were or could be more factors that were not identified or explained in the comparative analysis that could be relevant to the NQTL’s application. Most failed to confirm that the factors identified in the comparative analysis were the only factors used in the NQTL’s application.
- **Lack of sufficient detail about identified factors.** One of the core statutory requirements of the comparative analysis process is that all the various factors underlying an NQTL’s application must be clearly defined. Unless all relevant factors are explicitly defined to clearly show that the factor is applied in a comparable way in all cases, the parity analysis may be inaccurate, or even subject to manipulation. However, in many instances, comparative analyses did not define every factor and did not specify the evidentiary standard used in each factor’s application, especially when the factor was applied or evaluated in a quantitative way. For example, a comparative analysis was not sufficient if it named a factor like “cost containment” or “high-cost services” in how the plan determined which benefits should be subject to preauthorization, but did not contain a precise definition of those terms, an explanation of whether and how the plan derived a numerical standard for applying such terms to benefits, and supporting documents showing the term’s application. Absent precise definitions, these factors do not have objective meanings, and can result in an analysis comparing “apples to oranges.” Even if a numerical evidentiary standard used to define a factor was specified and defined, a comparative analysis could still be deficient if it used different standards for MH/SUD versus medical/surgical benefits and those differences were not explained.

Other comparative analyses fell short in similar fashion by naming a variety of factors but failing to explain how the identified factors related to each other in the overall evaluation process, such as whether any were given more weight or how and when each was considered in relation to the others. Other comparative analyses referred to “discretionary” factors, but did not define them, explain how they were applied or with whose discretion, or note the bounds or parameters of such discretion. For example, if a committee that manages network provider admissions can review additional discretionary criteria, such as “quality of care” or “network adequacy” to grant network status to providers that fail a base set of criteria, the discretionary criteria must be fully defined and explained.

- **Failure to demonstrate the application of identified factors in the design of an NQTL.** Many comparative analyses failed to explain precisely how each factor was applied and to which benefits, to show the outcome of the factor’s application, and to produce documentation showing this process. If a factor was actually considered in deciding which benefits would be subject to an NQTL, then plans and issuers must provide documentation showing the specific evaluation of benefits using that factor and a robust description demonstrating its actual application and

consideration in specific, articulable, and documented decisions concerning the design of an NQTL.

- **Failure to demonstrate compliance of an NQTL as applied.** Most comparative analyses failed to evaluate the relative stringency of how the NQTL is applied to MH/SUD versus medical/surgical benefits. Specifically, they failed to demonstrate that 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 benefits than to medical/surgical benefits. Submissions lacked both a sufficiently detailed explanation of how an NQTL was applied to MH/SUD versus medical/surgical benefits, and documentation showing review of how an NQTL is applied in operation.

Review of how an NQTL is applied in operation can include a comparison of outcomes resulting from an NQTL's application. While outcomes are not determinative of MHPAEA compliance, disparate outcomes can be relevant, and may constitute warning signs or indicators of potential operational MHPAEA parity non-compliance. The precise evidence a plan or issuer may use to demonstrate compliance of an NQTL as applied will vary depending on the NQTL. For example, a plan or issuer testing the relative stringency of how it applies the NQTL of concurrent care or preauthorization review to MH/SUD benefits versus medical/surgical benefits might test denial rates, reasons for denial, utilization rates, frequency of reviews, lengths of reviews, lengths of stays authorized, frequency of elevation to a peer-to-peer review, or review turnaround times. For an NQTL related to network admission standards, demonstration of comparability as applied might include comparisons of rates for acceptance/denial or withdrawal for MH/SUD and medical/surgical providers, application processing time, network reimbursement rates, latitude granted rate negotiators, or the role of network adequacy metrics.³¹

For the plans and issuers that did provide specific information on how an NQTL is applied in operation, such as information on claims metrics or relative percentages, many plans and issuers failed to provide the contextual information needed to evaluate the claims metrics provided. Necessary information includes a description of the methodology, source data, and calculations used to generate the numbers being compared. To the extent that a claims analysis or any data about how an NQTL is applied reveals any disparities in the application of an NQTL to MH/SUD and medical/surgical benefits, then the plan/issuer should explain how the NQTL is operationally comparable and not more stringently applied in light of such disparities.

When faced with comparative analyses that were deficient in these ways, EBSA issued detailed insufficiency letters. Through the insufficiency letters, EBSA gave plans and issuers opportunities to supplement their comparative analysis by answering specific questions raised by the materials and by providing and producing additional documentation. EBSA issued more than one insufficiency letter to some plans and issuers because their response to the first insufficiency letter did not cure the insufficiency or provided new information requiring additional clarification.

³¹ The preamble to the MHPAEA final regulation identifies network adequacy as a plan standard that must be applied in a manner that complies with the final regulations. 78 FR 68240, 68246 (Nov. 13, 2013)

c. Some Responses, Combined with Independently Investigated Information, Were Sufficient to Make a Preliminary Determination of Non-Compliance

In certain instances, the nature of the NQTLs allowed DOL to make determinations despite the lack of completeness and insufficiency of comparative analyses provided. Between August 5, 2021 and October 31, 2021, EBSA issued letters to 30 plans and issuers noting initial determinations of non-compliance for 48 NQTLs.³² EBSA is evaluating responses and gathering additional information to determine compliance for the remaining NQTLs for which it already requested comparative analyses.

3. EBSA’s Conclusions Regarding Compliance with Disclosure Requirements³³

As noted above, as of October 31, 2021, EBSA has determined it has sufficient information to allow for a compliance review on a total of 48 NQTLs (36 unique NQTLs) corresponding to 30 plans and issuers.³⁴ One hundred percent of these compliance reviews resulted in an initial determination of non-compliance with MHPAEA, and EBSA issued letters to the same 30 plans and issuers noting initial determinations of non-compliance for those 48 NQTLs. These initial determination letters involved the following NQTLs that were not applied in parity for MH/SUD benefits:

NQTL	Number of Initial Determinations of Non-compliance for that NQTL
Limitation or exclusion of applied behavior analysis therapy or other services to treat autism spectrum disorder	9
Billing requirements – licensed MH/SUD providers can bill the plan only through specific types of other providers	7
Limitation or exclusion of medication-assisted treatment for opioid use disorder	4
Preauthorization or precertification	4
Limitation or exclusion of nutritional counseling for MH/SUD conditions	4
Provider experience requirement beyond licensure	3
Care manager or specific supervision requirement for MH/SUD	2
Exclusion or limitation on residential care or partial hospitalization to treat MH/SUD conditions	2
“Effective treatment” requirement applicable only to SUD benefits	1
Treatment plan requirement	1
Employee assistance program referral requirement	1
Exclusion of care for chronic MH/SUD conditions	1
Exclusion of speech therapy to treat MH/SUD conditions	1
Concurrent care and discharge planning requirements	1

³² The 30 responses did not necessarily contain sufficient information, standing alone, to satisfy the requirements of ERISA section 712(a)(8). Instead, the information available to EBSA through its independent investigation and/or the responses from the plans contained sufficient information to find a violation of one or more of ERISA section 712’s requirements.

³³ This summary fulfills the Secretary’s reporting obligations under ERISA section 712(a)(8)(B)(iv)(III) – “for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary’s conclusions as to whether and why the plan or issuer is in compliance with the disclosure requirements under this section[.]”

³⁴ These 30 letters and 48 NQTLs exclude one instance in which a plan’s response to an initial determination letter highlighted that the plan’s previous communications to EBSA were incorrect and no corrective action plan was necessary.

Retrospective review	1
Maximum allowable charge and reference-based pricing	1
Other exclusion specifically targeting MH/SUD benefits	1
Age, scope, or durational limits	1
Formulary design	1
Limit on telehealth for MH/SUD	1
Restriction on lab testing for MH/SUD	1
Total	48

a. EBSA’s Comparative Analysis Review Detected Common Problems and Shed Light on Unexamined Plan Terms and Practices

In several instances where EBSA issued an initial determination of non-compliance, the NQTL functioned as an impermissible separate treatment limitation that was applied only to MH/SUD benefits. In other instances, plan language suggested that MH/SUD benefits were subject to more stringent limitations than medical/surgical benefits, and the plans failed to provide the statutorily required analysis supporting comparability.

b. EBSA’s Work Led to Increased Access to MH/SUD Benefits

Between September 17, 2021 and October 31, 2021, EBSA received corrective action plans from 19 plans in response to initial determination letters. These corrective action plans address 36 NQTLs (30 unique NQTLs). EBSA is evaluating those corrective action plans, and some corrective action is already underway. In other instances, where EBSA did not ultimately issue an initial determination of non-compliance, plans and issuers decided to remove an NQTL after receiving an initial request, insufficiency letter, or follow-up request.

As a result of EBSA’s reviews and as of October 31, 2021, 26 plans and issuers have indicated they intended to or are already in the process of making prospective changes to their plans for 43 NQTLs (32 unique NQTLs), including:

- Complete removal of a specific NQTL limiting MH/SUD benefits, including changes to plan document language and changes to claims processing procedures;
- Addition of coverage for MH/SUD benefits previously excluded;
- Reduction of scope of an NQTL imposed on MH/SUD benefits; and
- Notice to participants and beneficiaries of a change in plan terms.

Below we provide five examples that demonstrate the impact of these prospective corrections.

Example #1 – Removal of ABA Therapy Exclusion

Part of EBSA’s strategic approach to NQTLs is to identify and focus on service providers that are in a position to enact widespread change for an entire line of business and potentially many affected plans that they serve. In this instance, EBSA discovered that a large service provider was administering claims for hundreds of self-funded plans across the country to exclude applied behavior analysis (ABA) therapy to treat autism spectrum disorder (ASD). ASD is a developmental disability that is identified in about 1 in 54 children³⁵ and can cause significant life-long social, communication, and behavioral challenges.³⁶ ABA therapy, a primary treatment for ASD, is delivered by a behavioral specialist and often involves sessions recurring multiple times a week over the course of months or years.³⁷ Research shows that early intervention and access to treatments like ABA therapy can improve the trajectory of a child’s development,³⁸ so delays or limits on access to treatments like ABA therapy are especially harmful for children with ASD.

After identifying plans administered by the service provider that had an exclusion for ABA therapy, EBSA’s Los Angeles Regional Office issued requests for comparative analyses to some of those plans, and has issued initial findings of non-compliance for some of those plans. So far, three plans that received a request from the Los Angeles Regional Office for a comparative analysis for the ABA exclusion have confirmed the removal of the ABA exclusion going forward. These three plans will now cover ABA therapy for ASD. Corrections for these three plans affect over 18,000 participants.

Following discussions between EBSA and the service provider about the exclusion and the issuance of comparative analysis requests to its plan clients, EBSA learned that the service provider issued a notice to nearly one thousand plan clients, with over 500,000 participants, notifying the plans of EBSA’s parity concerns about the exclusion of ABA therapy. The service provider also advised the plans that it would not apply the ABA exclusion going forward unless a plan affirmatively states that it wishes to retain the exclusion, has consulted with legal counsel concerning the exclusion, and wishes to contend that the exclusion is compliant with MHPAEA. For plans that do not do so, the service provider will stop applying the ABA exclusion, effective starting between November 1, 2021 and January 1, 2022.

EBSA will continue to work with the service provider to ensure that it has contacted all affected self-funded plans and that the plans take appropriate corrective action, including working with the service provider to identify participants and beneficiaries who have had claims denied because of the ABA therapy exclusion.

