MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT COMPARATIVE ANALYSIS: A GUIDE FOR EMPLOYERS

INTRODUCTION AND BACKGROUND

The Mental Health Parity and Addiction Equity Act (MHPAEA) applies to plans and carriers offering health insurance that covers both medical/surgical (MED/SURG) and mental health/substance use disorder (MH/SUD) benefits. Self-insured plans sponsored by small employers (50 or fewer employees) and stand-alone retiree-only medical plans that do not cover current employees are exempted.

The Mental Health Parity and Addiction Equity Act applies to plans and carriers offering health insurance that covers both medical/surgical and mental health/ substance use disorder benefits.

Broadly, MHPAEA requires plans that cover MH/SUD benefits to provide such coverage on par with the plan's MED/SURG benefits. This means plans and insurers cannot impose financial requirements (e.g., deductibles, copays, coinsurance or out-of-pocket maximums), quantitative treatment limitations ("QTLs," e.g., number of covered days, visits or treatments) or non-quantitative treatment limitations ("NQTLs," e.g., coverage exclusions, prior authorization requirements, medical necessity guidelines or network restrictions) on MH/SUD benefits that are more restrictive than those applied to MED/SURG benefits. Parity does not mean a plan needs to cover all mental health treatment, only that coverage guidelines, exclusions, provider networks and claims practices must not be applied more stringently to MH/SUD benefits than to MED/SURG benefits.

The Consolidated Appropriations Act, 2021 (CAA) included an amendment to MHPAEA requiring that applicable group health plans and insurers document compliance with the law, specifically on NQTLs. For additional information on the CAA's amendment to MHPAEA, see the PPI publication **Consolidated Appropriations Act, 2021: Mental Health Parity Requirements**. The following guide for employers focuses on action steps plan sponsors should take towards MHPAEA NQTL compliance and assumes a baseline knowledge of MHPAEA requirements. (Note that although QTLs and financial requirements are not subject to the comparative analysis requirement that pertains to NQTLs, those measures must also be in parity.) The guide clarifies important distinctions between the MHPAEA compliance obligations of fully insured plans as distinct from self-insured plans (including level-funded plans). It also includes appendices with helpful tools for self-insured plan sponsors as described in greater detail in the Self-Insured Plans section below: **Suspect NQTL Inventory** (Appendix A), **TPA Document Request Template** (Appendix B) and **Guidance for Self-Insured Plans When Selecting an MHPAEA NQTL Comparative Analysis Vendor** (Appendix C). (A general introduction to MHPAEA can be found in the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) (the Departments) joint publication The Essential Aspects of Parity: A Training Tool for Policymakers. See link in the Resources section below.)

Understanding Nonquantitative Treatment Limitations (NQTLs)

Since the law was passed in 2008, MHPAEA enforcement has been a challenge for insurers, employers, regulators and courts. One somewhat elusive concept pertains to NQTLs. In simplest terms, NQTLs are limitations on benefits that cannot be expressed numerically. Commonly, impermissible NQTLs result in MH/SUD claims being reviewed more frequently or restrictively than MED/SURG claims. For example, a claims administrator may impermissibly flag outpatient psychotherapy claims for review after 20 visits without a comparable flagging practice for physical therapy claims. Similarly, a plan's

reimbursement rates may be impermissibly lower for outpatient psychotherapy than for outpatient physical therapy, despite comparable clinician qualifications.

NQTLs originate with the plan design of coverage limitations, provider network standards and claim reimbursement rates. Permissible sources that a plan can rely on when designing NQTLs include internal claims analysis, medical expert reviews, national accreditation standards, market analysis, Medicare physician fee schedules and evidentiary standards (e.g., published research studies, professional standards or clinical trials). From these sources, design decisions may be driven by excessive utilization, recent medical cost escalation, lack of clinical efficiency, high variability in cost, lack of adherence to quality standards or claims with high occurrence of fraud. Typical NQTLs deployed to address these factors include coverage exclusions, prior authorization, medical necessity management and step therapy protocols (i.e., "fail first" requirements).

Notably, MHPAEA does not prohibit the use of NQTLs altogether; rather, it requires that any NQTL applied to MH/SUD benefit not be designed or applied more stringently than how it is applied to the closest comparable MED/SURG benefit, if applied at all. To justify an NQTL, any differences must be based on consistent, coherent and *provable* factors.

The Consolidated Appropriations Act's MHPAEA Amendment: Documenting Comparative Analyses of NQTLs

Starting February 10, 2021, the CAA required group health plans and insurers to perform and document a comparative analysis of each NQTL imposed on MH/SUD benefits. At a high level, the comparative analysis requires four steps:

1. **Identify** the NQTL and relevant plan or coverage terms.
2. **Describe** the factors and sources of evidence relied upon to decide how the NQTL applies to both MH/SUD and MED/SURG benefits.
3. **Complete an analysis** demonstrating the factors, processes and strategies used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to those applied to MED/SURG benefits.
4. **Report on** coverage conclusions reached by the plan or issuer based on the analysis, including any results indicating noncompliance with MHPAEA.

