COMPLIANCE OVERVIEW

Mental Health Parity—Compliance FAQs

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires parity between a group health plan's medical and surgical benefits and its mental health or substance use disorder (MH/SUD) benefits. In general, if a health plan provides MH/SUD benefits, MHPAEA requires the plan to:

- Offer the same access to care and patient costs for MH/SUD benefits as those that apply to medical/surgical benefits;
- Treat MH/SUD coverage and medical/surgical coverage equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review; and
- Contain a single combined deductible for MH/SUD coverage and medical/surgical coverage.

The Departments of Labor, the Treasury, and Health and Human Services (Departments) have issued frequently asked questions (FAQs) on MHPAEA compliance. This Compliance Overview includes select FAQs on MHPAEA's requirements.

LINKS AND RESOURCES

- Final rule on MHPAEA
- Department of Labor (DOL) webpage on MHPAEA compliance, including links to frequently asked questions (FAQs)
- DOL's Fact Sheet on MHPAEA
- DOL's self-compliance tool on MHPAEA

Parity Requirements

The financial requirements applicable to MH/SUD benefits can be no more restrictive than the predominant financial requirements for substantially all medical and surgical benefits.

In addition, MHPAEA imposes parity requirements on a plan's:

- Treatment limits for MH/SUD benefits; and
- Nonquantitative treatment limitations (NQTLs) for MH/SUD benefits.

Disclosures

- Plans and issuers must disclosure the criteria for medical necessity determinations for MH/SUD benefits to a plan participant or participating provider upon request.
- Plans and issuers must conduct comparative analyses of NQTLs and make this information available upon request to the Departments.

MHPAEA—General Compliance FAQs

Q1: What protections does MHPAEA provide for participants and beneficiaries?

The Mental Health Parity Act of 1996 (MHPA) required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. MHPAEA expanded those provisions to include substance use disorder benefits. Thus, under MHPAEA, group health plans generally may not impose a lifetime or annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits.

MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to MH/SUD benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. MHPAEA regulations also require plans to ensure parity with respect to nonquantitative treatment limitations (such as medical management standards).

Q2: Can group health plans still apply financial requirements and treatment limitations, such as copays or visit limits on MH/SUD benefits?

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

There is a test for determining whether a financial requirement or treatment limitation for MH/SUD benefits is permissible. The general rule is that a plan may not impose a financial requirement or quantitative treatment limitation applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative limitation of that type applied to substantially all medical/surgical benefits in the same classification. How to apply this test is discussed in more detail in the following FAQs.

Q3: What is a financial requirement or quantitative treatment limitation?

The most common types of financial requirements include deductibles, copays, coinsurance and out-of-pocket maximums. Types of quantitative treatment limitations include annual, episode, and lifetime day and visit limits (for example, number of treatments, visits or days of coverage). These are just examples; therefore, you could find a type of financial requirement and quantitative treatment limitations that is not specifically listed here.

Q4: The test for determining parity refers to levels of types of financial requirements or treatment limitations. What is a level of a type of financial requirement or treatment limitation?

The level of a type of financial requirement or treatment limitation refers to the magnitude of the type of financial requirement or treatment limitation. For example, different levels of coinsurance include 20 percent and 30 percent, different levels of copays include $15 and $20, or different levels of an episode limit include 21 inpatient days per episode and 30 inpatient days per episode.

Q5: How can I determine if a financial requirement or quantitative treatment limitation applicable to MH/SUD benefits is permissible?

To determine if a quantitative financial requirement (such as a copay) or quantitative treatment limitation (such as a visit limit) is permissible, the parity analysis must be applied for that type of financial requirement or treatment limitation within a coverage unit for each of the six classifications of benefits separately. A coverage unit refers to the way in which

a plan groups individuals for purposes of determining benefits, or premiums or contributions (for example, self-only, family or employee plus spouse). Under MHPAEA, the six classifications of benefits are:

1. Inpatient in-network;
2. Inpatient out-of-network;
3. Outpatient in-network;
4. Outpatient out-of-network;
5. Emergency care; and
6. Prescription drugs.