Example #2 – Removal of Exclusion on Medication-Assisted Treatment (MAT) for Opioid Use Disorder

The United States is in the midst of a rapidly escalating opioid and other drug overdose epidemic.³⁹ Removing impermissible restrictions on access to SUD treatments is an enforcement priority, as timely

³⁵ <https://www.cdc.gov/ncbddd/autism/data.html>

³⁶ <https://www.cdc.gov/ncbddd/autism/facts.html>

³⁷ <https://www.cdc.gov/ncbddd/autism/treatment.html>

³⁸ <https://www.cdc.gov/ncbddd/autism/treatment.html>;

<https://www.nichd.nih.gov/health/topics/autism/conditioninfo/treatments/early-intervention>

³⁹ <https://www.cdc.gov/opioids/basics/epidemic.html>

access to evidence-based SUD treatments can mean the difference between life and death.⁴⁰ Medications for opioid use disorder (MOUD), alone or in combination with behavioral or psychosocial services, can successfully treat opioid use disorder, and ongoing MOUD can help sustain recovery.⁴¹ Research suggests that MOUD in combination with therapeutic services—also known as medication-assisted treatment (MAT)—may be more effective than MOUD alone.⁴²

In this instance, a large, self-funded Taft-Hartley health plan, covering 7,600 participants, specifically excluded methadone and naltrexone as treatment for SUD conditions. These medications are proven essential to a comprehensive, evidence-based opioid use disorder treatment continuum. In this instance, the plan did not place a similar restriction on medications to treat medical/surgical conditions and did not have a comparative analysis describing the processes, strategies, evidentiary standards, or other factors used to develop the exclusion. After receiving DOL’s initial determination letter, the plan removed the exclusion from its plan documents and notified its participants and beneficiaries of the change in plan terms.⁴³ EBSA’s Boston Regional Office is working with the plan to identify affected participants and beneficiaries and to take appropriate retrospective corrective action for the NQTL.

Example #3 – Removal of Nutritional Counseling Exclusion for MH/SUD Conditions

Two large plans using similar fully-insured products (an exclusive provider organization (EPO) product and a preferred provider organization (PPO) product) offered by the same health insurance issuer covered nutritional counseling for medical/surgical conditions like diabetes, but not for mental health conditions like anorexia nervosa, bulimia nervosa, and binge-eating disorder. Eating disorders are serious and often fatal illnesses associated with severe disturbances in people’s eating behaviors and related thoughts and emotions.⁴⁴ Eating disorders are among the deadliest MH/SUD conditions, and anorexia nervosa has the highest mortality rate of any mental health disorder.⁴⁵

EBSA’s New York Regional Office requested comparative analyses for the nutritional counseling limitation from both plans and directly from the issuer offering the fully-insured products used by the plans. The responses received from the plans and the issuer did not explain or demonstrate that the facially-discriminatory exclusion, which affected only MH benefits, was compliant with parity requirements. As a result, both plans have amended their coverage documents to remove the exclusion, and the issuer is in the process of submitting forms to state regulators to remove the NQTL from the fully-insured products. This correction will impact over 1.2 million participants covered by 602 ERISA-covered plans using the issuer’s fully-insured EPO and PPO products. The New York Regional Office is working with the plans and issuer to identify and specify appropriate retrospective corrective action for the NQTL.

⁴⁰ <https://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf>

⁴¹ <https://www.samhsa.gov/medication-assisted-treatment>

⁴² Providers’ Clinical Support System. (2021) Overview of Medications for Opioid Use Disorder (MOUD). Retrieved on December 10, 2021 at <https://pcssnow.org/medications-for-opioid-use-disorder/>

⁴³ As a result of EBSA’s findings, this plan also removed two more NQTLs: (1) a requirement that all services offered through a school system must be exhausted before services for autism are covered by the Plan, and (2) a requirement that outpatient lab testing services must be supervised by special SUD benefit administrator.

⁴⁴ <https://www.nimh.nih.gov/health/topics/eating-disorders>.

⁴⁵ <https://www.nimh.nih.gov/health/topics/eating-disorders>; <https://anad.org/get-informed/about-eating-disorders/eating-disorders-statistics/>; <https://anad.org/get-informed/about-eating-disorders/eating-disorders-statistics/>.

Example #4 – Removal of Limitation on Urine Drug Testing for MH/SUD Conditions

A service provider to many large, self-funded Taft-Hartley plans has been processing claims in a discriminatory manner that results in automatic denial of coverage for urine drug testing related to SUD disorders. Urine drug testing is an integral part of SUD treatment and is often required to continue residential treatment.⁴⁶ EBSA identified this NQTL through a detailed review of claims before the enactment of the CAA. Following the CAA's enactment, EBSA's Kansas City Regional Office issued requests for comparative analyses to a sample of the service provider's self-funded client plans, focusing on urine drug testing. Many of these plans were unprepared to provide a comparative analysis and seemed largely unaware of the problematic practice, which occurred at the service provider level. As a result of Kansas City Regional Office's engagement with the self-funded plans and their service provider directly, the service provider is in the process of identifying improperly denied claims and notifying its client plans of the MHPAEA compliance concern. To date, three plans covering a total of 2,200 participants have adopted new internal procedures for handling claims for urine drug testing that do not involve automatic denials for urine drug testing when related to SUD conditions. EBSA anticipates that additional prospective corrections will occur as the Kansas City Regional Office continues to work with the service provider and the dozens of other plans affected. The Kansas City Regional Office is also working with the service provider to identify and specify appropriate retrospective corrective action for the NQTL.

Example #5 – Removal of Blanket Pre-certification Requirement for MH/SUD Benefits

A large, self-funded Taft-Hartley health plan that provides MH/SUD benefits for more than 1,800 participants contained a plan provision requiring pre-certification of all MH/SUD outpatient services, but only a select list of medical/surgical outpatient services. The plan did not have a comparative analysis for this or any other NQTL and did not have an explanation for this facially discriminatory precertification provision. The plan had not taken steps to comply with the CAA requirements until receiving EBSA's initial request, when it began searching for an advisor to conduct a parity analysis. As a result of the review process, the plan amended its written plan document to no longer require precertification for all MH/SUD services. EBSA's Philadelphia Regional Office is working with the plan to confirm its operations, obtain a comparative analysis for the current precertification requirements, and review the claims process to assess whether any participants were affected by the non-compliant provision.

Beyond these specific examples, EBSA is also working with other plans and issuers to identify participants and beneficiaries harmed by impermissible NQTLs and provide relief, including the following types of corrective activity:

1. Retroactive change in plan terms to remove a limitation, reduce the scope of a limitation, or add a benefit previously excluded;
2. Notice to participants and beneficiaries of an opportunity to submit or resubmit claims as a result of a retrospective change in plan terms;
3. Re-adjudication or payment of improperly denied claims;
4. Amending medical policies, claims processing policies and procedures, or other practices; and
5. Training for claims processing staff.

⁴⁶ <https://pubmed.ncbi.nlm.nih.gov/28557958/>

The appropriate types of relief will depend on the specific facts and circumstances surrounding each NQTL and its application in practice. The process of identifying affected claims and affected participants and beneficiaries is lengthy. Many plans and issuers asserted that an impermissible NQTL did not result in any claim denials. EBSA is working in each case to verify these assertions, request and review source documentation, and obtain documentation showing the underlying methodologies relied upon. In some situations, identifying individuals harmed by an NQTL is not as simple as pulling a list of denied claims. Some NQTLs limit access to MH/SUD benefits in a way that discourages participants and beneficiaries from seeking care at all, such that those participants and beneficiaries never receive care that would otherwise result in the submission of claims. Sometimes the corrective action includes the plan or issuer allowing participants and beneficiaries a special period of time to submit or resubmit claims for services already received. In other instances, depending on the circumstances, corrective action could include automatic payments to affected participants and beneficiaries without requiring them to submit or resubmit paperwork.

EBSA is engaged in discussions with all 19 plans and issuers that submitted corrective action plans, as well as additional plans that offered corrective actions in earlier stages of the review process. The process of determining the appropriate retrospective relief and obtaining proof can be lengthy because of the unique facts and circumstances surrounding each NQTL and its administration. Many plans and issuers have already begun the process of identifying harmed participants and beneficiaries and are making plans to re-adjudicate affected claims. EBSA expects to have more to report on retrospective relief that has occurred by the time of the next annual report.

4. EBSA's Specifications Regarding Sufficiency of Responses⁴⁷

With respect to the 156 responses received from plans and issuers, EBSA has so far issued 80 letters noting that the plans and issuers have failed to provide sufficient information in response to requests for comparative analyses covering over 170 NQTLs (139 unique NQTLs). Below is a summary of EBSA's specifications provided to those plans and issuers, which draw from the statutory requirements of ERISA section 712(a)(8) and the guidance issued by the Departments in FAQs Part 45.

Some responses were insufficient because the plan or issuer did not produce any comparative analysis at all. For plans or issuers that did produce a comparative analysis, the comparative analyses were deficient because they:

1. Did not identify the benefits, classifications, or plan terms to which the NQTL applies;
2. Did not describe how the NQTL was designed or how it is applied in practice to MH/SUD benefits and medical/surgical benefits;
3. Did not identify or define factors, sources, or evidentiary standards used in designing and applying the NQTL to MH/SUD and medical/surgical benefits;
4. Did not include analysis comparing stringency of factors/sources; and/or
5. Did not demonstrate compliance of the NQTL as written and in operation.

⁴⁷ This summary is intended to comply with the Secretary's reporting obligations under ERISA section 712(a)(8)(B)(iv)(IV) – "the Secretary's specifications described in clause (ii) for each group health plan or health insurance issuer that the Secretary determined did not submit sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section[.]"

These specifications matched the specific ways that comparative analyses were deficient, as detailed more fully above in Section II.B.2.b. Examples of specific ways in which the comparative analyses were deficient include:

1. Failure to document comparative analysis before designing and applying the NQTL;
2. Conclusory assertions lacking specific supporting evidence or detailed explanation;
3. Lack of meaningful comparison or meaningful analysis;
4. Non-responsive comparative analysis;
5. Documents provided without adequate explanation;
6. Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification(s) affected by an NQTL;
7. Limiting scope of analysis to only a portion of the NQTL at issue;
8. Failure to identify all factors;
9. Lack of sufficient detail about identified factors;
10. Failure to demonstrate the application of identified factors in the design of an NQTL; and
11. Failure to demonstrate compliance of an NQTL as applied.

5. *EBSA's Specifications Regarding Compliance*⁴⁸

As of October 31, 2021, EBSA had not yet issued any final determinations of non-compliance but had issued 30 letters with initial determinations of non-compliance covering 48 NQTLs. As noted above, a number of plans and issuers have taken actions in response to EBSA's review, which appear to have addressed EBSA's concerns as to the MHPAEA violations cited in EBSA's initial determination letters. EBSA is reviewing corrective action plans in response to the preliminary determinations of non-compliance covering 36 NQTLs (30 unique NQTLs) and assessing the remainder of responses to requests issued during 2021 for sufficiency and compliance. Should any of these reviews result in a final determination of non-compliance, the final determination will be included in next year's report to Congress, and DOL will consider whether further enforcement activity is warranted on a case-by-case basis.

C. HHS' MHPAEA Enforcement Activity under the CAA

HHS has primary enforcement authority over issuers in states that do not have authority to enforce or fail to substantially enforce MHPAEA (referred to as direct enforcement states⁴⁹) and non-Federal

⁴⁸ This summary is intended to comply with the Secretary's reporting obligations under ERISA section 712(a)(8)(B)(iv)(V) - "the Secretary's specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance."

⁴⁹ CMS is responsible for enforcement of MHPAEA with respect to non-Federal governmental group health plans in all 50 states, the District of Columbia, and the territories. In the 2021 plan year, CMS was also the direct enforcer of MHPAEA with regard to issuers in Missouri, Texas, and Wyoming. In addition, six states (Alabama, Florida, Louisiana, Montana, Oklahoma, and Wisconsin) have entered into collaborative enforcement agreements with CMS which include MHPAEA enforcement. These latter states perform state regulatory and oversight functions with respect to MHPAEA; however, if the state finds a potential violation and is unable to obtain compliance by an issuer, the state will refer the matter to CMS for possible enforcement action.

governmental health plans in all states.⁵⁰ Sponsors of self-insured non-Federal governmental group health plans may elect to exempt those plans from (opt out of) the requirements of MHPAEA, including the NQTL comparative analysis requirements under the CAA.⁵¹ CMS is tasked with carrying out HHS's enforcement responsibilities under title XXVII of the Public Health Service Act (PHS Act), including enforcement of MHPAEA. Given the agency's relatively limited jurisdiction and resources, CMS requested 21 comparative analyses from four non-Federal governmental plan sponsors and nine issuers in direct enforcement states between May and November 2021.⁵² The requests were prompted by previous indications of MHPAEA non-compliance in market conduct examinations, findings of MHPAEA concerns during CMS's research in response to GAO-20-150 (MHPAEA Government Accountability Office Audit) for non-Federal governmental plans,⁵³ and random selection of issuers and of NQTLs imposed by issuers in direct enforcement states.