Essentially, the comparative analysis must justify the inclusion of each NQTL. The first stumbling block for plan sponsors is right out of the gate – that is, they lack adequate information to even identify all NQTLs, and likely lack the technical expertise to comparatively analyze each NQTL. This is because NQTLs often relate to the inner workings of claim administration and plan design. Unlike many QTLs, which are objective benefit measures like cost-sharing or quantity of care (e.g., number of visits or days of care) and are typically apparent in the plan document, identifying NQTLs, describing design choices and comparing NQTLs requires information typically not readily available to the plan sponsor. Unfortunately, some ASO Administrators and TPAs have been reluctant to release the necessary information to self-insured plan sponsors. Appropriate actions for employers will vary based on whether the plan is fully or self-insured. Those steps are discussed in more detail below under **Satisfying the Comparative Analysis Requirements – Next Steps**.

The CAA requires the Departments to request a fresh batch of comparative analyses from at least 20 plans each year. In 2021, the DOL's Employee Benefits Security Administration (EBSA) pursued 74 MHPAEA investigations. Given that MHPAEA compliance has been unequivocally declared a DOL enforcement priority, it would not be a surprise for them to go above the annual 20-plan mandate again. If, in the course of a MHPAEA investigation, the Departments' final determination concludes noncompliance, the plan or insurer must notify all enrollees of the determination within seven days. The CAA also requires the Departments to publicly identify each noncompliant plan or issuer after an investigation has been completed. Plan sponsors should expect such naming-and-shaming will invite lawsuits from participants who are denied MH/SUD benefits.

The Departments' 2022 MHPAEA Report to Congress

In early 2022, the Departments issued a MHPAEA Report to Congress on their collection of plans' and issuers' comparative analyses. PPI summarized this report in an article of *Compliance Corner*: 2022 MHPAEA Fact Sheet Released (see link in the Resources section below). The report revealed that all collected NQTL comparative analyses were insufficient. Out of 156 reports, none of the comparative analyses contained sufficient information, meaningful analysis and initial demonstration of compliance. The report described the DOL's own efforts in obtaining information from plans and issuers as complex and time-consuming. However, these difficulties acknowledged by the DOL should not be interpreted as an excuse for a plan's inaction. Instead, plan sponsors should be aware that the DOL is devoting additional resources to MHPAEA investigations.

Though no final determinations of compliance had been made at the time of the report, the Departments shared typical NQTLs analyzed for compliance and described common ways in which a comparative analysis fell short across ongoing investigations. The report identified 14 frequently detected and problematic NQTLs found in preauthorization requirements, network provider

admission standards, continuing care coverage reviews, Autism Spectrum Disorder (ASD) treatment limitations, out-of-network reimbursement rates, treatment plan requirements and opioid use disorder medication-assisted treatment limitations, among others. Specifically, the Departments identified four NQTLs currently in their focus: prior authorizations; concurrent reviews; standards for provider network admission, including reimbursement rates; and out-of-network reimbursement rates. Despite identifying these focus areas, the report repeated previous guidance that the comparative analyses must represent a "robust discussion" of all NQTLs in a plan, as written and in operation. Effectively, this means that general declarations of compliance and broadly stated practices are insufficient.

Addressing Congress, the Departments' report recommended amendments to MHP AEA and the Employee Retirement Income Security Act (ERISA), including the imposition of monetary penalties for noncompliance, authorization for the DOL to directly pursue parity violations against TPAs (which can currently only be reached indirectly through self-insured plans), expansion of access to telehealth services and provisions for defining objective and uniform MHPAEA benchmarks. With continuing enforcement difficulties in mind, the Departments intend to undertake further rulemaking with the aim of clarifying MHPAEA compliance obligations. What's clear for now is that the MHPAEA compliance bar is high, and employers should anticipate increased enforcement activity. Although not specific to the MHPAEA comparative analysis, employers should note that the ERISA penalty for failure to provide requested documents to plan participants within 30 days is up to $110/day, with no cap. The ERISA penalty for failure to timely provide requested documents to the DOL is $190 per day, capped at $1,906 per request (as of January 15, 2024, adjusted annually for inflation).

Growing Litigation Risk

Litigation from employees challenging denied MH/SUD claims also presents a growing risk for group health plans. The plaintiffs' bar is becoming more sophisticated in bringing MHPAEA claims. Many cases challenge coverage exclusions and medical necessity criteria used to decide MH/SUD claims as inconsistent with the medical community's standards of care. These claims often relate to residential treatment, wilderness therapy and ASD treatment. A January 2022 ruling from the United States Court of Appeals for the First Circuit, *N.R. v. Raytheon Co*., clarifies how MHPAEA may be litigated under ERISA. The N.R. case illustrates how some impermissible NQTLs are hidden from self-insured employers. Specifically, an exclusion applied more stringently to Applied Behavioral Analysis (ABA) speech therapy claims was evident only in the TPA's claims handling practices, despite seemingly innocent plan terms. PPI covered this ruling in further detail in an article of *Compliance Corner*: First Circuit Reverses Dismissal of Mental Health Parity Claim (see link in the Resources section below).

