

**EQUAL INSURANCE COVERAGE
OF SUBSTANCE USE AND
MENTAL HEALTH DISORDERS**

**PARITY AT
10**

IT'S THE LAW.

**State Attorney General
Parity Act Enforcement Toolkit**

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Executive Summary

State attorneys general (State AGs) can help stem the tide of the opioid crisis by improving access to evidence-based treatment through enforcement of federal and state mental health and addiction parity laws. Parity laws are health insurance mandates and non-discrimination standards that require equal insurance coverage for mental health and substance use disorder treatment benefits. Enforcement of parity laws by State AGs promotes consumer protection by ensuring health care consumers gain access to health benefits that insurance plans are obligated by law to cover. Enforcement of parity laws also fulfills State AGs' obligation as chief law enforcement officer to ensure that state regulated insurers and Medicaid managed care organizations meet contractual obligations and reimburse for services that they represent their plans offer.

The authority for State AGs to enforce parity varies by state. Many, although not all, State AGs can enforce parity through their existing authority to investigate fraudulent or illegal conduct in consumer products, including health insurance, or through specific statutory authority. Legislation may be required in states where State AGs lack statutory authority to address health insurance as a consumer product or service.

This Toolkit has been created specifically for State AGs to promote an understanding of the Parity Act and provide specific actionable steps to achieve parity's full promise through active enforcement. This Toolkit:

- explains the federal Parity Act standards;
- identifies important compliance tools that have been developed by federal regulators and can be easily implemented by state officials; and
- offers recommendations to help State AGs establish a parity enforcement program.

Part 1 of this Toolkit sets forth the federal and state laws that govern insurance coverage for mental health and substance use disorder treatment benefits. Such laws include parity laws, benefit mandates and network adequacy requirements. Part 2 sets forth recommendations for developing a parity enforcement program. Additional information, including a resource list, is provided in the Exhibits.

This Toolkit was created in support of the Parity at 10 Campaign, a three-year initiative to establish effective models for robust enforcement of the Parity Act in 10 states. For more information, please visit the Campaign's website at <http://parityat10.org>.

Introduction

The Mental Health Parity and Addiction Equity Act (Parity Act) is a federal civil rights law that prohibits discrimination against individuals with a mental health condition or substance use disorder and offers important consumer protections. While federal and state parity laws delegate primary enforcement authority to federal and state insurance regulators, a State Attorney General (State AG) may also have authority to protect consumers from the sale of insurance products that fail to meet state insurance and parity standards through enforcement of state consumer protection laws. Many State AG offices have dedicated health care bureaus that investigate health insurance violations. Attorneys general can work collaboratively with state insurance regulators to improve parity enforcement.

State Attorney General enforcement is an important complement to other enforcement efforts by state insurance and Medicaid regulators. State insurance regulators play an essential role in enforcement by conducting pre-market and retrospective reviews, performing market conduct examinations, and responding to consumer complaints that often arise from systemic parity violations. State Medicaid regulators perform similar functions for Medicaid plans. While State insurance and Medicaid regulators may be incentivized to quickly resolve individual complaints, State AGs can address systemic violations.

The Parity Act has been the law for ten years, but consumers suffering from mental illness and addiction desperately need help accessing treatment services, including services that insurers are required by law to provide. Lack of access to effective treatment continues to drive unrelenting suicide and opioid epidemics, indicating the need for better enforcement of parity laws. Every day, more than 320 people die from a drug overdose or suicide.¹ While State AGs are already actively responding to the opioid epidemic by investigating opioid manufacturers and distributors, supporting the states' multi-district litigation against these companies and establishing a variety of programs and initiatives to reduce prescription opioid misuse,² they can also have an important role in enforcing laws that improve access to life-saving mental health and addiction treatment.

¹ Centers for Disease Control and Prevention. (2018). *Data Brief 330. Suicide Mortality in the United States, 1999-2017*. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db330_tables-508.pdf#page=1.

Centers for Disease Control and Prevention. (2018). *Drug Overdose Death in the United States, 1999-2017*. Retrieved from <https://www.cdc.gov/nchs/products/databriefs/db329.htm>.

² Noguchi, Y. (2017, September 19). 41 States To Investigate Pharmaceutical Companies Over Opioids. *NPR*. Retrieved from <https://www.npr.org/sections/thetwo-way/2017/09/19/552135830/41-states-to-investigate-pharmaceutical-companies-over-opioids>.

Bronstad, A. (2018, August 15). 35 AGs File Amicus Briefs Citing a State's 'Unique Role' in Fixing the Opioid Crisis. *The National Law Journal*. Retrieved from <https://www.law.com/nationallawjournal/2018/08/15/35-ags-file-amicus-briefs-citing-a-states-unique-role-in-fixing-the-opioid-crisis/>.