Pursuant to PHS Act section 2726(a)(8)(B)(iii)(I)(aa), upon CMS's review of the comparative analysis and a determination of non-compliance, the plans and issuers were required to provide a corrective action plan and additional comparative analysis that demonstrated compliance within 45 calendar days of the date of the initial determination letter. The statute indicates that plans and issuers will first provide a corrective action plan upon the initial determination of non-compliance. Due to the considerable variability in processes, strategies, evidentiary standards, and other factors used in NQTL design by plans and issuers, CMS does not dictate what must be included in the initial corrective action plan submission. CMS provides information and technical guidance to plans and issuers regarding corrective action plan submissions upon request. Plans and issuers are generally expected to provide sufficient information to complete a review of their comparative analysis (e.g., conduct a stringency analysis to examine the implementation of the NQTL); correct the identified issue(s) of non-compliance (e.g., update their plan documents and policy language; remove an NQTL that applies only to MH/SUD benefits and not medical/surgical benefits; etc.); and perform a self-audit to identify consumers who were affected by the NQTL in order to re-adjudicate claims and/or denials. If the initial corrective action plans submitted by the plans and issuers do not correct the instances of non-compliance, the final determination letter from CMS will include an updated corrective action plan created by CMS directing the plan or issuer on next steps to come into compliance.

⁵⁰ Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies, GAO-20-150, Dec. 2019, available at: <https://www.gao.gov/assets/gao-20-150.pdf>.

⁵¹ See 45 CFR 146.180(a)(1)(v).

⁵² Multiple NQTL comparative analyses were requested from some issuers, resulting in 21 total comparative analysis reviews.

⁵³ In December 2019, the Government Accountability Office (GAO) issued a report on state and federal practices for overseeing compliance with MHPAEA. The report included the following recommendation: "The Administrator of CMS should evaluate whether targeted oversight in response to information received is effective for ensuring compliance with MH/SUD parity requirements for non-federal governmental plans. If this evaluation determines the current targeted oversight approach results in significant program risks, CMS should develop a plan to more effectively enforce MH/SUD parity requirements and if necessary seek additional oversight authority, as warranted." In response, CMS developed an evaluation to determine whether targeted oversight of non-Federal governmental plans is effective for ensuring compliance with MHPAEA. As part of this evaluation, CMS reviewed the plan documents of 10 non-Federal governmental plans (obtained through an electronic records search) for compliance with applicable federal requirements, including NQTLs, QTLs, and financial requirements under MHPAEA. A sample of these 10 plans with identified NQTLs were selected for comparative analysis review.

Of the 21 comparative analyses submitted in response to CMS’s initial comparative analysis requests,⁵⁴ all were found to be insufficient after the initial review. Following CMS’s request for further information and review of supplemental responses submitted by the plans and issuers, 14 comparative analyses remained insufficient and two plans and issuers were found to have impermissible separate treatment limitations in effect. One plan both failed to submit a sufficient comparative analysis and was found to have an impermissible separate treatment limitation in effect, resulting in initial determinations of non-compliance in 15 reviews. Review of the initial and supplemental responses submitted by plans and issuers resulted in final determinations of no findings of non-compliance for three reviews. CMS has issued one determination of no findings of non-compliance after reviewing a corrective action plan submission, resulting in four determinations of no findings of non-compliance as of December 3, 2021. CMS continues to assess the remaining responses from plans and issuers. While CMS has not made any final determinations of non-compliance as of the date of this report, this first report under the CAA outlines the agency’s impressions of compliance with the new provisions as well as the efforts made by CMS to enforce the law.

1. CMS’ Summary of Requests and Identification of Non-Compliant Plans and Issuers⁵⁵

Between May 7 and November 3, 2021, CMS requested a total of 21 comparative analyses across 11 NQTLs. The following is a comprehensive list of the NQTLs for which CMS requested a comparative analysis organized by benefit category.

NQTL	Number of Comparative Analyses Requested
Concurrent review	7
Provider credentialing standards	2
Prior authorization	5
Provider network participation requirements	6
Treatment certification requirements	1
Total:	21

Review of the initial and supplemental responses submitted to CMS by plans and issuers resulted in final determinations of no findings of non-compliance for four reviews. CMS has yet to make a final determination that a plan or issuer is not in compliance with MHPAEA under PHS Act section 2726(a)(8)(B)(iii)(I)(bb). CMS is reviewing the comparative analyses, corrective action plans, and other information received, as well as engaging with plans and issuers to obtain additional information to assess compliance. The results of these reviews will be included in the next annual report to Congress.

⁵⁴ Of the 21 comparative analyses requested by CMS for the 2021 plan year, 19 have been reviewed for an initial determination of sufficiency. At the time of this report, an initial sufficiency determination has not yet been made in two of the reviews requested by CMS for Plan Year 2021 and they are not included in the metrics within this summary. Findings for these reviews will be included in the next annual report to Congress.

⁵⁵ This summary fulfills the Secretary’s reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(I) - "A summary of the comparative analyses requested under clause (i), including the identity of each group health plan or health insurance issuer, with respect to particular health insurance coverage that is determined to be not in compliance after the final determination by the Secretary described in clause (iii)(I)(bb)."

2. CMS' Conclusions Regarding Sufficiency⁵⁶

After receiving a submission from a plan or issuer, CMS reviewed the submission to determine whether sufficient information was provided for CMS to assess compliance. If the information was insufficient, CMS made an initial determination of insufficiency and sent a letter to the plan or issuer describing the additional information that CMS needed to perform its review.

a. Summary – Initial Sufficiency Review Deficiencies

In every review for which CMS made an initial sufficiency determination for the 2021 review period,⁵⁷ the plan's or issuer's initial submission was insufficient in one or more areas. CMS observed several common themes in insufficiencies, and the following is a list of the most common reasons the initial comparative analysis submissions were determined to be insufficient:

- **The comparative analyses did not include all supporting policies and procedures relevant to the design and application of the NQTL.** PHS Act section 2726(a)(8)(A)(iii) requires that plans and issuers provide “any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.” In some instances, the plan or issuer provided only narrative explanations with no supporting policies and procedures. In other instances, the comparative analysis submission included some supporting documentation, but additional supporting documentation was required for CMS to perform a compliance review. Without sufficient supporting documentation, CMS is unable to evaluate whether a plan's or issuer's narrative explanation of parity compliance is accurate. CMS noted this insufficiency in 19 reviews.
- **The comparative analyses did not include sufficient information regarding decisions, decision-makers, and the timing of decisions.** PHS Act section 2726(a)(8)(A)(iii) requires that plans and issuers provide “any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.” This includes information describing the qualifications of any decision-makers or experts involved in the design and application of the NQTL. In some instances, the comparative analysis did not identify any decision-makers. In other instances, certain committees were identified as decision-makers involved in the design and application of the NQTL, but the information provided by the plan or issuer did not specify the qualifications, including clinical specialties, of the individuals on the committee making these decisions. For example, a committee may be used to make decisions about provider admission to participate in a network. That committee would be a source for that NQTL. As such, information about the membership of that committee is necessary to determine whether the NQTL is being applied consistent with parity requirements. If there was no MH/SUD provider representation on these committees, MH/SUD providers would have their qualifications evaluated by individuals who are not qualified or trained in their clinical specialty area, whereas

⁵⁶ This summary fulfills the Secretary's reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(II) “the Secretary's conclusions as to whether each group health plan or health insurance issuer submitted sufficient information for the Secretary to review the comparative analyses requested under clause (i) for compliance with this section.”

⁵⁷ Of the 21 comparative analyses requested by CMS in the 2021 plan year, 19 have been reviewed for an initial determination of sufficiency. At the time of this Report, an initial sufficiency determination has not yet been made in two of the reviews requested by CMS for the 2021 plan year and they are not included in the metrics within this summary. Findings for these reviews will be included in the next annual report to Congress.

medical/surgical providers would be evaluated by peers with similar qualifications. CMS noted this insufficiency in 19 reviews.

- **The plan or issuer provided insufficient information regarding factors, including definitions of factors, explanations for how factors were measured and applied, and any applicable quantitative thresholds used in the design and application of the NQTL.** PHS Act section 2726(a)(8)(A)(ii) requires plans and issuers to provide “[t]he factors used to determine that the NQTLs will apply to [MH/SUD benefits] and medical or surgical benefits.” For example, “cost of episode” may be a factor considered when determining which medical/surgical and MH/SUD services will be subject to an NQTL. This factor may have associated quantitative thresholds used in determining whether the factor applies to a benefit. One such example is that any service with a cost over a particular dollar amount threshold would be subject to the NQTL. Another example is applying an NQTL to any service with a cost increase above a certain percentage threshold. Quantitative thresholds utilized in the design and application of the NQTL, and whether there is any variability in those thresholds between MH/SUD benefits and medical/surgical benefits, are assessed in order to determine whether factors, evidentiary standards, or other aspects of the NQTL are applied comparably and no more stringently to MH/SUD benefits compared to medical/surgical benefits. CMS noted this insufficiency in 18 reviews.
- **The comparative analyses did not include a sufficiently reasoned discussion of the plan’s or issuer’s conclusions as to the comparability and stringency of the NQTL between MH/SUD benefits and medical/surgical benefits, as written and/or in operation.** Comparative Analyses often did not include any analysis or supporting documentation demonstrating that the NQTL was no more stringently applied in operation to MH/SUD benefits compared to medical/surgical benefits. CMS noted this insufficiency in 16 reviews.
- **The comparative analyses did not include sufficient information regarding any variations in the application of any guideline or standard between MH/SUD benefits and medical/surgical benefits.** CMS noted this insufficiency in 13 reviews.
- **The comparative analyses did not sufficiently describe any TPA involvement in the design and application of the NQTL or, if a TPA was involved, any supporting documentation.** CMS noted this insufficiency in 12 reviews.
- **The comparative analyses did not include specific identification or breakdown of MH/SUD benefits and medical/surgical benefits to which the NQTL applies within each benefit classification.** In some instances where a list of MH/SUD benefits and medical/surgical benefits subject to the NQTL was provided, clarification regarding the classification of certain benefits was requested regarding the list provided. CMS noted this insufficiency in 10 reviews.

b. Common Trends Identified in Initial Submissions

Often, CMS requested clarification following its initial review of the comparative analyses submitted because the comparative analyses did not specify whether certain information was applicable. For example, a comparative analysis may have listed factors utilized in the design and application of the

NQTL, but it did not state whether any quantitative thresholds applied. The following list includes the information commonly missing from the comparative analyses:

- Whether any of the factors, evidentiary standards, strategies, or processes utilized in the design and application of the NQTL were defined in a quantitative manner.
- Whether there was any variation in the application of a guideline or standard being relied upon between MH/SUD benefits and medical/surgical benefits, and if so, the process and factors relied upon for establishing that variation.
- A description of the decisions, decision maker(s), timing of the decisions, and qualifications of the decision maker(s) involved in the design and application of the NQTL.
- Whether any experts were involved in the design and application of the NQTL, and if so, an assessment of the expert(s)' qualifications and the extent to which the expert(s)' evaluations were ultimately relied upon in setting recommendations regarding the NQTL.

This list contains information that plans and issuers must make available in response to CMS's request for documentation of a comparative analysis, consistent with the requirements of PHS Act section 2726(a)(8)(A) and as delineated in FAQs Part 45.⁵⁸

It was also common for plans and issuers to fail to include a stringency assessment or analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to, and no more stringently applied than, those applied to medical/surgical benefits, as written and in operation. Often, the plan or issuer provided a conclusory statement asserting compliance, but did not demonstrate whether written processes were comparable and no more stringently applied to MH/SUD benefits as compared to medical/surgical benefits in operation or did not provide supporting data metrics or documentation.

For example, some plans and issuers concluded that their plans were in compliance by stating that their written processes were the same for MH/SUD benefits as for medical/surgical benefits. However, the plans and issuers offered no further analysis of the NQTL as applied in operation in their comparative analyses. This trend was common throughout each phase of the reviews and CMS noted 13 instances of non-compliance in this area, resulting in initial determinations of non-compliance for 12 reviews.

⁵⁸ FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021), available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/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>. *See specifically* Question 2 (describing what information plans and issuers must make available in response to the Departments' requests for documentation of their comparative analyses). *See also* Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (2020), available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf> (offering additional detail on what kinds of information a plan or issuer may provide to be responsive to the Departments' requests).