Transparency is another tracking trend in MHPAEA litigation and DOL enforcement. Self-insured employers should confirm their TPAs are providing adequate documentation in response to information requests from employees, commonly made as part of the claim appeals process. For MHPAEA and ERISA document requests, the scope of information required to be produced may stretch well beyond the plan document. Another aspect of transparency requires any NQTL applied to a claim decision be explained in the denial letter in easy-to-understand terms.

Shortcomings in MHPAEA and ERISA document disclosures leave plans exposed to substantial penalties. In August 2021, a federal court in Utah awarded the then current maximum $100 per day in ERISA penalties totaling $123,100 against the self-insured employer and TPA for failing to disclose complete claim coverage criteria and the Administrative Services Agreement between the plan administrator, Microsoft, and the claims administrator, Premera. Self-insured employers should verify solid procedures are in place to respond fully and timely to any MHPAEA or ERISA document request. The task of responding may be quite burdensome and, like the comparative analyses, require extensive information controlled by the TPA. For these reasons, the responsibility for responding to document requests should be explicitly addressed in administrative services agreements.

SATISFYING THE COMPARATIVE ANALYSIS REQUIREMENTS – NEXT STEPS

Increased DOL investigations and MHPAEA litigation call for employers to proceed proactively on MHPAEA compliance. Waiting to act until contacted by the DOL may be a dangerous approach, especially if the plan is at high risk of being targeted (e.g., already being investigated, larger group, participant MH/SUD coverage complaints or suspect NQTLs in plan document). MHPAEA investigations have demanded responses to notably detailed requests. Likewise, the CAA requires plans to have already completed the comparative analysis and to make it available to the Departments, state regulators or a plan participant within days of a request. If the DOL determines documentation produced is insufficient or reveals noncompliance, plans only have a 45-day timeframe to correct. However, just the initial step of gathering required documents may prove to be a difficult and prolonged endeavor spanning several months. Despite the reality that most plan sponsors are unable to even identify all NQTLs in their plan – much less analyze them – the DOL's position is that if an NQTL has been incorporated into a plan, the comparative analysis should have already been completed. Importantly, it is not enough to merely complete the comparative analyses: NQTLs that cannot be justified as comparable between MH/SUD and MED/SURG must be corrected.

Completing the comparative analysis is no small task. It is made more difficult by the lack of additional regulatory guidance or models and, for self-insured plans, the disconnect between the parties holding legal responsibility to comply and the parties

holding the information necessary to document compliance. Based on what we know now, we have outlined appropriate next steps for plans to take towards NQTL comparative analysis compliance.

Fully Insured Plans

Insurance carriers are required to provide the analyses for fully insured plans. This obligation should be acknowledged in the carrier agreement. Fully insured plan sponsors should ensure they have the plan's latest comparative analyses on hand. They should also consider asking their insurance carrier whether their analysis has been found to be insufficient through a DOL request or investigation.

Self-Insured Plans (Including Level-Funded Plans)

Employers sponsoring self-insured group health plans serve as the fiduciary responsible for plan administration, which includes completing the comparative analyses. Very few self-insured health plans are administered without TPAs deciding claims and designing plan coverage terms. The comparative analysis is not straightforward. Simply identifying NQTLs to analyze requires a sophisticated understanding of plan design and administration, which most plan sponsors lack. As a result, it is imperative for self-insured plans to have their TPA's full cooperation in completing the required comparative analysis. That cooperation may mean providing plan, network and claims information timely, coherently and with sufficient detail; alternatively, it may mean completing the comparative analysis for the plan. Even where a TPA takes on the comparative analyses, a self-insured plan sponsor remains responsible for the plan's compliance with MHPAEA and will need to monitor the TPA's work.

Some TPAs will not complete adequate comparative analyses on behalf of plan sponsors. In those cases, self-insured groups will need to conduct the analysis internally with their legal counsel or hire a vendor to run the analysis. The **PPI Comparative Analysis Vendor Guide** (Appendix C) offers relevant considerations in choosing a vendor to run the analysis. It is important to note that even if the TPA will not complete the comparative analysis for the plan, the TPA must still be committed to providing all relevant information, and in substantial detail.

Working with Your TPA

Notably, many TPAs also serve as insurance carriers with direct responsibility to complete the comparative analyses on insured plans. Analyses on certain self-insured plan aspects that mirror the TPA's insured model may be transferrable, especially with regards to plan design choices. Self-insured plan sponsors should start by requesting those insured model reports and further ensuring any deviations from the insured model, including claim denial trends unique to a particular plan, are reviewed for potential NQTLs. TPAs should also be pressed to provide information on how their plan design has fared so far in ongoing DOL investigations. Any identified noncompliant NQTLs should be addressed immediately.

Because the comparative analysis is a relatively new requirement, it may not be addressed in self-insured employers' existing agreements with TPAs. Going forward, it is important to ensure that conducting the analysis, making timely disclosures to participants, and responding to any DOL audits is clearly addressed in these administrative services agreements. At the very least, where an ASO administrator or TPA has given assurances of compliances, self-insured plan sponsors should document that mutual understanding in writing. Ideally, given their relative expertise and control of required information, TPAs will complete comparative analyses, handle disclosure requests and confirm they are offering a MHPAEA-compliant plan design.

