MHPAEA NQTL COMPARATIVE ANALYSIS: A GUIDE FOR EMPLOYERS

Starting February 10, 2021, the CAA 2021 required group health plans and insurers to perform and document a MHPAEA comparative analysis of each nonquantitative treatment limitation imposed on mental health or substance use disorder benefits. Increased MHPAEA litigation and continued regulatory enforcement necessitate proactive compliance from employers.

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 exempt from MHPAEA requirements. The Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the departments) share federal agency enforcement of MHPAEA. The Employee Benefits Security Administration (EBSA) of the DOL handles the majority of federal enforcement efforts. Many states have other mental health parity laws that apply to fully insured policies issued in that state.

This publication focuses exclusively on federal MHPAEA requirements and does not address state-specific parity laws. Specifically, the guide discusses the following topics related to federal MHPAEA compliance:

OVERVIEW

Broadly, while MHPAEA does not mandate mental health coverage, it requires plans that cover MH/SUD benefits to do so 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), or nonquantitative treatment limitations (NQTLs) on MH/SUD benefits that are more restrictive than those applied to MED/SURG benefits. (Examples of QTLs include number of covered days, visits, or treatments; examples of NQTLs include coverage exclusions, prior authorization requirements, medical necessity criteria, or network limitations.) Parity does not mean a plan must 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.

Our Observation:	While self-insured plans are not required to cover MH/SUD benefits at all, MHPAEA requirements are triggered if they do cover them. Specifically, if a plan covers benefits in one of six classifications (in-network inpatient; out-of-network inpatient; in-network outpatient; outpatient out-of-network; emergency care; or prescription drugs) to treat a particular MH/SUD condition, the plan generally would be required to cover MH/SUD benefits for that condition in each of the other five classifications. This means, for example, that self-insured plans cannot carve out telehealth therapy or provide prescription drug coverage for MH/SUD conditions without covering certain MH/SUD benefits in all other classifications.

The Consolidated Appropriations Act, 2021 (CAA 2021) included an amendment to MHPAEA requiring that group health plans and insurers document compliance with the law, specifically on NQTLs. Further, although QTLs and financial requirements are not subject to the comparative analysis requirement for NQTLs, they must still maintain parity.

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. The guide clarifies important distinctions between the MHPAEA compliance obligations of fully insured plans and self-insured (including level-funded) plans. It also includes appendices with helpful tools for self-insured plan sponsors as described in greater detail in the Satisfying the Comparative Analysis Requirements – Next Steps section below: **MHPAEA Compliance: Red Flag NQTLs** (Appendix A) and **TPA NQTL Communication Template** (Appendix B).

UNDERSTANDING NQTLs

Since the law's enactment in 2008, MHPAEA has posed challenges for insurers, employers, regulators, and courts. One particularly elusive aspect involves NQTLs. In simplest terms, NQTLs are limitations on benefits that cannot be expressed numerically. These include coverage exclusions, prior authorization requirements, additional review standards, medical necessity guidelines, and network restrictions.

Impermissible NQTLs result in barriers to accessing medically necessary MH/SUD treatment or 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 five 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. For a list of red flag NQTLs, see Appendix A.

NQTLs originate from the medical (including pharmacy) plan design, encompassing coverage limitations, provider network standards, and claim reimbursement rates. Permissible sources that an insurer, third-party administrator (TPA), or insurer providing administrative services only (ASO) can rely on when designing NQTLs include internal claims analyses, medical expert reviews, national accreditation standards, market analyses, Medicare physician fee schedules, and evidentiary standards (e.g., published research studies, professional standards, or clinical trials). From these sources, plan design decisions may be influenced by factors such as excessive utilization, escalating medical costs, clinical inefficiencies, cost variability, nonadherence to quality standards, or a high incidence of fraudulent claims. Typical NQTLs deployed to address these factors include coverage exclusions, prior authorization requirements, 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 NQTLs applied to MH/SUD benefits not be designed or applied more stringently than those 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.

NQTL Comparative Analysis Elements

Starting February 10, 2021, the CAA 2021 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 must include four parts:

1. **Identification of** the NQTL and relevant plan terms.
2. **Description of** the factors and sources used to design how the NQTL applies to both MH/SUD and MED/SURG benefits.
3. **Demonstration that** the factors, processes, strategies, and evidentiary standards used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to and no more stringent than those applied to MED/SURG benefits.
4. **Report on** compliance conclusions, including any noncompliance.