3. CMS' Conclusions Regarding Compliance with the Requirements of PHS Act Section 2726(a)(8)

After reviewing initial submissions, CMS sent plans and issuers a request for additional information that CMS required to complete an initial review of their comparative analyses. CMS staff were available to plans and issuers to respond to questions and provide additional guidance, including communicating via email and holding meetings with plans and issuers to discuss any questions in depth. CMS provided one opportunity for the submission of additional information before making an initial compliance determination. As a result, CMS made many initial determinations of non-compliance on the basis of plans' and issuers' failures to provide adequate supplemental responses.

CMS sent letters requesting additional information and received supplemental responses for 19 reviews. Of the comparative analyses submitted and reviewed by CMS for the 2021 review period,⁵⁹ the initial compliance determination resulted in 41 instances of non-compliance across 14 of the comparative analysis reviews because the plan or issuer did not provide sufficient information. Without this information, CMS was unable to validate whether the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to medical/surgical benefits, as written and in operation under PHS Act section 2726(a)(8)(A)(iv), or determine compliance with other provisions of MHPAEA.

Plans or Issuers with an Initial Determination of Non-Compliance due to Insufficient Information	Number of NQTL Comparative Analysis Reviews
Non-Fed Plan 1	1
Non-Fed Plan 2	1
Issuer 1	1
Issuer 2	3
Issuer 3	3
Issuer 4	1
Issuer 5	3
Issuer 6	1
Total:	14

4. CMS' Specifications Regarding Sufficiency

CMS observed several common themes in insufficient plan or issuer responses to a request for information when reviewing the supplemental responses. The following is a list of the most common ways in which CMS determined a comparative analysis lacked sufficient information following its review of the initial and supplemental responses:

⁵⁹ Of the 21 comparative analyses requested by CMS in the 2021 plan year, 19 have been reviewed for an initial determination of compliance. At the time of this Report, an initial compliance determination has not yet been made in two of the reviews requested by CMS in the 2021 plan year and they are not included in the metrics within this summary. Findings for these reviews will be included in the next annual report to Congress.

- The plan or issuer did not provide sufficient information and supporting documentation regarding a reasoned discussion of 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 written and in operation. CMS noted this insufficiency in 12 reviews. One review resulted in an initial determination of two instances of non-compliance in this area.
- The plan or issuer did not provide sufficient information and supporting documentation identifying and defining the factors, evidentiary standards, strategies, or processes considered in the design and application of the NQTL which were defined in a quantitative manner. CMS noted this insufficiency in seven reviews.
- The plan or issuer did not provide sufficient information and supporting documentation regarding the decisions, decision maker(s), timing of the decisions, and qualifications of the decision maker(s) involved in the application of the NQTL. CMS noted this insufficiency in seven reviews.
- The plan or issuer did not provide sufficient information and supporting documentation regarding the factors, evidentiary standards or sources, 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, would be subject to the NQTL. CMS noted this insufficiency in five reviews.
- The plan or issuer did not provide sufficient information and supporting documentation regarding any variation in the application of a guideline or standard being relied upon by the plan or issuer between MH/SUD benefits and medical/surgical benefits, or provide a description of the process and factors relied upon for establishing that variation. CMS noted this insufficiency in four reviews.
- The plan or issuer did not provide sufficient information and supporting documentation related to the sources, evidentiary standards, or guidelines considered in the design or application of the NQTL. CMS noted this insufficiency in two reviews.

5. *CMS' Specifications Regarding Compliance*⁶⁰

a. Summary - Initial Findings of Non-Compliance

CMS identified 45 instances of non-compliance across 15 comparative analysis reviews during its initial compliance determinations as of December 3, 2021.⁶¹ Instances of non-compliance resulting from the initial compliance determinations are summarized below:

⁶⁰ This summary is intended to comply with the Secretary's reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(III) - "for each group health plan or health insurance issuer that did submit sufficient information for the Secretary to review the comparative analyses requested under clause (i), the Secretary's conclusions as to whether and why the plan or issuer is in compliance with the requirements under this section."

⁶¹ Of the 21 comparative analyses requested by CMS in the 2021 plan year, 19 have been reviewed for an initial determination of compliance. At the time of this Report, an initial compliance determination has not yet been made in two of the reviews

- CMS identified 41 instances of non-compliance across 14 of the comparative analyses reviewed due to insufficient information provided. Without this information, CMS was unable to validate whether the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits were comparable to and no more stringently applied than those applied to medical/surgical benefits, as written and in operation under PHS Act section 2726(a)(8)(A)(iv), or to determine compliance with other provisions of MHPAEA. Please see Section II.C.3 above regarding themes that CMS observed in insufficient comparative analyses which resulted in findings of non-compliance.
- The review of two of the comparative analyses submitted resulted in four instances of non-compliance due to findings of impermissible separate treatment limitations under PHS Act section 2726(a)(3)(A)(ii) that the Plan or issuer applied only to MH/SUD benefits and not to medical/surgical benefits in the same benefit classification. These included:
 - MH/SUD continued-stay criteria, requirement of evident progress for continued care coverage;
 - MH/SUD discharge criteria, no coverage if no significant improvement in condition;
 - MH/SUD discharge criteria, no coverage if enrollee leaves against medical advice; and
 - MH/SUD covered charges, no coverage if no certification that participant completed full continuum of care necessary and available at the facility.

b. Examples of Corrective Actions

For any reviews resulting in instances of non-compliance discussed in the summary in Section 5.a above, CMS sent an initial determination letter to the plan or issuer describing each instance of non-compliance. The initial determination letters also requested that the plan or issuer submit a corrective action plan within 45 days of the date of the letter describing corrective actions taken or in progress to correct the instances of non-compliance described in the letter, a timeline for completion, supporting documentation confirming corrective actions are in progress or completed, and a revised NQTL comparative analysis demonstrating compliance based on the corrective actions identified in the corrective action plan. CMS staff were available to plans and issuers to respond to questions and provide additional guidance, including communicating via email and holding meetings with plans and issuers to discuss any questions in depth.

As a result of CMS's initial determination letters, plans and issuers implemented changes to increase MH/SUD benefit coverage, as well as more proactively and thoroughly assess compliance with PHS Act section 2726(a)(8)(A) and other provisions of MHPAEA. Examples of these changes are described below.

requested by CMS this year and they are not included in the metrics within this summary. Findings for these reviews will be included in the next annual report to Congress.

Example #1 – Removal of Criteria Limiting Coverage of MH/SUD Benefits

One of the issuers reviewed was found to have impermissible separate treatment limitations in the form of MH/SUD continued-stay criteria requiring demonstrable progress for continued care coverage, as well as MH/SUD discharge criteria resulting in a loss of coverage if there was no significant improvement in an enrollee's condition or if the enrollee left against medical advice. There were no similar criteria applied to medical/surgical benefits in the same benefit classification. After receiving CMS's initial determination letter, the issuer included revised continued-stay and discharge criteria along with supporting documentation showing that the more stringent limitations on MH/SUD benefits were removed and no longer in effect in its corrective action plan submission for this review. In addition, since the impermissible separate treatment limitations may have affected enrollees while the limitations were in effect, the issuer also initiated a self-audit to identify claims impacted by the criteria described in the initial determination letter and has committed to re-adjudicating claims. The issuer is currently undertaking the self-audit process and CMS will report on the results of this review in the next annual report to Congress.

Example #2 – Increased Analysis of Operational Comparability and Stringency

As discussed above, many of the initial submissions lacked a stringency assessment or analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits are comparable to and no more stringently applied than those applied to medical/surgical benefits, as written and in operation. Following CMS's request for information letters and review of supplemental responses, there were 13 instances of non-compliance across 12 reviews related to this issue. After receiving CMS's initial determination letter, plans and issuers included plans to compile and analyze additional supporting documentation demonstrating the relative stringency of the NQTL in their corrective action plan submissions. In order to demonstrate that written processes were comparable and no more stringently applied to MH/SUD benefits compared to medical/surgical benefits, plans and issuers included analysis of operational data metrics to demonstrate the relative stringency of the NQTL in their corrective action plan submissions. For example, operational data metrics analyzed for the review of a prior authorization NQTL may include denial rates comparing medical/surgical and MH/SUD prior authorization decisions, appeal rates, and decision timeliness rates. The analysis of operational data metrics allows for plans and issuers to more thoroughly assess the comparability and stringency of its NQTLs in operation, and to be able to demonstrate compliance with supporting evidence in their comparative analysis.

Example #3 – Implementation of Annual Compliance Review Processes

Corrective action plan submissions for six reviews described plans for new annual compliance review processes to assess and ensure compliance with PHS Act section 2726(a)(8)(A) and other provisions of MHPAEA. For example, one issuer is in the process of implementing and performing its first annual review of its network adequacy standards to proactively assess compliance, and to include more thorough evidence of the processes, strategies, evidentiary standards, and other factors used to establish its selected network adequacy standards. Another issuer is implementing an annual process to monitor and ensure compliance, including more robust documentation supporting its comparative analysis and conclusions of

compliance. Another issuer is establishing a new enterprise MHPAEA compliance program for all operational functions subject to MHPAEA, which includes new enterprise MHPAEA training as well as new policies, procedures, disclosure templates, and workflows.

During this first year of comparative analysis reviews, it was evident that many plans or issuers did not perform a full comparative analysis, which required them to submit clarifications regarding the information and supporting documentation needed in order for CMS to complete its review. By establishing these annual compliance reviews, plans and issuers may be able to more proactively assess compliance with PHS Act section 2726(a)(8)(A) and other provisions of MHPAEA and be better prepared to provide a complete comparative analysis as requested.

c. Identification of plans that were issued a final determination of non-compliance and description of findings⁶²

As stated above, CMS made four final determinations with no finding of non-compliance. However, CMS has yet to make a final determination under PHSA section 2726(a)(8)(B)(iv)(V) that a plan or issuer is not in compliance with MHPAEA. CMS is currently reviewing the comparative analyses, corrective action plans, and other information received, as well as engaging with plans and issuers to obtain additional information to assess compliance. Conclusions of these reviews will be summarized and included in the next annual report to Congress.

D. EBSA’s FY2020 Enforcement Evaluation Program

EBSA continuously reviews and works to improve its enforcement, compliance assistance, and education programs to help ensure compliance with ERISA (including MHPAEA) in an effective and efficient manner. Most recently, in its 2020 MHPAEA Report to Congress, EBSA included several action items, which constituted a Five-Point MH/SUD Enforcement Evaluation Program, in furtherance of this ongoing practice. The evaluation program consisted of the following action items:

1. Stakeholder engagement;
2. Compliance assistance;
3. Capturing data on other ERISA violations impacting MH/SUD benefits;
4. Quality assurance review; and
5. FY2021 national enforcement initiative.

These efforts, taken together, have helped to inform EBSA’s recent MHPAEA implementation and enforcement activity. In response to the quality assurance review, EBSA developed several training modules incorporating lessons learned, and used them to train investigators and benefits advisors across the country. The stakeholder engagement initiative provided vital feedback for the finalization of the 2021 update to the MHPAEA self-compliance tool. As reflected in the appendix below, EBSA has also refined its data tracking system to better capture its enforcement activity. This section of the 2022 Report

⁶² This summary is intended to comply with the Secretary’s reporting obligations under PHS Act section 2726(a)(8)(B)(iv)(V) - "the Secretary’s specifications described in clause (iii) of the actions each group health plan or health insurance issuer that the Secretary determined is not in compliance with this section must take to be in compliance with this section, including the reason why the Secretary determined the plan or issuer is not in compliance."

summarizes information regarding notable activity related to the FY2020 Enforcement Evaluation Program.

1. 2020 Stakeholder Listening Session

In the 2020 MHPAEA Report to Congress, EBSA committed to hosting a listening session with interested parties to hear feedback on EBSA’s interpretive guidance and enforcement program in connection with MHPAEA compliance. On July 16, 2020, DOL hosted a listening session/roundtable discussion with consumer advocates, group health plan representatives, health insurance issuers, managed behavioral health organizations, state and federal regulators, and other interested parties. The event consisted of three panel discussions involving presenters with various viewpoints, and stakeholders offering their perspectives in an interactive and dynamic conversation.