Importantly, a self-insured employer's role as plan administrator includes the fiduciary responsibility to carefully select and monitor service providers. One option for employers facing a noncompliant plan design or uncooperative TPA is to consider finding another administrative services provider.

Assessing Your Plan's Risk

Since the DOL will be looking for a new batch of plans to investigate annually with vigorous enforcement efforts dedicated to MHPAEA, the best course is to complete the comparative analyses on all NQTLs. Ideally, all employers should have a completed comparative analysis report on hand. Fully insured groups may rely on their carrier to complete the analysis. Understanding not every self-insured employer has the resources to complete the comparative analysis, the following questions can help assess the risk of a DOL investigation or litigation:

- Does the plan document contain certain problematic MH/SUD limitations?
- What is the TPA's response to a request for comparative analysis documentation?
- How unique is the plan design?
- Have there been any employee MH/SUD coverage complaints?
- Is the plan already being audited by the DOL?
- What is the employer's overall risk tolerance?

For example, an employer sponsoring a self-insured plan with disparate prior authorization requirements, an uncooperative TPA and multiple employee complaints regarding mental health coverage is at high risk of being investigated and found noncompliant. To properly prepare, they should engage legal counsel as soon as possible to complete the analysis and correct any noncompliant NQTLs.

Tools for Self-Insured Plan Sponsors

Completing the comparative analysis alone is a massive undertaking that requires legal, actuarial and clinical expertise. There are initial steps all self-insured plans can take using the following PPI tools. Employers should review these tools with their legal counsel.

- **Appendix A: Suspect NQTL Inventory**. The path towards MHPAEA compliance starts with reviewing your plan terms. That's where the DOL would start their investigation. Some NQTLs will be apparent in the plan document. PPI has provided a list of suspicious terms to look out for. Even if a TPA agrees to take on the comparative analysis, self-insured plan sponsors should scrutinize the results. At the very least, make sure the TPA completed comparative analyses on any of these suspect NQTLs.
- **Appendix B: TPA Document Request Template**. Ideally, the TPA will complete the comparative analysis. But if they resist, the TPA still must provide all necessary plan design and administration information. PPI has provided a template document request to engage TPAs in collecting this information. This request covers detailed and technical information required to complete the comparative analysis. Employers should keep records of communications with TPAs regarding completing the comparative analysis, including these types of information requests.
- **Appendix C: Guidance for Self-Insured Plans When Selecting an MHPAEA NQTL Comparative Analysis Vendor**. PPI has summarized relevant considerations when selecting a vendor to complete the comparative analysis.

SUMMARY

The Departments have reported widespread noncompliance in both insufficient comparative analyses and NQTLs commonly applied exclusively or more stringently to MH/SUD. Despite murky instructions on how to document compliance, specifically, how to justify NQTLs, the DOL continues investigating plans. Given the DOL's ongoing vigorous MHPAEA enforcement agenda, self-insured plan sponsors with fiduciary responsibility should be attentive to MHPAEA compliance by scrutinizing plan terms (see Appendix A), seeking assistance from TPAs (see Appendix B) and engaging a qualified expert to perform thorough comparative analysis as needed (see Appendix C).

Plan sponsors may consider initiating a MHPAEA compliance program to document ongoing comparative analysis efforts, respond to employee parity complaints, flag compliance issues with quarterly claim audits, influence plan design choices and ensure timely and adequate disclosures are made to plan participants. DOL publications to guide MHPAEA compliance are available on the Mental Health and Substance Use Disorder Parity page of the DOL website (dol.gov), including an online self-compliance tool.

RESOURCES

FAQS About Mental Health and Substance Use Disorder Parity Implementation and the CAA, 2021

Warning Signs – Plan or Policy NQTLs that Require Additional Analysis to Determine Mental Health Parity Compliance

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

The Essential Aspects of Parity: A Training Tool for Policymakers

EBSA MHPAEA Enforcement Fact Sheet

2022 MHPAEA Report to Congress

2022 MHPAEA Fact Sheet Released

First Circuit Reverses Dismissal of Mental Health Parity Claim Against Group Health Plan

PPI BENEFIT SOLUTIONS

APPENDIX A

Suspect NQTL Inventory

The DOL has identified common "red flag" plan terms that signal possible MHPAEA noncompliance. While these terms do not automatically violate MHPAEA, they call for scrutiny. Plan sponsors should review their plan documents for the following red flags. These terms are typically found in the summary plan description's sections labeled "Covered Services," "Eligible Services," "Exclusions," "Definitions," or wherever prior authorization requirements are discussed. Red flag plan terms include NQTLs such as:

- Additional prior authorization/precertification requirements particular to MH/SUD treatment.
- Additional or stricter review standards for continuing MH/SUD treatment (e.g., requiring review of continuing care every X number of days).
- Exclusions or restrictions on out-of-network MH/SUD benefits.
- Applying experimental/investigational exclusions only to MH/SUD treatment.
- Denial of higher-cost therapies until a lower-cost therapy has been tried and failed (known as "fail first policies" or "step therapy protocols").
- Exclusions for MH/SUD treatment where plan beneficiary fails to comply with treatment plan, such as leaving treatment early against a provider's medical advice.
- Exclusions for MH/SUD treatment based on chronicity or lack of treatability, likelihood of improvement or functional progress.
- Exclusions, limitations or additional requirements for treatment related to Autism Spectrum Disorder (e.g., applied behavioral analysis (ABA), intensive behavioral treatment (IBT) therapies or speech therapy).
- Required treatment plan or physician supervision for a MH/SUD service.
- Exclusions or limitations specific to eating disorders (e.g., nutritional counseling limitations).
- Exclusions, limitations or additional requirements for MH/SUD residential treatment or partial hospitalization programs.
- Exclusions for MH/SUD treatment if provided in certain settings (e.g., wilderness, outward-bound, ranch, vocational, recreational or educational settings).
- Exclusions for MH/SUD treatment programs or facilities based on licensing or accreditation.
- Geographical limitation related only to MH/SUD treatment.
- Virtual or telephonic visit restrictions on MH/SUD treatment.
- Exclusions for certain providers based on licensing (any additional training requirement must be applied to all providers and not have a disparate impact on MH/SUD providers whose state licensing may not require the additional training).
- Exclusions based on MH/SUD diagnosis (e.g., excluding neuropsychological testing if ordered for depression but not if ordered for traumatic brain injury; excluding methadone for opioid addiction but not for pain management).
- Telehealth benefits for MED/SURG conditions only (or MH/SUD covered on more restrictive terms or higher cost-share).

If any of the above-listed terms are found, the first step is to look for a comparable exclusion or limitation applied to MED/SURG treatment in the same benefit classification (i.e., in-network inpatient; out-of-network inpatient; in-network outpatient; out-of-network outpatient; emergency care; and prescription drugs). Any term that appears to cover MH/SUD benefits less favorably than MED/SURG benefits should be further scrutinized. Note that the above list is not exhaustive.

Since the plan documents are readily accessible to employers, the plan terms are a good place to start in assessing MHPAEA compliance. However, NQTLs are often concealed from the plan document (i.e., "as written"), only surfacing in how claims are reviewed, denied or reimbursed (i.e., "in operation"). Therefore, plan sponsors should treat employee complaints as red flags for potential areas of noncompliance. The challenged plan terms or practices (e.g., exclusion, limitation, coverage guideline or reimbursement rate) should be closely examined with the carrier or third-party administrator handling claims. Attention to employee plan grievances may prevent a lawsuit or DOL investigation of a complaint

APPENDIX B

TPA Document Request Template

PPI has provided this template document request to be used to obtain all detailed and technical information from TPAs required to complete the comparative analysis. This request may be appropriate to engage TPAs unwilling to complete the comparative analysis for the plan. Self-insured plan sponsors should complete bracketed sections as applicable to your plan. Records of communications with TPAs regarding completing the comparative analysis should be kept, including these types of information requests. It is important to review this document request with your legal counsel.

[DATE]

[TPA Contact]

[TPA Name]

[Address]

[Address]

[Address]

Dear [TPA Contact]:

Under the Consolidated Appropriations Act, 2021 (CAA 2021) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), plan administrators and insurers must document an analysis of the design and application of each nonquantitative treatment limitation (NQTL) applied to mental health and substance use disorder (MH/SUD) benefits as compared to medical and surgical (MED/SURG) benefits, referred to as a "Comparative Analysis."

Upon a request from the Departments of Labor, Treasury, or Health and Human Services (the Departments), applicable state authorities, or plan participants, plans and insurers must produce the comparative analysis. As sponsor of the [Plan Name] (Plan), we lack the necessary claims administration information to complete a "sufficiently specific, detailed, and reasoned" comparative analysis as instructed by the Departments. As a third-party administrator of our plan, you are an important partner in ensuring our plan remains compliant with applicable law. [[Specifically, as a fiduciary exercising discretion in administering claims and under the terms of our Administrative Services Agreement, [TPA Name], shares responsibility for MHPAEA compliance.]]We appreciate your assistance with these efforts.

MHPAEA is an enforcement focus for the Departments. Therefore, we wish to ensure compliance as soon as possible. Please provide any comparative analysis completed in relation to this plan design, along with the following information:

I. Disclosures

a) Please provide [TPA]'s comparative analyses conducted on all NQTLs present in the design or claims administration of the [Plan Name].

b) What are your processes for responding to MHPAEA information requests from members? Please provide a sample response.

c) Please provide copies of any responses or reports to the Departments or applicable state agencies regarding [TPA] and MHPAEA compliance.

d) Please identify all plan terms in any [TPA]-administered plan deemed an impermissible NQTL by the Departments, state enforcement agency, or reviewing court in the last five years.

e) What are your processes for responding to members' claim file requests under ERISA and document requests under MHPAEA? Please provide a sample response.

II. Prior Authorization/Precertification Requirements

a) General.