If a type of financial requirement or quantitative treatment limitation applies to substantially all medical/surgical benefits in a classification (for example, if a copay applies to substantially all medical/surgical benefits), then it may be permissible for that requirement or limitation (the copay) to apply to MH/SUD benefits in the same classification. In some circumstances, plans can subdivide certain classifications to account for multiple network tiers, among other things.

Generally, a financial requirement or treatment limitation is considered to apply to substantially all medical/surgical benefits if it applies to two-thirds or more of the medical/surgical benefits for the same classification and coverage unit. This two-thirds calculation is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid for the year (or portion of the plan year after a change in plan benefits that affects the applicability of the financial requirement or quantitative treatment limitation).

The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on MH/SUD benefits within that classification. There is a detailed test for determining the predominant level, which is discussed in the next FAQ. If, for example, for self-only coverage a $10 copay is the predominant level of copay that applies to substantially all inpatient in-network medical/surgical benefits, that is the most restrictive copay that can apply to inpatient in-network MH/SUD benefits. With respect to the prescription drug classification, there is a special rule for multi-tiered prescription drug benefits.

Q6: If as determined under MHPAEA, it is permissible for my plan to impose a copay on my inpatient, in-network MH/SUD benefits, is there any restriction on the amount of copay that can apply?

Yes. The predominant level of a type of requirement or limitation applicable to medical/surgical benefits within a classification is the most restrictive level of the requirement or limitation that can be imposed on MH/SUD benefits within that classification.

Generally, the predominant level will apply to more than one-half of the medical/surgical benefits in that classification subject to the requirement or limitation. If there is no single level that applies to more than one-half of medical/surgical benefits in the classification, the plan can combine levels until the combination of levels applies to more than one-half of the medical/surgical benefits subject to the requirement or limitation in the classification. The least restrictive level within the combination is considered the predominant level. The determination of the portion of medical/surgical benefits in a classification subject to a financial requirement or treatment limitation is based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the plan for the plan year.

Q7: Can my plan impose a higher "specialist" financial requirement with respect to MH/SUD benefits?

A plan may not create sub-classifications for generalists and specialists to determine separate predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. However, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical specialist, then that level of that type of financial requirement can be applied for MH/SUD benefits within that classification.

On the other hand, if the predominant level of a type of financial requirement that applies to substantially all medical/surgical benefits in a classification is the one charged for a medical/surgical generalist, then the level of that financial requirement charged for MH/SUD benefits within that classification cannot be higher than the level of that financial requirement for "generalist" medical/surgical benefits.

Q8: My mental health benefits were denied. What information am I entitled to receive from my plan under MHPAEA?

Under MHPAEA, the criteria for medical necessity determinations made under a group health plan (or health insurance coverage offered in connection with the plan) with respect to MH/SUD benefits must be made available by the plan administrator or the health insurance issuer to any current or potential participant, beneficiary or contracting provider upon request. In addition, under the Employee Retirement Income Security Act (ERISA), documents with information on the medical necessity criteria for both medical/surgical benefits and MH/SUD benefits are plan documents, and copies must be furnished within 30 days of your request.

Additionally, the individual (or a provider or other individual acting as a patient's authorized representative) may request these documents consistent with the DOL claims procedure regulation (and, if the plan is a non-grandfathered health plan, the external review requirements added by the Affordable Care Act would apply).

Q9: I am a participant in a group health plan that provides treatment for anorexia as a mental health benefit. In accordance with the plan terms, my provider, on my behalf, requested prior authorization for a 30-day inpatient stay to treat my anorexia. The request was denied based on the plan's determination that a 30-day inpatient stay is not medically necessary under the plan terms.
I then requested from the plan administrator a copy of its medical necessity criteria for both medical/surgical and MH/SUD benefits (including anorexia), as well as any information regarding the processes, strategies, evidentiary standards, or other factors used in developing the medical necessity criteria and in applying them. May the plan administrator deny me this information based on an assertion that the information is "proprietary" and/or has "commercial value"?

No. The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, regardless of any assertions as to the proprietary nature or commercial value of the information.