The listening session focused on three areas: (1) network adequacy and provider directory accuracy, (2) advancing NQTL compliance, and (3) best practices for establishing an internal MHPAEA compliance plan. Stakeholders noted challenges with regard to reduced access to care for MH/SUD conditions because of restrictive networks and inaccurate provider directories. Stakeholders also commented on compliance issues with NQTLs and requested more guidance, including guidance with respect to provider reimbursement rates, and a uniform assessment and process for analyzing NQTLs.

The discussions at the 2020 MHPAEA Listening Session and additional written comments received from stakeholders informed the final 2020 MHPAEA Self-Compliance Tool developed by DOL, as well as MHPAEA guidance and publications that have followed. The Departments will continue to maintain an open dialogue with stakeholders.

2. 2020 Update to the MHPAEA Self-Compliance Tool

EBSA maintains a MHPAEA Self-Compliance Tool⁶³ on its website to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with MHPAEA.

In the 2020 MHPAEA Report to Congress, EBSA committed to update its MHPAEA Self-Compliance Tool to reflect new trends and red flags. EBSA also promised to solicit public input before finalizing the tool. On June 19, 2020, EBSA proposed an updated 2020 MHPAEA Self-Compliance Tool with a request for comments from stakeholders. After careful consideration of the comments received, EBSA issued a final 2020 MHPAEA Self-Compliance Tool on October 23, 2020, as discussed in more detail below.

3. Updated Case Tracking

In the 2020 MHPAEA Report to Congress, EBSA stated that it would update its information tracking systems to better track all types of ERISA violations that involve MH/SUD benefits, including those related to ERISA’s fiduciary standards, claims procedures, and reporting and disclosure obligations. Following this, EBSA made several changes to its ERISA Management System (EMS) to better capture and track investigative data related to MHPAEA. EMS now includes specific investigative questions on the MHPAEA provisions within Part 7 of ERISA, and tracks health results obtained in investigations by NQTL type. EBSA incorporated these questions into EMS for contemporaneous tracking of data, easier compilation of data and identification of violations, and enhanced ability to run more meaningful data

⁶³ Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (2020), available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>.

reports. EMS also now tracks results obtained, including results where MH/SUD benefits are impacted in non-MHPAEA cases. In addition, EBSA's Office of Outreach, Education and Assistance (OEA) updated coding in the Technical Assistance Inquiry System (TAIS) to differentiate inquiries relating to NQTLs from inquiries about financial requirements and QTLs.

4. Quality Assurance Review and MHPAEA Training

In the 2020 MHPAEA Report to Congress, EBSA committed to conducting a quality review of MHPAEA investigations to ensure EBSA investigators conduct full and accurate investigations, assess current industry practices and trends, and inform investigator training. The purpose of the review was to evaluate whether MHPAEA violations were fully identified and corrected during investigations, to flag any trends or patterns in potential MHPAEA violations, and to recognize best practices and areas of need for additional training.

In response to this initiative, EBSA developed and conducted multiple training programs to enhance the agency's proficiency in identifying NQTLs, as well as MHPAEA issues generally. This training consisted of three new separate large-group presentations (9.5 hours in total) focused on identifying, investigating, and analyzing NQTLs under the MHPAEA statutory and regulatory framework, including the enhanced enforcement provisions added to MHPAEA by the CAA. EBSA supplemented this training with over 10 training sessions delivered to smaller groups of investigators focusing on various aspects of NQTL analysis. In addition, EBSA dedicated more time and attention to MHPAEA enforcement issues in its annual Health Enforcement Training. EBSA investigators, supervisors, and leadership, and DOL attorneys from across the country, participated in these training programs. EBSA also developed a new tool for investigators to use in their MHPAEA investigations. The tool includes several analytical functions that test health plan data for red flags related to potential areas of MHPAEA non-compliance.

5. National MHPAEA Enforcement Project

EBSA committed to using the information gathered from its quality assurance review and stakeholder engagement to inform a new national MHPAEA enforcement project for FY2021. As part of this initiative, EBSA established three working groups to consider legal theories for enforcement, targeting methods and leads with regard to network accuracy, network adequacy, and coverage of autism.

EBSA's working group for network accuracy examined approaches to improving the accuracy of MH/SUD network directories. Inaccurate provider directories can compound difficulties finding available providers and serve as a significant barrier in accessing MH/SUD care. The working group developed investigative approaches, template requests, scripts for survey calls to providers, and provider sampling plans. Under the CAA, plans will be required to implement procedures to update their provider directories every 90 days and at other specific times beginning January 1, 2022. EBSA helps ensure that plans are abiding with the requirements of ERISA, including the CAA's new network directory accuracy requirements.

EBSA's working group for network adequacy focused on in-network and out-of-network provider reimbursement rates. This focus area is intended to ensure parity with how medical/surgical reimbursement rates are determined, which in many cases may increase individuals' ability to access MH/SUD treatment. The working group examined potential investigative leads by using claims data to identify networks with reimbursement parity "red flags," and then identified specific plans with certain characteristics that use those networks. The working group was also involved in EBSA's investigation

involving United Behavioral Health and United Healthcare Insurance Company (UBH) resulting in corrective action taken in connection with out-of-network provider reimbursements (discussed below).

The autism working group considered QTLs and NQTLs that plans applied to limit or exclude coverage for ASD, to determine subjects for investigation for MHPAEA compliance, and to identify issuers and plans that might include limitations that violate MHPAEA's requirements. Those efforts led, among other things, to investigations of issuers and plans that exclude coverage for ABA therapy, a core treatment for ASD. Many of the issues identified by the autism working group were included in requests for comparative analyses under the CAA.

E. Other EBSA Enforcement Efforts

EBSA strives to broadly support compliance without compromising its commitment to rigorous enforcement. Specifically, EBSA works with health insurance issuers and other service providers (such as TPAs and managed behavioral health organizations) to obtain voluntary global corrections whenever possible in cases where a violation relates to an insurance product, prototype document, or systemic operation affecting multiple plans. Additionally, EBSA has jurisdiction to enforce MHPAEA with respect to insurance companies when they serve as administrative services-only providers (ASOs) to self-insured plans covered by ERISA. EBSA pursues cases against the ASOs to achieve widespread compliance and greater impact for participants and beneficiaries. EBSA also collaborates with state departments of insurance and conducts parallel investigations of issuers who act as both insurers and ASOs within a state's jurisdiction.

1. United Behavioral Health Settlement

In August 2021, EBSA and the New York Attorney General's office jointly entered into settlement agreements with United Behavioral Health and United Healthcare Insurance Co., and Oxford Health Insurance Inc. (United) totaling \$13.6 million in restitution to participants and beneficiaries, \$2.08 million in penalties, \$3.35 million in attorneys' fees, and \$750,000 already paid to affected participants and beneficiaries, plus processing commitments. The issues investigated by EBSA's New York Regional Office included: a provider reimbursement NQTL that discounted MH/SUD lower-level licensures disproportionately, the Algorithms for Effective Reporting and Treatment (ALERT), an outlier management NQTL that disproportionately applied to MH/SUD services, and disclosures to participants and beneficiaries that failed to provide detailed information about the NQTLs such that participants and beneficiaries did not have enough information regarding the application of the NQTLs to adequately appeal denials or reductions in benefits.

In the settlement, United agreed to cease the practices investigated, improve its disclosures to plan participants and beneficiaries, and committed to future compliance. The settlement provided for a Common Fund to pay for improperly denied or reduced claims relating to the provider reimbursement and ALERT policies. Additionally, United raised its reimbursements for MH/SUD out-of-network providers (resulting in lower costs for participants and beneficiaries), discontinued the use of the ALERT policies to deny or reduce coverage, and committed to providing disclosures to participants and beneficiaries that will provide more individualized information to allow for adequate appeal of denials or reductions in benefits. DOL's Office of the Solicitor provided legal support to EBSA in this matter.

2. Other Notable Enforcement Results

EBSA's Chicago and Dallas Regional Offices conducted an investigation of a large claims administrator for self-insured ERISA health plans. EBSA investigated the exclusion of coverage for ABA therapy, a primary treatment for ASD, by self-insured plans, and specifically, whether the exclusion of ABA therapy for ASD violated MHPAEA. The claims administrator offered the plans the option to exclude coverage for ABA therapy. As a result of EBSA's investigation, the claims administrator made changes beginning in the 2021 plan year that made ABA therapy coverage the default coverage for all of its self-insured plans instead of offering the option to exclude coverage for ABA therapy. EBSA has been advised that this change resulted in the elimination of the exclusion for ABA therapy for ASD for nearly a million participants. This enforcement result was unrelated to the result described in Example #1 of Section II.B.3 above. DOL's Office of the Solicitor provided legal support to EBSA in this matter.

In a plan-level investigation, EBSA's Kansas City Regional Office determined that claims for outpatient drug testing related to SUD diagnoses were being impermissibly denied for failure to establish medical necessity in violation of MHPAEA. As a result of EBSA's investigation, the plan reprocessed over 250 claims, which resulted in payments to providers and savings to 33 participants in the amount of approximately \$175,000. The plan's Board of Trustees also adopted a new policy for processing claims relating to outpatient drug screening, using a TPA. The related service provider case is also expected to significantly contribute to the national MHPAEA project due to the expected reprocessing of approximately 30 ERISA plans' claims for outpatient drug testing that were previously denied.

EBSA's Boston Regional Office determined that a self-insured plan violated MHPAEA by excluding coverage for out-of-network residential treatment for MH/SUD conditions. The coverage exclusion did not apply to medical/surgical benefits in the same classification. As a result of EBSA's investigation, the plan reprocessed and paid two denied residential treatment claims totaling \$88,402 and agreed to amend its plan language to eliminate the exclusion and to change claims processing procedures to prevent similar claims denials in the future.

In a plan-level investigation, EBSA's Philadelphia Regional Office found that a plan's financial requirements were not compliant with MHPAEA in the classification of outpatient/in-network services, where participants seeking MH/SUD benefits were charged higher co-pays when compared to medical/surgical benefits in the same classification. As a result of the investigation, plan fiduciaries re-adjudicated claims spanning a four-year period that were not in parity and reimbursements of overpaid cost sharing were made to 1,945 affected participants in the aggregate amount of \$82,065.

III. OUTREACH AND CONSUMER AND COMPLIANCE ASSISTANCE EFFORTS

EBSA's benefits advisors are on the front lines assisting participants and beneficiaries. Through EBSA's toll-free hotline and online web portal, and in response to mail sent to EBSA offices, benefits advisors provide expert assistance to participants and beneficiaries across the country who have questions or complaints related to their health plan's compliance with MHPAEA and other federal laws.⁶⁴ If an individual's inquiry or complaint suggests that there may be violations of the law or improper benefit denials, a benefits advisor will seek voluntary compliance by working with the individual and their health plan to determine if there is such a violation or benefit denial and if so, to help obtain the benefits to which

⁶⁴ Ask EBSA, available at <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

they are entitled. Benefits advisors also provide compliance assistance to employers and other stakeholders. These interactions also help inform EBSA's understanding of where additional guidance is needed for both consumers and the regulated community. In fiscal years 2020 and 2021, EBSA received 296 inquiries from participants and beneficiaries in connection with MHPAEA.

A. Notable Consumer Assistance Efforts

An example of the assistance EBSA's benefits advisors provide came from the Chicago Regional Office. A parent contacted the agency on behalf of their minor child, who was the claimant. The claimant's doctors determined that she required residential behavioral health treatment for several conditions, including a substance use disorder; they also felt that she was a danger to herself. The health plan denied the claim on the grounds that a residential level of care was not medically necessary. After the benefits advisor's intervention, the plan covered \$21,300 in claims for residential care for the claimant. Additionally, because it appeared that the plan was applying the NQTL (medical necessity review) more stringently to MH/SUD benefits than to medical/surgical benefits, the matter was transferred to EBSA's Boston Regional Office, which already had an open and on-going MHPAEA investigation relating to the plan's fiduciary.