1) Please describe the Plan's prior authorization/precertification requirements for MH/SUD claims* in design and application.

2) Please describe the Plan's prior authorization/precertification requirements for MED/SURG claims in design and application.

3) Please describe factors** that support any difference between II(a)(1) and (2).

b) Autism Spectrum Disorders.

1) Please describe any prior authorization/precertification requirements the Plan applies to applied behavioral analysis (ABA), intensive behavioral treatment (IBT) therapies, or speech therapy for Autism Spectrum Disorders (ASD).

2) Please describe any prior authorization/precertification requirements the Plan applies to comparable MED/SURG therapies or services.

3) Please describe factors that support any difference between II(b)(1) and (2).

c) Prescription Drugs.

1) Please describe any prior authorization/precertification requirements the Plan applies to prescription drugs for MH/SUD diagnosis.

2) Please describe any prior authorization/precertification requirements the Plan applies to prescription drugs for MED/SURG diagnosis.

3) Please describe factors that support any difference between II(c)(1) and (2).

III. Utilization Reviews

a) Medical Necessity Guidelines.

1) Please describe all evidence-based standards used in designing the medical necessity guidelines applied to MH/SUD claims.

i. Please describe whether these guidelines have been endorsed by any independent medical experts as meeting the standard of care.

2) Please describe all evidence-based standards used in designing the medical necessity guidelines applied to MED/SURG claims.

i. Please describe whether these guidelines have been endorsed by any independent medical experts as meeting the standard of care.

3) Please describe factors that support any difference between III(a)(1) and (2).

b) "Fail First" Requirements.

1) Do any medical necessity guidelines applied to MH/SUD claims first require the member complete a lower level of care (i.e., "fail first" requirements)?

2) Do any medical necessity guidelines applied to MED/SURG claims first require the member complete a lower level of care (i.e., "fail first" requirements)?

3) Please describe factors that support any difference between III(b)(1) and (2).

c) Treatment Plan Requirements.

1) Does the Plan require a treatment plan for any MH/SUD services?

2) Does the Plan require a treatment plan for any MED/SURG services?

3) Please describe factors that support any difference between III(c)(1) and (2).

d) Physician Oversight Requirements.

1) Does the Plan require treatment be provided under the direction of a physician for any MH/SUD services?

2) Does the Plan require treatment be provided under the direction of a physician for any MED/SURG services?

3) Please describe factors that support any difference between III(d)(1) and (2).

e) Improvement Requirements.

1) For intermediate MH/SUD treatment (e.g., residential treatment, partial hospitalization, intensive outpatient treatment), is improvement required under the Plan's medical necessity guidelines?

2) For intermediate MED/SURG treatment (e.g., skilled nursing facilities, rehabilitation hospitals), is improvement required under the Plan's medical necessity guidelines?

3) Please describe factors that support any difference between III(e)(1) and (2).

f) Utilization Review Operational Data.

1) Initial Claim Reviews.

i. What is the average denial rate (percentage of occurrence) of initial claims for MH/SUD benefits? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., residential treatment, partial hospitalization, intensive outpatient treatment) both in- and out-of-network.

ii. What is the average denial rate (percentage of occurrence) of initial claims for MED/SURG benefits? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., skilled nursing facilities, rehabilitation hospitals) both in- and out-of-network.

2) Concurrent Care Claim Reviews.

i. How often, in average number of days, are concurrent reviews conducted for MH/SUD claims? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., residential treatment, partial hospitalization, intensive outpatient treatment) both in- and out-of-network.

ii. How often, in average number of days, are concurrent reviews conducted for MED/SURG claims? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., skilled nursing facilities, rehabilitation hospitals) both in- and out-of-network.

iii. What is the average denial rate (percentage of occurrence) of concurrent care claims for MH/SUD benefits? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., residential treatment, partial hospitalization, intensive outpatient treatment) both in- and out-of-network.

iv. What is the average denial rate (percentage of occurrence) of concurrent care claims for MED/SURG benefits? Please include claims for outpatient, inpatient, and intermediate benefits (e.g., skilled nursing facilities, rehabilitation hospitals) both in- and out-of-network.

v. What evidence-based standards or other factors were relied on in developing concurrent review practices of MH/SUD claims?

vi. What evidence-based standards or other factors were relied on in developing concurrent review practices of MED/SURG claims?

vii. Please describe factors that support any difference between III(f)(2)(v) and (vi).

g) Utilization Reviewer Qualifications.

1) What are MH/SUD claim decision-makers' qualifications?

2) What are MED/SURG claim decision-makers' qualifications?

3) Please describe factors that support any difference between III(g)(1) and (2).

IV. Exclusions/Limitations

a) Treatment Setting Exclusions.

1) Please describe any plan exclusions for MH/SUD treatment if provided in certain settings (e.g., wilderness, outward-bound, ranch, recreational, vocational or educational settings), including the criteria for determining whether a program is in an excluded setting.

2) Please describe any plan exclusions for MED/SURG treatment if provided in certain settings, including the criteria for determining whether a program is in an excluded setting.