Robust Discussion Requirement

According to the departments, a "robust discussion" of all NQTLs in a plan, as written and in operation, is required in the comparative analysis. This means that general declarations of compliance and broadly stated practices are insufficient. Essentially, the comparative analysis must justify the inclusion of each NQTL. The first challenge for self-insured plan sponsors tends to be that they lack adequate information to identify all NQTLs and likely lack the technical expertise to comparatively analyze each NQTL. (By contrast, the insurer is required to complete the analysis for fully insured plans.)

The second challenge for self-insured plans arises because NQTLs often relate to the inner workings of claim administration and plan design, and plan sponsors typically rely on a TPA to administer claims and design specific coverage terms. The departments expect that a comparative analysis of the NQTL has already been completed at the design phase, before being integrated into coverage guidelines or provider network arrangements. 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.

Another challenge for plans that use different service providers for MH/SUD benefits and MED/SURG benefits (e.g., to administer claims or maintain provider networks) is that each service provider lacks the other service provider's data to actually compare the NQTLs. Typically, this means the plan sponsor needs to take additional steps to reconcile and compare each service provider's NQTL design and application descriptions.

Our Observation:	Unfortunately, some ASO administrators and TPAs have been reluctant to complete a comparative analysis on behalf of their clients (plan sponsors). For self-insured plans, the task of creating this analysis is complicated by a disconnect between the parties. Specifically, the party legally responsible for compliance (e.g., an employer sponsoring a self-insured plan) may not have ready access to the necessary information, which is held by another party (typically the TPA). Insurers, however, are directly responsible for completing a plan's NQTL comparative analysis. As a result of this distinction, 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.

Fiduciary Role for ERISA Plans

As a fiduciary, the plan must monitor the service provider's work. This means that an ERISA plan fiduciary takes an active role in the process, minimally by reviewing the comparative analysis, confirming and understanding the findings, and seeking assurances from the service provider(s) that the plan's NQTLs and comparative analysis comply with MHPAEA. These duties align with the general duties of that ERISA imposes on plan fiduciaries. For further information on ERISA fiduciary duties, see the PPI publications **ERISA Compliance Considerations for Health and Welfare Plans** and ERISA Fiduciary Governance: A Guide for Employers.

No Annual Submission

While there is no annual submission requirement, plans must complete and maintain a comparative analysis and be prepared to produce it upon request by the departments, state agency, or plan participant. The departments are required to request a fresh batch of comparative analyses from at least 20 plans each year. If, in the course of a MHPAEA investigation, the departments' final determination concludes noncompliance, the plan or insurer must notify all plan participants of the determination within seven days. The departments are also required to publicly identify each noncompliant plan or issuer after completing an investigation.

In addition, Treasury has the authority to impose excise taxes on sponsors of noncompliant plans in the amount of $100 per day per affected individual, and EBSA recently indicated that it intends to refer more violations to Treasury for this tax levy. However, the the departments have reported that most plans prefer to work with them to correct noncompliant NQTLs rather than face public identification.

Separately, and more likely, a plan may receive a comparative analysis request from a participant or beneficiary following a claim denial. The analysis must be produced within 30 days to avoid late penalties of up to $110 per day.

GROWING LITIGATION RISK

Group health plans face a growing risk of litigation from employees challenging denied MH/SUD claims. The lawsuits typically challenge coverage exclusions and the medical necessity criteria used to decide MH/SUD claims, arguing that they are inconsistent with the medical community's standards of care. These claims often relate to residential treatment or wilderness therapy exclusions, limitations on treatment for autism spectrum disorder (ASD), or stricter review processes applied to MH/SUD claims. The cases illustrate how some impermissible NQTLs are hidden from employers. For example, an exclusion applied more stringently to Applied Behavioral Analysis (ABA) speech therapy claims may be evident only in the TPA's claims handling practices, despite seemingly permissible plan terms. Or stricter review processes on MH/SUD claims may be evident only in the medical necessity criteria or the TPA's internal guidelines on how often claims are reviewed for continuing plan coverage.