When the agency's benefits advisors find potential MHPAEA violations that impact an entire plan they can refer the inquiry to an EBSA investigator. Here are a few examples where benefits advisors have made such referrals:

- EBSA's Boston Regional Office received a complaint from a group health plan participant who was having difficulty finding an in-network mental health provider. The participant stated that the list of participating providers offered by the insurer was inaccurate; when she called the providers on the list, she discovered that many of them were no longer participating providers or they had moved out of the area. The benefits advisor referred the complaint for investigation.
- EBSA was contacted on behalf of a residential SUD treatment facility that was having difficulty getting reimbursed for care rendered to a patient. The patient had coverage through an employment-based group health plan. The claim and appeal were denied on the grounds that treatment at a residential care facility was not covered under the terms of the plan. EBSA reviewed the claims at issue and plan documents, and saw a potential MHPAEA violation in that the plan appeared to have an NQTL that it applied only to in-patient SUD benefits, but did not apply a comparable exclusion to medical/surgical benefits in the same classification. The inquiry was transferred to the Atlanta Regional Office, which has jurisdiction over the health plan. That office opened an investigation.
- The Chicago Regional Office received a complaint regarding a health plan's failure to cover ABA therapy for a beneficiary. A review of the plan document revealed a 25 day/year visit limit for ABA therapy. The plan allowed additional visits beyond the 25th day if the visits satisfied the plan's medical necessity criteria. The benefits advisor referred the complaint for investigation on the plan.

There are also instances where a health plan participant or beneficiary contacts EBSA about matters unrelated to MHPAEA, but in the course of assisting the person a potential MHPAEA violation is discovered. For example, benefits advisors in EBSA's Los Angeles Regional Office found two such situations:

- An individual contacted EBSA for assistance with their Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights. In the process of assisting the individual, the benefits advisor reviewed the health plan's documents and discovered a potential MHPAEA violation relating to co-pays for outpatient mental health visits. The matter was referred to EBSA's New York Regional Office because the health plan was based in that office's jurisdiction. The New York Regional Office opened an investigation as a result of the benefits advisor referral.
- A health plan participant contacted EBSA about an out-of-network anesthesia bill. While helping that individual, the benefits advisor reviewed plan documents and noted a possible MHPAEA violation relating to co-pays for outpatient mental health visits. The matter was referred to the Atlanta Regional Office because the health plan was based in that office's jurisdiction, and an investigation commenced.

EBSA's benefits advisors attended Task Force training in the spring of 2021 to ensure that they understood NQTLs in relation to MHPAEA's requirements, as amended by the CAA. In addition, OEA amended its standard operating procedures, effective July 14, 2021, to ensure that MHPAEA complaints relating to NQTLs are referred as investigative case leads. OEA trained the benefits advisors on the updated procedures in August 2021. At that time, OEA also redistributed existing MHPAEA training materials. Agency staff also created new materials to assist benefits advisors in handling MHPAEA inquiries.

B. Stakeholder Outreach

In addition to enforcement of MHPAEA, collaboration with stakeholders is a vital component to facilitating greater access to MH/SUD treatment. In light of EBSA's limited resources, it is imperative to focus agency resources on the areas where such efforts are most needed, and where the greatest impact can be achieved. Often, stakeholders are acutely aware of where there is an immediate need for enforcement. Furthermore, to ensure that meaningful guidance is issued, it is crucial to know where there are gaps in understanding in the regulated community, and where consumers feel that barriers remain. Stakeholders are often in the best position to provide this information, which aids EBSA in ensuring that MHPAEA's full protections are realized. Consumer advocacy groups and provider organizations are uniquely positioned to communicate the challenges that consumers still face in realizing parity. EBSA recognizes stakeholders' efforts to move toward full parity compliance and values their input. EBSA therefore seeks out opportunities to work with all stakeholders to ensure compliance with MHPAEA. Additionally, DOL works with these stakeholders to help raise awareness of the prevalence of MH/SUD and reduce stigma for those who may need to utilize MH/SUD benefits.

In addition to the July 16, 2020 listening session mentioned above, DOL has engaged with and continues to meet with stakeholders on an ongoing basis. On May 27, 2021, Secretary Walsh was the featured speaker in a webcast discussion with the Kennedy Forum about the need to end discrimination in the delivery of MH/SUD benefits. The Kennedy Forum, founded by former Congressman Patrick J. Kennedy, fosters a national dialogue on transforming the nation's MH/SUD systems, and works to advance full implementation of MHPAEA. The discussion addressed challenges faced by people seeking care and focused on state and federal efforts to enforce MHPAEA.

Secretary Walsh spoke about the Administration's recognition of the importance of MH/SUD parity, and about DOL's focus on implementing and enforcing the new provisions added by the CAA. He stated

that EBSA has embraced the challenge and has created the Task Force, highlighting EBSA's (at the time) dozens of requests for comparative analyses. Secretary Walsh explained that DOL was working with HHS and the Department of the Treasury to put into effect the CAA's provisions on MH/SUD parity and also would work in coordination with the states. The Secretary also spoke of his personal interest in MH/SUD parity issues and urged the MH/SUD communities to let DOL know about perceived parity violations. He noted that when someone calls for treatment, that is the moment they need to receive it. By participating in this forum, the Secretary was able to raise awareness of mental health conditions and substance use disorders and of those who have a history of and live with these conditions.

Following the webcast session with the Kennedy Forum, Secretary Walsh has continued to be a fierce advocate for those suffering from MH/SUD conditions, making himself available to patients, families, and providers throughout the country. For example, Secretary Walsh visited Health Place in Louisville, KY with Mayor Greg Fisher to provide support to patients and staff. In commemorating national and world MH/SUD events, Secretary Walsh educates the country on these disorders and highlights the importance of parity. Similarly, on World Suicide Prevention Day, Secretary Walsh released a video publicizing the role MHPAEA's protections play in preventing suicide. Secretary Walsh has continued to utilize his position to highlight the importance of MHPAEA, its protections, and the impact it can have on patients' lives, as well as the lives of their families and loved ones.

Following the lead of Secretary Walsh, EBSA has continued to meet with stakeholders, ensuring an ongoing dialogue with plans, issuers, consumers, providers, and others to identify the challenges to realizing full compliance. EBSA has met with stakeholders such as the National Coalition for Access to Autism Services and the Bowman Family Foundation, ensuring that those who speak for participants, beneficiaries and their families are heard, and their stories are told. EBSA is also committed to meeting with provider organizations and industry stakeholders. EBSA has met with the National Association for Behavioral Healthcare, the HR Policy Association, the American Benefits Council, the ERISA Industry Committee, the National Coordinating Committee for Multiemployer Plans, and the North America's Building Trades Unions to emphasize the importance of MH/SUD coverage and the protections of MHPAEA. EBSA has also met with representatives from the American Psychiatric Association and Association for Behavioral Health and Wellness.

In the 2020 Report, EBSA highlighted efforts by regional offices to cooperate with other stakeholders to further MHPAEA compliance. These regional offices have continued their work with partners in their areas of the country. EBSA's Chicago Regional Office regularly partners with regional stakeholders, including the Kennedy Forum of Illinois and the National Alliance on Mental Illness (NAMI) Illinois, to gather feedback on EBSA's MHPAEA enforcement initiatives and collaborates on how the Kennedy Forum, NAMI, and EBSA can best work together to assist those individuals in need.

EBSA's Chicago and Kansas City Regional Offices, in partnership with the Kennedy Forum of Illinois, also sponsored a virtual workshop on MHPAEA for Illinois-based organizations, including parity advocacy groups and healthcare service providers, titled "A Parity Conversation with US DOL/EBSA." EBSA's regional Senior Advisors for Health Investigations (SAHIs) provided an overview of EBSA's jurisdiction under ERISA in addition to enforcement priorities and outreach activities. The SAHIs also facilitated a dialogue with the goal of learning from attendees about the current state of the industry, as well as any changes that participating organizations were seeing since the new CAA-mandated requirements took effect. Information and resources provided included guidance available on EBSA's public webpages.

The Chicago Regional Office also partnered with the Cincinnati Regional Office in July 2021 to brief the Wellness Council of Indiana, which is a subsidiary of the Indiana Chamber of Commerce, on compliance assistance outreach initiatives, including MHPAEA. The Wellness Council of Indiana leads various initiatives and facilitates access to resources and educational opportunities for over 17,000 Indiana-based employers to promote a culture of well-being in the workplace in order to spur economic vitality.

In July of 2021, the SAHI for the Cincinnati Regional Office attended a meeting of the Ohio Parity at 10 Coalition. The Ohio Parity at 10 Coalition currently has 27 members and is led by the Ohio Council of Behavioral Health and Family Service Providers, a trade and advocacy organization that works to ensure effective enforcement of MHPAEA. The SAHI discussed EBSA and MHPAEA as an enforcement priority.

In October 2021, the SAHI for Cincinnati's Regional Office served as a panel member for a discussion on the current state of MHPAEA enforcement at the annual conference of the Ohio Council of Behavioral Health and Family Service Providers. During the panel discussion, the SAHI introduced herself, discussed EBSA and its jurisdiction, and discussed MHPAEA enforcement. The annual conference had 118 attendees.

Another SAHI from EBSA's Dallas Regional Office participated in outreach to the Texas Association of Benefits Administrators to discuss MHPAEA issues in September 2021. EBSA's presentation covered MHPAEA financial requirements and QTLs, NQTL requirements, and disclosure requirements. The new MHPAEA provisions in the CAA and EBSA's enforcement efforts and results were also discussed. There were 80 participants.

EBSA's Los Angeles Regional Office gave a webcast presentation on "What to Expect in an EBSA Health Investigation" for the Los Angeles Association of Health Underwriters Virtual Symposium in May 2021. During the presentation, the SAHI for the Los Angeles Regional Office also reviewed red flags for MHPAEA. There were 115 attendees, including insurance brokers, human resources professionals, and consultants.

Agency staff has also conducted outreach presentations to groups like the Mental Health & Addiction Advocacy Coalition, the United Way of Metropolitan Chicago, various other state and metropolitan-area Associations of Health Underwriters, and chapters of the Society for Human Resource Management. These efforts are just a few examples of the many ways in which EBSA and its regional offices cooperate with their regional partners to promote parity and access to MH/SUD treatment.

HHS similarly values the input of stakeholders and seeks out opportunities to work together with stakeholders to ensure compliance with MHPAEA. Additionally, HHS works with these stakeholders to help raise awareness of the prevalence of MH/SUD and increase access to MH/SUD benefits. In support of this mission, in May 2021 HHS announced the formation of the Behavioral Health Coordinating Council. The goal of the council is to align federal resources and address gaps within the systems for studying and treating MH/SUD conditions.

In October, HHS Secretary Xavier Becerra announced the release of the new HHS Overdose Prevention Strategy, designed to increase access to the full range of care and services for individuals who use substances that cause overdose and for their families. The Overdose Prevention Strategy focuses on the multiple substances involved in overdose and the diverse treatment approaches for substance use disorder and recognizes that the full continuum of integrated care and services are needed to help prevent

substance use, expand quality treatment, and sustain recovery from substance use disorders. The strategy also provided coordinated, federal support for harm reduction and recovery support, which have been supported by grassroots efforts by stakeholders for decades.

C. State Partnership Efforts

EBSA is also committed to working with states as partners in carrying out its obligations to regulate group health plans. Although EBSA has primary enforcement jurisdiction over private, employer-sponsored group health plans, states are the primary enforcers for health insurance issuers. Additionally, many group health plan requirements included in ERISA create a federal floor, and states may be more protective of consumers in carrying out their obligations that relate to health insurance issuers under parallel provisions in the PHS Act.

As part of their work with states, EBSA and HHS participate in regular and ongoing dialogue with the National Association of Insurance Commissioners (NAIC). EBSA, along with other government representatives, participated in a panel on MHPAEA enforcement issues at the NAIC Insurance Summit in September 2021. The panel addressed the federal and state MH/SUD parity laws, enforcement priorities and results, coordination among state and federal agencies, and emerging issues, including the MH/SUD parity provisions of Title II of Division BB of the CAA.

EBSA and HHS staff also attend quarterly national NAIC meetings to engage state regulators on MHPAEA implementation and enforcement efforts. As part of this dialogue, EBSA provides technical assistance to state regulators on complex parity issues. EBSA and the states exchange ideas to help inform EBSA and state parity implementation and to promote greater uniformity in parity implementation and enforcement efforts. In addition to the quarterly meetings, EBSA, along with HHS, participates in regular conference calls with state regulators through the NAIC to address discrete issues that arise between the quarterly meetings. EBSA provides individual technical assistance to state regulators and has met with regulators from Pennsylvania and Connecticut on MH/SUD parity. Additionally, EBSA's benefits advisors have briefed state insurance departments in Puerto Rico, Michigan, New Hampshire, Wisconsin, Massachusetts, Florida, and Ohio on EBSA's responsibilities in enforcing federal law, including MHPAEA. Finally, to inform its enforcement efforts, EBSA closely follows the work that many states have done to advance MH/SUD parity.