3) Please describe factors that support any treatment setting exclusions described in IV(a)(1) or (2) and applicable criteria.

b) Licensing/Accreditation Requirements.

1) Please describe any exclusions for MH/SUD providers, programs, or facilities based on licensing or accreditation.

2) Please describe any exclusions for MED/SURG providers, programs, or facilities based on licensing or accreditation.

3) Please describe factors that support any exclusions described in IV(b)(1) or (2).

c) Treatment Programming Requirements.

1) Please describe any exclusions for MH/SUD programs or facilities based on treatment programming requirements (e.g., patient must be treated by psychiatrist at a minimum frequency, program must be directed by a psychiatrist, or behavioral health clinician must be always on duty).

2) Please describe any exclusions for MED/SURG programs or facilities based on treatment programming requirements.

3) Please describe factors that support any exclusions described in IV(c)(1) or (2).

d) Treatment Plan Compliance Requirements.

1) Please describe any exclusions for MH/SUD services in the event the member fails to comply with a plan of treatment (e.g., leaves the program against medical advice).

2) Please describe any exclusions for MED/SURG services in the event the member fails to comply with a plan of treatment.

3) Please describe factors that support any exclusions described in IV(d)(1) or (2).

e) ASD Exclusions.

1) Please describe any exclusion for treatment relating to Autism Spectrum Disorder, including factors that support such exclusion.

f) Diagnostic Exclusions.

1) Please describe any exclusions based on MH/SUD diagnosis (e.g., excluding neuropsychological testing if ordered for depression but not if ordered for traumatic brain injury; excluding methadone for opioid addiction but not for pain management), including factors that support such exclusion.

2) Please describe any exclusions based on MED/SURG diagnosis, including factors that support such exclusion.

g) Other Exclusions.

1) Please describe any other exclusions applied to MH/SUD benefits, including factors that support such exclusion.

2) Please describe any other exclusions applied to MED/SURG benefits, including factors that support such exclusion.

h) Other Limitations.

1) Please describe any other treatment limitation, including limitation in frequency or duration, on any MH/SUD treatment, and the factors that support such limitation.

2) Please describe any other treatment limitation, including limitation in frequency or duration, on any MED/SURG treatment, and the factors that support such limitation.

V. Sources for NQTL Design

a) If any prior authorization requirements, medical necessity guidelines, exclusion, or other coverage guidelines applied to MH/SUD claims were developed based on recommendations of a committee, what are the qualifications and expertise of the committee(s) members?

b) If any prior authorization requirements, medical necessity guidelines, exclusion, or other coverage guidelines applied to MED/SURG claims were developed based on recommendations of a committee, what are the qualifications and expertise of the committee(s) members?

c) Are nationally recognized clinical standards used to determine coverage for MH/SUD benefits?

1) If so, what are they?

2) If not, why does the Plan deviate from those standards?

d) Are nationally recognized clinical standards used to determine coverage for MED/SURG benefits?

1) If so, what are they?

2) If not, why does the Plan deviate from those standards?

VI. Network Adequacy/Reimbursement Rates

a) Reimbursement Rate Methodology.

1) Please describe the process for determining reimbursement rates for in-network and out-of-network providers for MH/SUD benefits.

2) What factors are considered in establishing reimbursement rates for MH/SUD benefits (e.g., market dynamics, supply and demand, geographic location, quality measures, or treatment outcomes)?

3) Please describe the process for determining reimbursement rates for in-network and out-of-network providers for MED/SURG benefits.

4) What factors are considered in establishing reimbursement rates for MED/SURG benefits (e.g., market dynamics, supply and demand, geographic location, quality measures, or treatment outcomes)?

b) Network Adequacy.

1) What percentage of the total number of MH/SUD claims were out-of-network during the most recent plan year?

2) What are the requirements for coverage of out-of-network MH/SUD treatment?

3) What percentage of the total number of MED/SURG claims were out-of-network during the most recent plan year?
4) What are the requirements for coverage of out-of-network MED/SURG treatment?
5) Please describe factors that support any differences in the requirements described in VI(b)(2) and (4).
6) What measures have been taken to address any shortages in MH/SUD specialist providers (e.g., adjusting provider admission standards, increasing reimbursement rates, accelerating enrollment)?
7) What measures have been taken to address any shortages in MED/SURG specialist providers (e.g., adjusting provider admission standards, increasing reimbursement rates, accelerating enrollment)?
8) Please provide average plan outpatient treatment reimbursement rates as indicated in the following chart:

Specialty	CPT Codes	Average Plan In-Network Reimbursement Rate	Medicare Rate	Plan Rate as % of Medicare Rate
Orthopedic Surgeons	99203 99213	$ $	$ $	
Cardiologists	99203 99213	$ $	$ $	
Internists MDs	99203 99213	$ $	$ $	
Endocrinologists	99203 99213	$ $	$ $	
Gastroenterologists	99203 99213	$ $	$ $	
Neurologists	99203 99213	$ $	$ $	
Pediatricians	99203 99213	$ $	$ $	
Dermatologists	99203 99213	$ $	$ $	
Psychiatrists	99203 99213	$ $	$ $	
Psychologists	90832 (1 hour) 90791 (1/2 hour)	$ $	$ $	
LCSWs	99203 99213	$ $	$ $	
Podiatrists	99203 99213	$ $	$ $	
Chiropractors	99203 99213	$ $	$ $	
Occupational Therapists	97165 97166 97163 97164	$ $ $ $	$ $ $ $	
Physical Therapists	97161 97162 97163 97164	$ $ $ $	$ $ $ $	
Speech Therapists for ASD	92507	$	$	
ABA Therapists	97153	$	$	