MHPAEA litigation and federal enforcement efforts have also targeted lack of transparency to participants, namely, failure to provide documents related to NQTLs and coverage guidelines. Self-insured employers should confirm their TPAs are providing adequate documentation in response to information requests from plan participants or beneficiaries, commonly made as part of the claim appeals process. Under ERISA (the law that governs most group health plans), the scope of information required to be produced by a plan sponsor stretches well beyond the plan document to include the plan's comparative analysis, medical

Our Observation:	Shortcomings in MHPAEA and ERISA document disclosures leave plans exposed to substantial late penalties, up to $110 per day. Even if a plan responds to a document request within 30 days (as required under ERISA), penalties may still accrue if any documents are missing from the response. Self-insured employers should verify that robust 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 completing the comparative analysis, may 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 between plan sponsors and TPAs.

SATISFYING THE COMPARATIVE ANALYSIS REQUIREMENTS – NEXT STEPS

Increased MHPAEA litigation and continued federal enforcement necessitate proactive compliance from employers. Waiting until a lawsuit filing or DOL contact emerges can be risky, especially for plans at high risk of being targeted. High risk plans include those with participant MH/SUD coverage complaints or that include suspect NQTLs in the plan document or plans that are already under federal agency investigation.

Unfortunately, as of the most recent MHPAEA report to Congress in early 2025, the departments have yet to provide a sample comparative analysis, though they have noted an intention to provide this guidance. Despite these challenges, MHPAEA lawsuits and investigations often demand detailed responses. The CAA 2021 requires plans to complete the comparative analysis and make it available to the departments, state regulators, or participants upon request. If the departments find the documentation insufficient or noncompliant, plans have 45 days to remedy. In addition, plans must produce complete documents within 30 days of a participant request to avoid daily penalties. Gathering the required documents can be a lengthy process, often taking months. Importantly, NQTLs that cannot be justified as comparable between MH/SUD and MED/SURG must be corrected.

Our Observation:	Corrective actions may include removing the NQTL, adding coverage for previously excluded benefits, and changing claims processing procedures. These types of coverage changes may require a plan amendment (through a Summary of Material Modifications or updated Summary Plan Description), notification to participants, and re-adjudication of claims impacted by an impermissible NQTL.

Action Items: Fully Insured Plans

Although insurers are directly subject to the comparative analysis requirements, fully insured plan sponsors should still take all of the following steps:

1. Confirm the carrier agreement explicitly acknowledges the insurer's obligation to comply with the comparative analysis.
2. Request a copy of the insurer's latest comparative analysis whenever plan design changes impact MH/SUD benefits. (Plan sponsors might not be aware when this happens, so making an annual request is a good rule of thumb.)
3. Ask the insurer whether their comparative analysis has been found to be insufficient through a federal or state agency investigation. If it has, ask what corrective actions the insurer has taken or been instructed to take.

Action Items: Self-Insured (Including Level-Funded) Plans

Employers sponsoring self-insured group health plans serve as fiduciaries responsible for plan administration, which includes completing the comparative analysis. Very few self-insured health plans are administered without TPAs deciding claims, designing plan coverage terms, and maintaining provider networks. The comparative analysis is not straightforward. Simply identifying NQTLs to analyze requires a sophisticated understanding of plan design and administration. As a result, it is imperative for self-insured plans to have their TPA's full cooperation in completing the required comparative analysis. This means completing the comparative analysis for NQTLs designed by the TPA such as exclusions, coverage guidelines and restrictions, prior authorization requirements, network composition, and reimbursement rates. Importantly, even where a TPA performs the comparative analysis, a self-insured plan sponsor remains responsible for the plan's compliance with MHPAEA and will need to monitor the TPA's work.

Self-insured plan sponsors should take the following steps:

1. Confirm administrative services agreements with TPAs address responsibility for providing a MHPAEA-compliant plan design; completing a sufficient comparative analysis; making timely disclosures to participants; and responding to any federal agency request.
2. Review current plan designs for any problematic NQTLs (see Appendix A) and raise any identified problematic NQTLs with the TPA, requesting a specific comparative analysis on the identified items (see Appendix B). The list of red flag NQTLs is intended to serve as a starting point to review a specific plan's MHPAEA compliance, an exercise that should be completed by legal counsel.
3. Select a qualified service provider (e.g., insurer, TPA, pharmacy benefit manager (PBM), or specialized vendor) to complete the plan's comparative analysis. TPAs are in the best position to complete a plan's comparative analysis. But if the TPA will not provide the comparative analysis, then sponsors of self-insured plans should work with a qualified specialized vendor or legal counsel to satisfy the requirement (see below discussion on Choosing a Comparative Analysis Testing Vendor).
4. Correct any problematic NQTLs that cannot be justified through a comparative analysis.