Whether a plan that is subject to ERISA can refuse to provide "instruments under which the plan is established or operated" on the basis that the information is "proprietary" was specifically addressed in the DOL's Advisory Opinion 96-14A. The Advisory Opinion rejected that basis for refusal. In that Advisory Opinion, the DOL stated that any documents or instruments that specify formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan (in that case, a schedule of a plan's usual and customary fees) would constitute "instruments under which the plan is established or operated," and must be provided, notwithstanding that the plan asserted that such fee schedules are of a "proprietary" nature. Such information must be disclosed, even in cases where the source of the information is a third-party commercial vendor.

Q10: Can my plan, upon request, provide a summary description of the medical necessity criteria for both MH/SUD benefits and medical/surgical benefits that is written to be understandable for a layperson?

Yes. Although not required to do so, group health plans and issuers can provide a document that provides a description of the medical necessity criteria in layperson's terms. However, providing such a summary document is not a substitute for providing the actual underlying medical necessity criteria, if such documents are requested.

Q11: Are there plans that are exempt from MHPAEA?

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

Q12: Who enforces MHPAEA?

The Departments, as well as the states, all have important roles with respect to MHPAEA's implementation. The Departments are working with plans, issuers, and their service providers to help them understand and comply with MHPAEA, and to ensure participants and beneficiaries receive the benefits they are entitled to under the law. Employees with questions about MHPAEA, including complaints about compliance by their employment-based group health plans, can contact the DOL at www.askebsa.dol.gov or 866-444-3272. The DOL will work with the other federal departments and the states, as appropriate, to ensure MHPAEA violations are corrected.

Q13: Does MHPAEA apply to any benefits a plan may offer for Medication Assisted Treatment for opioid use disorder?

Yes. Medication Assisted Treatment (MAT) is any treatment for opioid use disorder that includes medication that is FDA-approved for detoxification or maintenance treatment in combination with behavioral health services. The Departments' final regulations implementing MHPAEA define "substance use disorder benefits" as benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage, and in accordance with applicable federal and state law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Opioid use disorder is a type of substance use disorder and MAT is a "substance use disorder benefit" within the meaning of the term as defined by MHPAEA.

Group health plans and issuers that offer MAT benefits must do so in accordance with the requirements of MHPAEA and, accordingly, any financial requirements and treatment limitations may not be more restrictive than the predominant financial requirements and quantitative treatment limitations that apply to substantially all medical and surgical benefits

in a classification. In addition, the special rule for multi-tiered prescription drug benefits also applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA.

Q14: Does MHPAEA apply to any benefits a plan or issuer may offer for treatment of an eating disorder?

Yes. The Departments' regulations implementing MHPAEA define "mental health benefits" as benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, which must be defined to be consistent with generally recognized independent standards of current medical practice. Eating disorders are mental health conditions and therefore treatment of an eating disorder is a "mental health benefit" within the meaning of that term as defined by MHPAEA.

FAQs on NQTLs

Q15: What are nonquantitative treatment limitations (NQTLs)?

NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan methods for determining usual, customary and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

This is an illustrative, non-exhaustive list.

Q16: How does MHPAEA provide for parity with respect to NQTLs?

Under MHPAEA, a plan may not impose a NQTL with respect to MH/SUD benefits in any classification (such as inpatient, out-of-network) unless under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the limitation to MH/SUD benefits in the classification are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

Q17: When must plans and issuers make available their NQTL comparative analyses, as required by the Consolidated Appropriations Act, 2021 (CAA)?

Plans and issuers that offer both medical/surgical benefits and MH/SUD benefits and impose NQTLs must make their comparative analyses of the design and application of NQTLs available to the Departments or applicable State authorities upon request, beginning 45 days after the date of enactment of the CAA. Because the CAA was enacted on Dec. 27, 2020, the requirement applies beginning Feb. 10, 2021. Accordingly, plans and issuers should now be prepared to make their comparative analyses available upon request.

Q18: What information must plans and issuers make available in response to the Departments' requests for documentation of their comparative analyses?

Plans and issuers should ensure that comparative analyses are sufficiently specific, detailed and reasoned to demonstrate whether the processes, strategies, evidentiary standards or other factors used in developing and applying an NQTL are comparable and applied no more stringently to MH/SUD benefits than to medical/surgical benefits, as described further below. To that end, a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, evidentiary standards, or other factors is insufficient to meet this statutory requirement.