D. Federal Partnerships to Advance Parity

EBSA and the Departments frequently coordinate with other federal agencies to ensure that MHPAEA is being interpreted consistently, provide education, and improve enforcement of parity requirements. In the past, EBSA has worked with the Substance Abuse and Mental Health Services Administration (SAMHSA) to issue consumer publications to help individuals understand their rights under the law⁶⁵ and to host several policy academies intended to provide support for state insurance regulators tasked with

⁶⁵ Parity of Mental Health and Substance Use Benefits with Other Benefits: Using Your Employer-Sponsored Health Plan to Cover Services, available at <https://store.samhsa.gov/product/Parity-of-Mental-Health-and-Substance-Use-Benefits-with-Other-Benefits-Using-Your-Employer-Sponsored-Health-Plan-to-Cover-Services/SMA16-4937>; Know Your Rights: Parity for Mental Health and Substance Use Disorder Benefits, available at <https://store.samhsa.gov/product/Know-Your-Rights-Parity-for-Mental-Health-and-Substance-Use-Disorder-Benefits/SMA16-4971>; and Consumer Guide to Disclosure Rights: Making the Most Of Your Mental Health and Substance Use Disorder Benefits, available at <https://store.samhsa.gov/product/Consumer-Guide-To-Disclosure-Rights-Making-The-Most-Of-Your-Mental-Health-and-Substance-Use-Disorder-Benefits/SMA16-4992>.

MHPAEA enforcement responsibilities. EBSA is also involved in ongoing collaboration with its federal partners to develop additional educational materials to assist families and caregivers as well as state policy makers and regulators.

Further, HHS announced the distribution of \$3 billion in American Rescue Plan Act of 2021⁶⁶ funding through SAMHSA's mental health and substance use block grant programs, the largest aggregate amount of funding to date for these programs. The Community Mental Health Services Block Grant (MHGB) Program and Substance Abuse Prevention and Treatment Block Grant Program (SABG) will disburse \$1.5 billion each to states, territories, and tribes.⁶⁷ The MHGB program enables states and territories to provide comprehensive community health services to address needs and gaps in existing services for those with severe mental health conditions. The SABG program allows states and territories to implement and evaluate activities to prevent, treat, and help more people recover from substance use disorder. SAMHSA has also expedited federal funding to grantees to help communities grappling with MH/SUD needs during the COVID-19 pandemic.

HHS also announced through the Health Resources and Services Administration the availability of \$103 million in American Rescue Plan Act of 2021 funding to reduce burnout and promote mental health among the health workforce, taking into particular consideration the needs of rural and medically underserved communities. These investments support training efforts that establish a culture of wellness among the health workforce and build resiliency for those at the beginning of their health careers. HHS also awarded through SAMHSA \$825 million in grant funding to expand access to mental health and behavioral services through the Community Mental Health Centers (CMHC) Grant Program that was authorized under both the CAA and the Coronavirus Response and Relief Supplement (CRRS) Act of 2021.

E. Compliance Assistance

1. Webinars

EBSA conducts robust outreach initiatives and works extensively to improve the understanding of MHPAEA among plans, issuers, participants and beneficiaries, health care providers, and state regulators. These initiatives include webcasts, in-person seminars, and nationwide compliance outreach events for the regulated community. In fiscal years 2020 and 2021, EBSA conducted 39 compliance assistance outreach events nationwide that covered MH/SUD parity, and which were attended by employers, employee benefit plan administrators, attorneys, accountants, and other plan officials. Attendees received information about their responsibilities under federal laws affecting group health plans, including MHPAEA. In addition to the compliance assistance events, EBSA conducted 91 participant assistance and public awareness events that educated workers and other stakeholders about rights and benefits safeguarded under MHPAEA.

Since the last MHPAEA Report to Congress, EBSA has also conducted MHPAEA compliance webcasts targeting consumers. The goal of these webcasts is to help consumers make informed decisions and empower them with information about their rights under MHPAEA. Compliance webcasts are designed to address common issues that plans and issuers grapple with as they work toward parity compliance.

⁶⁶ Pub. L. 117-2 (March 11, 2021).

⁶⁷ Substance Abuse and Mental Health Services Administration. (May 18, 2021). *HHS Announces \$3 Billion in American Rescue Plan Funding for SAMHSA Block Grants to Address Substance use disorder, Mental Health Crisis.* <https://www.samhsa.gov/newsroom/press-announcements/202105181200>.

In furtherance of the goal of improving the understanding of MHPAEA among stakeholders, on May 27, 2021, EBSA hosted a webcast updating group health plans on MHPAEA compliance and enforcement. There were 433 participants in the live webcast, and the archived recording of the webcast has been viewed 85 times as of November 1, 2021. Through the webcast, EBSA provided an overview of MHPAEA, including a brief summary of financial requirements and QTLs and the basic rules for NQTLs. The webcast also reviewed the CAA’s requirement that plans perform and document detailed comparative analyses of NQTLs as applied to MH/SUD and medical/surgical benefits, and outlined the new statutory enforcement provisions requiring plans to provide their analyses to DOL upon request. The presenters discussed the new MHPAEA FAQs Part 45, which explains in detail the information and documentation plans should provide to the DOL in submitting comparative analyses.⁶⁸ Finally, the presenters reviewed the updated 2020 MHPAEA Self-Compliance Tool, including the “best practice” four-step comparative analysis for each plan NQTL. The presenters emphasized that MHPAEA enforcement is an ongoing high priority for DOL, and that complaints received or potential violations identified by DOL would be potential triggers for enforcement action.

Similarly, HHS presented two webinars to non-Federal governmental plans and issuers in states where CMS has authority over MHPAEA compliance and enforcement. These presentations were held on August 26, 2021 and September 2, 2021. The webinars reviewed the general requirements of MHPAEA and focused on the CAA’s requirement that plans and issuers provide detailed comparative analyses of NQTLs as applied to MH/SUD and medical/surgical benefits to HHS upon request. The presentation discussed compliance assistance materials, including the new MHPAEA FAQs Part 45 and the 2020 MHPAEA Self-Compliance Tool.

2. Publications

EBSA has developed a number of publications to improve awareness of the requirements of Part 7 of ERISA, including MHPAEA. In 2022, EBSA will release *Understanding Mental Health and Substance Use Disorder Benefits for Employees*, which will help covered employees understand their right to access MH/SUD benefits in parity with medical/surgical benefits when MH/SUD benefits are included in their health benefits plan. The publication will explain what parity means, and provide examples of financial requirements, QTLs, and NQTLs. In addition, it will include examples of red flags signaling potential parity violations. Additionally, the publication will explain how to find or request information from a plan about benefits and limitations, and will describe steps a claimant can take to appeal a benefit denial. Finally, the publication will include a list of resources, including links, where individuals can get help or learn more about MHPAEA and the benefit claim appeals process.

IV. GUIDANCE TO THE REGULATED COMMUNITY

EBSA is committed to ensuring that plans and issuers have the guidance they need, so that individuals receive the benefits to which they are entitled and plans and service providers operate in compliance with the law. In the previous report to Congress, EBSA discussed Final FAQs Part 39 and the MHPAEA disclosure template, which were finalized in 2019. Since then, EBSA has continued to issue guidance on MH/SUD parity. Examples of recent guidance are discussed below.

⁶⁸ 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-ebbsa/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>.

A. Self-Compliance Tool

EBSA maintains a MHPAEA Self-Compliance Tool⁶⁹ on its website to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with MHPAEA. The MHPAEA Self-Compliance Tool is similar to the audit checklist that EBSA’s investigators use. In addition, as directed by section 13001(a) of the 21st Century Cures Act, this publicly-available tool serves as a compliance program guidance document intended to improve compliance with MHPAEA. Since the MHPAEA Self-Compliance Tool was last updated before the enactment of the CAA, it does not indicate that plans and issuers are required to conduct and document their NQTL comparative analysis. However, with the new requirements under the CAA, plans and issuers are now required to perform and document a comparative analysis with respect to the design and application of NQTLs and make this analysis available to the Departments or applicable state authorities upon request.

On June 19, 2020, the Departments proposed an updated MHPAEA Self-Compliance Tool with a request for comments from stakeholders. The proposed update included amendments that generally fell into four main categories: (1) integration of recent guidance; (2) revised compliance examples; (3) best practices for establishing an internal compliance plan; and (4) plan provisions or practices that serve as “warning signs” of a possible violation. After careful consideration of the comments received, DOL issued a final 2020 MHPAEA Self-Compliance Tool with minor modifications and clarifications in response to these comments.

DOL proposed including relevant guidance from FAQs Part 39 in the 2020 MHPAEA Self-Compliance Tool to better ensure that the regulated community is aware of the FAQs’ content. Commenters were generally supportive of these updates, though some offered suggestions for further improvement. In particular, several commenters offered feedback on the integrated guidance regarding how methods for establishing provider reimbursement rates must comply with MHPAEA’s requirements for NQTLs. The final version of the Self-Compliance Tool included language integrating FAQs Part 39, as well as revisions in response to requests for additional guidance on how methods for establishing provider reimbursement rates must comply with MHPAEA’s requirements. Additionally, DOL has added an introduction to the tool in Appendix II, Provider Reimbursement Rate Warning Signs, which explains the tool’s purpose and how it may be used.

DOL also added a new Section H to the Self-Compliance Tool. This section addresses best practices for establishing an internal MHPAEA compliance plan and provides examples of the types of records that a plan or issuer should be prepared to provide in the event of an EBSA investigation. Some commenters asked that an internal compliance plan be required, rather than optional. Though not a requirement, DOL’s goal in including this new section was to demonstrate how an internal compliance strategy that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. After review of the comments, that section was revised. It now recommends clear protocols and documentation of internal monitoring and compliance reviews when such responsibilities are delegated to other entities, and also refers to state MHPAEA compliance reporting requirements.

⁶⁹ Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (2020), available at <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>.

The 21st Century Cures Act required issuance of a guidance document including examples of both non-compliance and compliance with the requirements of MH/SUD parity.⁷⁰ To meet this requirement, the proposed 2020 update revised the examples and illustrations of non-compliance included in the 2018 version of the Self-Compliance Tool to add an explanation of how plans and issuers could correct certain parity violations. The proposed Self-Compliance Tool also included a new Appendix I with additional examples and illustrations of compliance. Commenters were broadly supportive of these updates about how to correct parity violations and the inclusion of the additional illustrations of compliance. Therefore, these proposed additions were included in the final 2020 MHPAEA Self-Compliance tool.

DOL previously issued guidance on warning signs based on past investigations.⁷¹ These warning signs are not determinative of a MHPAEA violation but may serve as red flags regarding potential impermissible treatment limitations that warrant further review. In the proposed update, DOL incorporated additional examples of treatment limitations that may operate as warning signs of potential parity violations. Commenters offered a number of suggestions of additional warning signs that should be included or warning signs that could be omitted, and clarifications that could be made to those that were included in the proposed update. DOL made revisions in response to these comments.

The 2020 Self-Compliance Tool, issued before enactment of the CAA, outlines four steps plans and issuers should take to assess their compliance with MHPAEA with regard to NQTLs. For each step, the Self-Compliance Tool identifies information plans and issuers can use to support their analysis and conclusions regarding MHPAEA compliance. This information closely aligns with the information set forth in FAQs Part 45, outlined below, that plans and issuers must include as part of their comparative analyses. EBSA will update its MHPAEA Self-Compliance Tool again in 2022 and will incorporate additional guidance, including guidance related to the CAA's new requirements.

B. FAQs Part 45

To clarify the requirements for NQTL comparative analyses and to promote compliance by plans and issuers, on April 2, 2021, the Departments released *FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021, Part 45* (FAQs Part 45).⁷²

These FAQs made clear that a general statement of compliance by plans or issuers, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is *not* sufficient to meet the statutory requirement to provide a comparative analysis. Rather, an analysis 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, as stated in Question 2 of FAQs Part 45, sufficient analyses must include a robust discussion of all of the following elements:

1. A clear description of the specific NQTL, plan terms, and policies at issue.

⁷⁰ Pub. L. 114-255 (December 13, 2016).