Our Observation:	Sponsors of self-insured plans may also consider initiating a MHPAEA compliance program to document their ongoing MHPAEA compliance efforts, create processes to address employee parity complaints, conduct quarterly claim audits, influence plan design choices, and ensure timely and adequate ERISA document disclosures (including the comparative analysis) to plan participants.

Working with Your TPA

Notably, many TPAs also serve as insurance carriers with direct responsibility to complete the comparative analysis on their fully insured plans. Analysis on certain self-insured plan aspects that mirror the TPA's insured model may be interchangeable, especially with regard to the TPA's standard NQTLs (e.g., exclusions, coverage guidelines and restrictions, prior authorization requirements, network composition, and reimbursement rates). Self-insured plan sponsors should request those insured model reports and scrutinize any deviations from the insured model, including claim denial trends unique to a particular plan, for potential NQTLs. Plan sponsors should also ask TPAs to provide information on how their plan design has fared so far in ongoing federal or state agency investigations. Any identified noncompliant NQTLs should be addressed immediately.

Our Observation:	In addition to analyzing NQTLs, a plan's financial requirements and QTLs should be reviewed for parity. In particular, the DOL has targeted visit limits on ASD-related therapy, numerical limits on drug testing for MH/SUD disorders, and higher cost sharing for MH/SUD benefits, including imposing higher specialist copays on all MH/SUD outpatient services. Self-insured employers should request financial and QTL parity testing from their TPAs, which is generally readily available for standard plan designs.

Because the comparative analysis is a relatively new requirement, it may not be addressed in existing agreements with TPAs. Going forward, it is important to ensure that TPA administrative service agreements clearly address responsibilities for conducting the analysis, making timely disclosures to participants, and responding to any department audit. Ideally, given their relative expertise, their primary role in designing a plan's NQTLs, and their direct control of required information, TPAs will complete the comparative analysis, handle disclosure requests, and confirm that the plan design complies with MHPAEA. At the very least, where an ASO administrator or TPA has given assurances of compliance, self-insured plan sponsors should document that mutual understanding in writing.

Our Observation:	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 an uncooperative TPA is to consider finding another administrative services provider.

Choosing a Comparative Analysis Testing Vendor

If a TPA will not provide an adequate comparative analysis on behalf of a plan sponsor, the plan sponsor will need to conduct the analysis with legal counsel or hire a specialized vendor. Note that some vendors claiming to offer a comparative analysis are actually providing an analysis of 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), a high-level plan review, or an otherwise insufficient NQTL comparative analysis in terms of breadth and specificity.

Our Observation:	The DOL has signaled that it did not intend to create a new type of plan vendor to complete the comparative analysis, instead expecting that the analysis will be completed by the TPAs that design and administer a plan's NQTLs. However, some plans may choose to engage a vendor where a TPA will not provide an adequate comparative analysis.

Selecting a vendor to complete a plan's comparative analysis is a fiduciary act under ERISA. Plan sponsors should carefully choose vendors due to the complexity of the analysis, the information gathering challenges from TPAs, and the lack of a model from the departments. Importantly, even after engaging a comparative analysis vendor, a self-insured plan sponsor must monitor the service provider's work, remain attentive to problematic NQTLs, and take corrective action as needed. For more information on fiduciary responsibilities when selecting and monitoring plan service providers, see the PPI publication **ERISA Fiduciary Governance: A Guide for Employers**.

If the TPA will not complete the comparative analysis, the following questions may be helpful in identifying a different qualified service provider such as a MHPAEA comparative analysis testing vendor:

- Will you offer assurances that, to the best of your ability, the comparative analysis complies with the requirements of MHPAEA and its implementing regulations?
- What is your expertise in MHPAEA and specifically, what is the approximate number of comparative analyses you've completed?
- What customization is provided on a plan-specific level?
- What level of support do you provide in obtaining the information required to complete the comparative analysis?
- What has the departments' response been to your comparative analysis in terms of detail and sufficiency?