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

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

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

- A clear description of the specific NQTL, plan terms and policies at issue.
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.
- Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.
- The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.
- A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.
- The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

Q19: What are examples of reasons why the Departments might conclude that documentation of comparative analyses of NQTLs is insufficiently specific and detailed?

As noted above, a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, standards or other factors is not sufficient. Accordingly, comparative analyses that consist of conclusory or generalized statements without specific supporting evidence and detailed explanations or a mere production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analyses are insufficient. Analyses that are sufficient include all the elements set forth in the response to the question above.

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

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

- Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
- Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

Q20: In addition to documentation of the comparative analyses, what types of documents should plans and issuers be prepared to make available to the Departments to support the analysis and conclusions reached in their comparative analyses of NQTLs?

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

- Records documenting NQTL processes and detailing how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under State law.
- Any documentation, including any guidelines, claims processing policies and procedures or other standards that the plan or issuer has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support its rationale.
- Samples of covered and denied MH/SUD and medical/surgical benefit claims.
- Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

For example, if comparative analyses reference studies, testing, claims data, reports, or other considerations in defining or applying factors (such as meeting minutes or reports showing how those considerations were applied), then the plan or issuer should be prepared to provide copies of all those items. 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.

Q21: What actions will the Departments take if they determine that a plan or issuer has not submitted sufficient information to review comparative analyses of the design and application of NQTLs, or if the Departments conduct a review and determine that a plan or issuer is not in compliance with MHPAEA?

If the Departments conclude a plan or issuer has not provided sufficient information to review the comparative analyses, the CAA provides that the Departments shall specify to the plan or issuer the information the plan or issuer must submit to be responsive to the request.

In instances where the Departments have reviewed the comparative analyses and any other materials submitted upon request from a plan or issuer and determined that the plan or issuer is not in compliance with MHPAEA, the CAA requires

the plan or issuer to specify to the Departments the actions the plan or issuer will take to come into compliance. Specifically, the plan or issuer must submit additional comparative analyses that demonstrate compliance not later than 45 days after the initial determination of noncompliance. Following the 45-day corrective action period, if the Departments make a final determination that the plan or issuer is still not in compliance, not later than 7 days after such determination, the plan or issuer must notify all individuals enrolled in the plan or coverage that the coverage is determined to be noncompliant with MHPAEA. The Departments will also share findings of compliance and noncompliance with the State where the group health plan is located or where the issuer is licensed to do business. In addition, the Departments will comply with other laws applicable to their particular review processes.

Q22: May a participant, beneficiary, or enrollee (or their authorized representative), or state regulator request an NQTL analysis?

Yes. Under the CAA, plans and issuers must make available their respective comparative analyses of NQTLs and other applicable information to the applicable State authority upon request. The term "applicable State authority" means, with respect to a health insurance issuer in a State, the State insurance commissioner or an official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service (PHS) Act for the State involved with respect to the issuer.

Furthermore, as stated in previous guidance, participants and beneficiaries (or their authorized representatives) in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan. The types of documents contemplated in previous guidance would include any analyses performed by the plan as to how the NQTL complies with MHPAEA. Therefore, for plans subject to ERISA, plans and issuers must make the comparative analyses and other applicable information required by the CAA available to participants, beneficiaries, and enrollees upon request. If a provider or other individual is acting as a patient's authorized representative, the provider or other authorized representative may request these documents.

In addition, as stated in previous guidance, with respect to non-grandfathered group health plans and non-grandfathered group or individual health insurance coverage, claimants (or their authorized representative) 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 claim for benefits. This right includes access to documents with information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as documents reflecting the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan. These documents would include any analyses performed by the plan or issuer as to how the NQTL complies with MHPAEA.

Q23: Are there specific NQTLs that the Departments intend to focus on when requesting comparative analyses from plans and issuers for purposes of review in accordance with the requirements of the CAA?

To the extent that the Departments become aware of potential MHPAEA violations or complaints regarding noncompliance with MHPAEA that concern NQTLs, the Departments may request comparative analyses on the NQTLs that are the subject of the complaint or potential violation. For example, in the event that a complaint is received regarding

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

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

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

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

Source: Departments of Labor, the Treasury, and Health and Human Services