9) Please provide average plan inpatient treatment reimbursement rates as indicated in the following chart:

Primary Diagnosis	CPT Codes	Average Plan In-Network Reimbursement Rate	Medicare Rate	Plan Rate as % of Medicare Rate
Heart Failure	99221 99222	$ $	$ $	
Acute Myocardial Infarction	99221 99222	$ $	$ $	
Stroke	99221 99222	$ $	$ $	
Septicemia	99221 99222	$ $	$ $	
Pneumonia	99221 99222	$ $	$ $	
Psychoses	99221 99222	$ $	$ $	
Eating Disorder	99221 99222	$ $	$ $	
Mood Disorder	99221 99222	$ $	$ $	
Alcohol Use Disorder	99221 99222	$ $	$ $	

VII. Claims Decisions

a) Please provide sample claim decision letters as follows:

1) In-network MH/SUD denied claim in each of the six benefit classifications.
2) Out-of-network MH/SUD denied claim in each of the six benefit classifications.
3) In-network MED/SURG denied claim in each of the six benefit classifications.
4) Out-of-network MED/SURG denied claim in each of the six benefit classifications.

VIII. Reports to Agencies

a) Please provide copies of all reports made to state and federal mental health parity enforcement agencies in the past three years.

Thank you for providing the information outlined above as soon as reasonably possible. As we are not experts in plan design or claims administration, we appreciate this information be provided in accessible formats with adequate descriptions of relevancy. Please provide any other information required to complete the comparative analysis as instructed by the Departments. We look forward to working with you to ensure the plan's MHPAEA compliance.

Sincerely,
[Employer contact]

[Employer name]

*Please assume any question related to MH/SUD claims is seeking information on benefits in each of the following classifications: in-network inpatient; out-of-network inpatient; in-network outpatient; out-of-network outpatient; emergency care; and prescription drugs.

**References to "factors" include processes, strategies or evidentiary standards.

APPENDIX C

Guidance for Self-Insured Plans When Selecting an MHPAEA NQTL Comparative Analysis Vendor

There are a number of vendors offering to complete the comparative analysis for fees ranging from $2,000 to over $110,000. Plan sponsors should be cautious in engaging a vendor given the complexity of the analysis required, the challenges in obtaining required information from TPAs, and the absence of model reports from the DOL. First, identifying and analyzing NQTLs is a complex task requiring legal expertise on MHPAEA. A preferred vendor should be well-versed in MHPAEA and DOL investigations. Second, a major obstacle in completing the comparative analysis is obtaining all necessary information from the TPA that typically administers claims and designs plan coverage terms. Simply knowing what information to request requires technical knowledge of MHPAEA. Even the DOL has reported struggling to gather sufficient information. Since the quality of the comparative analysis depends on obtaining the required information, ideally the vendor will assume the task of gathering information from TPAs. Third, as of early 2024, the DOL has not provided a model comparative analysis to justify an NQTL. We hope to receive more guidance later this year. Right now, plan sponsors should keep in mind that all vendors performing the comparative analysis lack clear instructions. No vendor can realistically guarantee their analysis without knowing what the DOL expects.

While we are unable to endorse any vendor until the DOL provides additional guidance or a model comparative analysis, NFP's Benefits Compliance team has identified a law firm with appropriate technical expertise in MHPAEA that will complete the NQTL comparative analysis at (and gather the required information) rates that appear reasonable for a project of this scope:

- **Hall Benefits Law**. HBL is an ERISA law firm that completes the MHPAEA NQTL comparative analyses and documents efforts taken on behalf of the client to obtain claims administration and plan design information from TPAs. This may be a good option for self-insured plan sponsors faced with TPAs who will not provide a complete comparative analysis. HBL produces a memorandum attaching a comparative analysis for the client to have on hand. The memorandum includes a description of the plan administration and benefit options, network analysis, plan design analysis, and emergency services analysis. If HBL (on behalf of the plan sponsor) is unable to obtain information related to a particular analysis, it documents its efforts and completes the analysis as thoroughly as possible with the information available.

  HBL charges an hourly rate of $550, with an estimated 10 to 20 hours of work required to complete the analysis (totaling $5,500 to $11,000). Interested plan sponsors may contact Anne Hall at **athall@hallbenefitslaw.com** or 678.439.6236.

Plan sponsors should start by reviewing all available options to complete the comparative analysis (e.g., by their legal counsel, by their plan TPA/carrier, or through a vendor). Our Benefits Compliance team will continue to monitor and report on new guidance from the DOL as it becomes available.