Assessing a Plan's Risk

Ideally, all plan sponsors should maintain a completed NQTL comparative analysis report. Understanding not every plan sponsor has the resources to pay legal counsel or a qualified vendor to complete the comparative analysis, the following questions can help assess the risk of an employee DOL complaint or litigation:

- Does the plan document contain certain problematic MH/SUD limitations (see Appendix A, **MHPAEA Compliance: Red Flag NQTLs**)?
- What is the TPA's response to an employee's request for comparative analysis documentation?
- How unique is the plan design (i.e., in what ways does it differ from the TPA's model)?
- Have there been any employee MH/SUD coverage complaints or pattern of MH/SUD claim denials?
- Is the plan already being audited by a federal agency?
- What is the employer's overall risk tolerance?

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

Our Observation:	Participant lawsuits alleging MHPAEA violations must be brought under ERISA and typically follow a claim denial based on a benefit exclusion or medical necessity dispute. As a result, self-insured plan sponsors should pay close attention to MH/SUD appeals related to red flag NQTLs and explore potential corrective action with legal counsel.

SUMMARY

The departments have reported widespread noncompliance with MHPAEA, particularly in insufficient comparative analyses and NQTLs applied more stringently to MH/SUD. Given vigorous enforcement and the growing risk of participant lawsuits, plan sponsors should prioritize compliance.

Specifically, fully insured employers should confirm that their carrier agreements acknowledge the insurer's compliance obligations, including responding to document requests. Insurers are required to comply with MHPAEA's comparative analysis requirements and should readily provide assurances of their compliance. Self-insured employers should confirm that their administrative services agreements with their TPAs address responsibility for MHPAEA compliance. If necessary, these agreements should be amended to address how the TPA will support the plan's NQTL comparative analysis. If the TPA will not provide the comparative analysis, then a self-insured plan should work with legal counsel or a qualified vendor. Importantly, self-insured employers should evaluate their TPA's or other vendors' comparative analysis with their legal counsel and correct any problematic NQTLs.

RESOURCES

Departments Release MHPAEA 2024 Report to Congress | PPI

Tools and Resources for Employers, Plans, and Service Providers | DOL

Warning Signs – Plan NQTLs that Require Additional Analysis | DOL

The Essential Aspects of Parity: A Training Tool for Policymakers | SAMHSA

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APPENDIX A

MHPAEA Compliance: Red Flag NQTLs

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.

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 nonquantitative 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 plans need 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 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 that may be problematic if they are applied more restrictively to MH/SUD benefits than to MED/SURG benefits include NQTLs such as those bulleted below. Note that this NQTL list is not exhaustive.

- Additional or stricter prior authorization/precertification requirements particular to MH/SUD treatment, including prescription drugs.
- Additional or stricter review standards for continuing MH/SUD treatment (e.g., requiring peer-to-peer review of continuing care every X number of days).
- Requiring a case manager (also known as "care manager") only for MH/SUD benefits.
- Exclusions or restrictions on out-of-network MH/SUD benefits.
- Applying experimental/investigational exclusions only to MH/SUD treatment.
- Denial of higher-cost MH/SUD therapies (including prescription drugs) until a lower-cost therapy has been tried and failed (known as "fail first policies" or "step therapy protocols"), or stricter application of fail first policies on MH/SUD benefits.
- 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). These may include limitations on Autism Spectrum Disorder treatment based on age.
- Exclusions for speech therapy or cognitive therapy to treat MH/SUD conditions.
- Required treatment plan or physician supervision for MH/SUD services.
- 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, 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 must 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).
- Exclusions for medication-assisted treatment (MAT) for substance use disorders (e.g., 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).
- EAP exhaustion requirement applicable only to MH/SUD benefits.

If plan sponsors identify any of these bulleted terms in their plans, 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 to determine whether the plan design disparity is supported by independent professional medical and clinical standards.

In addition to red flag NQTLs, the plan's financial requirements and QTLs should be reviewed for parity. In particular, the DOL has targeted numerical limits on drug testing for MH/SUD disorders, visit limits on Autism Spectrum Disorder-related therapy, and higher cost-sharing for MH/SUD benefits, including imposing higher specialist copays on all MH/SUD outpatient services.