⁷¹ Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance, available at <https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>.

⁷² 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>.

2. 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.
3. 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.
4. 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.
5. 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.
6. 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).
7. 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.
8. 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 MHPAEA.
9. The date of the analyses and the name, title, and position of the person(s) who performed or participated in the comparative analyses.

FAQs Part 45 also provided examples of practices that plans and issuers should avoid in responding to requests for comparative analyses. 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. However, as stated in Question 3 of FAQs Part 45, plans and issuers, when responding to requests for comparative analyses, should generally try to avoid:

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice;
5. 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

6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

FAQs Part 45 also provided guidance on the types of documents that plans and issuers should be prepared to make available. This includes records documenting NQTL processes and detailing how the NQTLs are being applied, and 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. Plans and issuers should also be prepared to make available samples of covered and denied MH/SUD and medical/surgical benefit claims, as well as documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits).

These FAQs also provided information on how the Departments may proceed after requesting the comparative analyses. If the Departments determine that a plan or issuer has not provided sufficient information to review the comparative analyses, the Departments will request additional information that the plan or issuer must submit. If the plan or issuer is found to be out of compliance with MHPAEA, the plan or issuer must submit additional comparative analyses to demonstrate compliance not later than 45 days after the initial determination of non-compliance. If, after the 45-day period, the Departments make a final determination that the plan or issuer still is not in compliance, the plan or issuer must notify all enrolled individuals within 7 days after the final determination that the coverage has been determined to be non-compliant. The Departments will share their findings with the state where the group health plan is located or where the issuer is licensed to do business.

Since the enactment of MHPAEA, the Departments have been committed to using their existing disclosure authority to ensure that participants and beneficiaries are able to obtain information on their MH/SUD benefits. FAQs Part 45 clarified that ERISA-covered plans and issuers must make their comparative analyses and other applicable information available to participants and beneficiaries upon request. Additionally, for non-grandfathered group health plans and non-grandfathered group or individual health insurance coverage, as well as for all ERISA-covered plans and issuers, claimants (or their authorized representatives) have a right upon appeal of an adverse benefit determination (or 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 benefit claim.

FAQs Part 45 also provide valuable information on where the Departments may focus their enforcement efforts. To the extent the Departments become aware of potential MHPAEA violations or complaints regarding NQTLs, the Departments may request comparative analyses on the NQTLs that are the subject of the complaint or potential violation. The FAQs also note that in the near term, DOL expects to focus its enforcement efforts on:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. 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. The FAQs stress that an initial focus by DOL on the above four NQTLs does not in any way limit the Departments' or an applicable state authority's ability to request additional comparative

analyses for MHPAEA compliance. As explained below, the Departments are considering what, if any, additional guidance may be required.

V. CONCLUSION: STRENGTHENING MHPAEA'S CONSUMER PROTECTIONS

As demonstrated through the Departments' recent actions and as detailed in this 2022 Report, EBSA and HHS are committed to using all their available authority to ensure that individuals realize the full promise of MHPAEA, and to ensure that Americans with MH/SUD coverage can access MH/SUD care that is not limited in any way that medical/surgical care is not. The Departments have determined that this goal can only be achieved through proactive and rigorous enforcement of MHPAEA. To that end, EBSA and HHS have dedicated significant resources to strengthening their enforcement efforts. This includes developing and conducting extensive training for existing agency staff, recruiting and retaining additional staff, and employing experts when necessary.

These efforts are and will continue to be informed by stakeholder feedback. In order to make the most meaningful impact, the Departments have remained engaged with stakeholders to identify potential violations of the law, and to better understand ongoing compliance challenges. Given the Departments' experience implementing and enforcing the law since the enactment of MHPAEA, and in light of the stakeholder feedback received throughout the course of their implementation and enforcement of MHPAEA, the Departments will be, through notice and comment rulemaking, considering what amendments to MHPAEA's implementing regulations are warranted. Since the issuance of the MHPAEA interim final rules in 2010, and final rules in 2013, EBSA has learned a great deal from its enforcement efforts and work with stakeholders. Additionally, the Departments have worked to implement the statutory amendments to MHPAEA made by the 21st Century Cures Act, the SUPPORT Act and, most recently, the CAA. In light of this experience and the statutory amendments, and as reflected on the Departments' Fall 2021 Regulatory Agendas, the Departments are of the view that it is now appropriate to undertake additional rulemaking under MHPAEA.

While the Departments are fully committed to utilizing all their statutory authority and leveraging their experience to help address the national MH/SUD epidemics, they believe that, with additional tools, their efforts to help facilitate greater access to MH/SUD treatment could be greatly augmented. Moreover, as the primary federal regulator of MHPAEA responsible for overseeing two million group health plans covering 136.5 million individuals, DOL is uniquely positioned to evaluate and identify areas where there are impediments to full enforcement of the law. Accordingly, this 2022 Report offers statutory recommendations to strengthen MHPAEA's consumer protections and better position the Departments to enforce the law. These recommendations span three critical areas that are essential to achieving meaningful MH/SUD parity: (1) recommendations intended to enhance enforcement, (2) recommendations designed to ensure the coverage of benefits for individuals, and (3) recommendations that would require group health plans and health insurance issuers to further evidence compliance.

A. Enhancing Enforcement

As stated earlier, proactive and rigorous enforcement is vital to ensuring meaningful MH/SUD parity. From EBSA's standpoint, MHPAEA is a unique law to enforce, as compliance is predicated on drawing comparisons between the design of different categories of benefits, and the information necessary to make those comparisons is possessed by the entity that is subject to the investigation (or a party in a contractual relationship with the entity that is subject to the investigation). The Departments applaud Congress for

enacting amendments to MHPAEA that require plans and issuers to document these comparative analyses, as the lack of these analyses is has historically been a major impediment to enforcing the law.

Often, much of the investigative work involves identifying the parties responsible for the relevant information and verifying the accuracy of the information that is provided, to the extent that it is sufficient to make a meaningful determination. This process takes time and can often span multiple plan years. During this time, the individual who raised the complaint is faced with foregoing treatment and trying to challenge the denial of treatment or, if able, paying for treatment out of pocket in hopes of reimbursement when the dispute is resolved. And while, ultimately, EBSA may be able to recover the benefit to which the individual was entitled, meaningful MH/SUD parity should aim to avoid placing the individual in this situation in the first instance. Additional tools that serve as a strong deterrent could greatly incentivize compliance and help individuals avoid having to challenge discriminatory practices in the first place. **EBSA believes that authority for DOL to assess civil monetary penalties for parity violations has the potential to greatly strengthen the protections of MHPAEA.** In the absence of the authority to impose civil monetary penalties, DOL is limited in its ability to ensure appropriate corrective action in response to findings of non-compliance with MHPAEA. In 2016, a report issued by the Mental Health and Substance Use Disorder Parity Task Force concluded that authority to impose civil monetary penalties for MHPAEA violations, similar to the authority granted to DOL for enforcement of other laws relating to group health plans, would lead to more meaningful penalties for non-compliance and would incentivize compliance.⁷³ DOL recommends that Congress amend ERISA to provide DOL with this authority.

Another change in the statute that EBSA believes could greatly augment its efforts in achieving meaningful parity is to authorize EBSA to pursue all appropriate actors when it encounters a violation. EBSA has primary jurisdiction over both fully-insured and self-insured group health plans. In EBSA's experience, plan sponsors often rely on the issuer of fully-insured plans (or the TPA, in the case of self-insured plans) to administer its MH/SUD benefits, including by designing and implementing the limitations and coverage terms that are the subject of parity compliance. While EBSA leverages its existing tools to achieve MHPAEA compliance, EBSA believes that having authority to pursue all the entities directly involved in and responsible for the design and administration of a group health plan's MH/SUD benefits, including the application of the applicable limitations and coverage terms, would greatly strengthen the agency's MHPAEA efforts. **In particular, DOL recommends that Congress amend ERISA to expressly provide the agency with the authority to directly pursue parity violations by entities that provide administrative services to ERISA group health plans (including health insurance issuers that provide administrative services to ERISA plans and TPAs).** No matter how egregious the violation, and regardless of the evidence demonstrating that a health insurance issuer has caused the underlying group health plan to violate MHPAEA, EBSA's only recourse is to determine who is a fiduciary under ERISA and bring a civil action against the plan and its fiduciaries. If this impediment were removed, DOL would be in a stronger position to correct and deter violations, and to address harm to plan participants in a more efficient manner.

B. Ensuring Coverage of Benefits for Participants and Beneficiaries

In order to ensure that individuals have the benefit of meaningful MH/SUD parity, the law not only should clearly specify the prohibited conduct, but should ensure that there are appropriate remedies available to correct violations when uncovered. **To ensure that participants and beneficiaries receive**

⁷³ The Mental Health and Substance Use Disorder Parity Task Force: Final Report, available at <https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.PDF>.

coverage of their benefits, DOL recommends that Congress amend ERISA to expressly provide that participants and beneficiaries, as well as DOL on their behalf, may recover amounts lost by participants and beneficiaries who wrongly had their claims denied in violation of MHPAEA, ensuring that participants and beneficiaries are made whole. While DOL believes that ERISA currently provides this authority, it is not explicit in the statute. This authority would empower participants and beneficiaries, better equipping them to redress the harm caused by parity violations. This authority is especially important for individuals with health coverage that is not otherwise required to provide any minimum level of behavioral health or substance use disorder treatment, as MHPAEA may be the only recourse to obtaining the care that is sought.⁷⁴ Moreover, this express grant of remedial authority would place DOL in a much better position to make meaningful recoveries for participants and beneficiaries when violations are uncovered.

Finally, the Departments recommend that Congress consider ways to permanently expand access to telehealth and remote care services. Telehealth has become a vital means of providing health care, including MH/SUD health care, especially in light of the COVID-19 pandemic. Nonetheless, there are noteworthy barriers to ensuring access to telehealth services, including limited broadband access and interstate licensing requirements. The Departments recommend that Congress take steps to ensure access to telehealth services and look forward to working with Congress and stakeholders to identify ways to achieve this goal.

C. Evidencing Compliance

Through their experience implementing and enforcing the law, the Departments believe that where possible, the use of objective national standards could greatly help regulators and individuals determine compliance with MHPAEA. As it stands, MHPAEA affords plans and issuers great latitude in defining what constitutes a MH/SUD benefit, and therefore what is subject to parity, versus what is a medical/surgical benefit under the terms of the health coverage. This latitude results in non-uniform, subjective determinations that have real consequences, and can result in the primary treatment modality for a condition falling outside of the protections of MHPAEA. Moreover, this subjectivity results in different standards for parity from plan to plan and state to state. In other contexts, such as the preventive services requirements of the Affordable Care Act, Congress set the scope of the requirements by reference to external benchmarks, and designated entities with the requisite expertise to determine the scope of the particular requirement. **The Departments recommend that Congress consider amending MHPAEA to ensure that MH/SUD benefits are defined in an objective and uniform manner pursuant to external benchmarks that are based in nationally recognized standards.** For example, defining mental health conditions and substance use disorders by reference to authoritative external sources, such as 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 other standards established by an independent, nationally recognized organization could provide greater transparency for the scope of conditions that are covered under parity, and will ensure that these terms comport with the appropriate medical standards.

In conclusion, the Departments are firmly committed to facilitating access to MH/SUD treatment. While the Departments continue to enforce the law, promote compliance, and assist consumers, as

⁷⁴ While some health coverage is required to include some minimum level of behavioral health treatment (for example, through state insurance mandates or through the essential health benefit requirements of the Affordable Care Act), MHPAEA itself does not mandate a minimum level of behavioral health or substance use disorder treatment.

evidenced by this 2022 Report, the Departments are instituting new approaches to amplify their efforts to achieve greater parity. This 2022 Report outlines the first steps in a change in course marked by more rigorous enforcement, greater stakeholder engagement, and increased collaboration to identify ways to support the Administration's effort to increase access to MH/SUD treatment. The Departments are hopeful that, as a result of these efforts, individuals will continue to receive the benefits of parity protections under the law and receive the often life-saving treatment they need. The Departments look forward to working with stakeholders, other regulators, and Congress to achieve the shared goal of ensuring meaningful MH/SUD parity for individuals.