Since employers have ready access to plan documents, the plan terms are a good place to start the MHPAEA compliance assessment. However, NQTLs are often concealed from the plan documents (i.e., "as written"), only surfacing in how claims are reviewed, denied, or reimbursed (i.e., "in operation"). The DOL has also targeted practices related to disparate provider network adequacy or admission standards and reimbursement rates. These practices include arbitrarily applying a special reduction to all MH/SUD reimbursement rates, with no comparable reduction on MED/SURG reimbursement rates; creating vague or unexplainable disparities in reimbursement rates (e.g., lower rates for MH/SUD providers based on asserted "market characteristics," "leverage," or "negotiations"); or maintaining network adequacy or admission measurements that disfavor MH/SUD providers (e.g., a network composition target of 95% of members living within 10 miles of a MED/SURG provider compared to 95% of members living within 30 miles of a MH/SUD provider). These practices are typically controlled by third-party administrators.

Because plan sponsors typically lack ready access to the design factors and application processes behind claims administration guidelines or network composition, they 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. A plan sponsor's close attention to employee plan grievances may prevent a lawsuit or DOL investigation of a complaint.

PPI BENEFIT SOLUTIONS

APPENDIX B

TPA NQTL Communication Template

Instructions

The following Comparative Analysis Communication Template is designed to help plan sponsors request information from a TPA regarding the TPA's plan design related to nonquantitative treatment limitations (NQTLs). The template is intended to be used along with the PPI publication **MHPAEA Compliance: Red Flag NQTLs**, which catalogs common "red flag" plan terms that indicate possible MHPAEA noncompliance.

Plan sponsors should review their plan documents for these NQTLs related to mental health/substance use disorder (MH/SUD) benefits and compare any identified red flags to coverage for medical/surgical (MED/SURG) treatment in the same benefit classification (e.g., 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.

For suspect ("red flagged") NQTLs resulting from the TPA's plan design, plan sponsors should request specific Comparative Analysis information from the TPA. Plan sponsors may use this Communication Template or another instrument of their choosing to make these requests. Plan sponsors should review suspect NQTLs and all related TPA communications with their legal counsel and maintain thorough records of all such communications.

[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 specific to each NQTL. 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.

I. General Comparative Analysis Information

Please provide the most recent Comparative Analysis completed in relation to this plan design, along with the following information:

1. [TPA]'s Comparative Analysis conducted on all NQTLs present in the design or claims administration of the [Plan Name];
2. [TPA]'s processes for responding to MHPAEA information requests from members (along with a sample response);

3. Copies of any responses or reports to the departments or applicable state agencies regarding [TPA] and MHPAEA compliance;
4. Identification of 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; and
5. [TPA]'s processes for responding to members' claim file requests under ERISA and document requests under MHPAEA (along with a sample response).

II. Sources for NQTL Design

i. Are independent professional medical or clinical standards, or standards related to fraud, waste, and abuse, used to determine coverage for MH/SUD benefits?
   1. If so, what are they?
   2. If not, what other types of standards are used to determine coverage for MH/SUD benefits?

ii. Are independent professional medical or clinical standards, or standards related to fraud, waste, and abuse, used to determine coverage for MED/SURG benefits?
   1. If so, what are they?
   2. If not, what other types of standards are used to determine coverage for MED/SURG benefits?

III. Plan Design Components of Specific Concern

Upon review, we have identified the following NQTLs in [TPA's] plan design:

- [Describe red flag plan terms related to coverage of MH/SUD treatment]
- [Describe red flag plan terms related to coverage of MH/SUD treatment]
- [Describe red flag plan terms related to coverage of MH/SUD treatment]
- [Describe red flag plan terms related to coverage of MH/SUD treatment]

Please provide a Comparative Analysis specific to each of the above NQTLs that: 1) identifies the benefits, classifications, or plan terms to which the NQTL applies; 2) describes in sufficient detail how the NQTL was designed and how it applies in practice to MH/SUD benefits and MED/SURG benefits; 3) identifies in sufficient detail the factors, sources, and evidentiary standards used in designing and applying the NQTL; 4) analyzes in sufficient detail the stringency with which factors, sources, and evidentiary standards are applied; and 5) demonstrates MHPAEA compliance of the NQTL as written and in operation.

Thank you for providing this information as soon as reasonably possible. We appreciate this information being provided in a format that is reasonably understandable and relevant to plan sponsor. We look forward to working with you to ensure the plan's MHPAEA compliance.

Sincerely,

[Employer contact]

[Employer name]