National Association of Attorneys General National Attorneys General Training & Research Institute. *Attorney General Programs and Initiatives Listed by State*. Retrieved from <http://www.naag.org/publications/papers-briefs-and-other-research/nagri-prescription-opioid-projects/prescription-opioid-education-toolkit-for-consumer-education/attorney-general-program-and-initiatives-listed-by-state.php>.

Part 1: Federal and State Laws Related to Mental Health and Substance Use Disorder Treatment Access

A combination of federal and state laws form the legal standards for securing more comprehensive coverage of mental health (MH) and substance use disorder (SUD) benefits. Federal law and some state insurance mandates require parity, or equitable coverage, for MH and SUD benefits. Federal law requires coverage of MH and SUD benefits in plans subject to Essential Health Benefits requirements (individual and small group and Medicaid alternative benefit plans), and many state laws establish benefit mandates for MH/SUD services and medications. Some states have also enacted laws that establish specific utilization management and network adequacy standards for these benefits and state enforcement tools, which include various compliance and data reporting requirements.

Federal Parity Law

Overview

The federal Mental Health Parity and Addiction Equity Act (“Parity Act”), was signed into law October 3, 2008.³ The Parity Act “requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations” under most private and public insurance plans.⁴

The Parity Act does not require health plans to cover MH and SUD benefits nor does it require plans to cover all MH/SUD conditions; rather, it requires plans that offer these benefits to cover them at the same level as medical and surgical benefits.⁵ The Parity Act prohibits discrimination in virtually all insurance plan features, including financial requirements, limitations on the quantity and duration of treatment and a full range of plan design features that limit access to services through medical necessity criteria, utilization management standards, benefit exclusions and provider networks.

Below is a summary of the Parity Act’s applicability and non-discrimination standards. This summary is based on statutory and regulatory standards, sub-regulatory guidance prepared by the Departments of Labor and Health and Human Services⁶ and resources created by parity experts from non-governmental organizations,

³ P.L. 110-343, 122 Stat. 3881 (Oct. 3, 2008).

⁴ 78 Fed. Reg. 68,240 (Nov. 13, 2013).

⁵ *Id.* at 68,251.

⁶ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>.

including the Legal Action Center,⁷ American Psychiatric Association,⁸ and Parity Track.⁹ There are a number of other helpful resources from the Department of Labor¹⁰ and the Substance Abuse and Mental Health Services Administration.¹¹ See [Exhibit 1, Resource List](#).

Applicability

The Parity Act applies to most public and private health insurance products, including:

- Individual market plans
- Small group plans (non-grandfathered plans under the Affordable Care Act)
- Large group plans
- Medicaid Managed Care plans
- Medicaid Alternative Benefit plans (Medicaid Expansion plans under the Affordable Care Act)
- Children’s Health Insurance Program plans (CHIP)
- State and local government plans (*may elect to opt-out*)
- Church-sponsored plans (*may elect to opt-out*)
- Federal Employee Health Benefits Program plans (by Executive Order)

The following types of plans are not subject to the Parity Act:

- Fee-for-service Medicaid (if no services are delivered by a Managed Care Organization)
- Medicare
- Self-funded small employer plans
- TRICARE
- Retiree-only plans
- Self-insured state and local government plans that elect an opt-out¹²
- Church-sponsored plans that elect an opt-out.¹³
- Plans that receive a cost increase exemption¹⁴
- Short-Term, Limited Duration plans (unless state law provides coverage protections for MH/SUD benefits)

United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>.

⁷ Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*. Retrieved from <https://lac.org/wp-content/uploads/2016/06/LAC-Parity-Guide-2016.pdf>.

⁸ American Psychiatric Association. (2018). *Mental Health Parity*. Retrieved from <https://www.psychiatry.org/psychiatrists/practice/parity>.

⁹ The Kennedy Forum & Scattergood Foundation. *ParityTrack*. Retrieved from the ParityTrack website: <https://www.paritytrack.org/>.

¹⁰ United States Department of Labor. *Mental Health and Substance Use Disorder Parity*. Retrieved from <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.

¹¹ United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2017). *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

¹² 42 U.S.C. § 300gg-21(a)(2) (2010).

¹³ *Id.*

¹⁴ 26 C.F.R. § 54.9812-1(g) (2016); 29 C.F.R. § 2590.712(g) (2010); 45 C.F.R. § 146.136(g) (2004).

For additional information on applicability to various types of insurance products, please see [Exhibit 2, Parity Act Applicability](#).

Parity Act Standards

The Parity Act prohibits the use of separate or more restrictive standards for MH/SUD benefits than for medical/surgical benefits. Such standards (or, plan design features) include financial requirements (e.g., deductibles, copayments and coinsurance), quantitative treatment limitations (e.g., visit limits) and non-quantitative treatment limitations (e.g., prior authorization requirements, medical necessity determinations and network standards). The “comparative” analysis is performed by analyzing plan design features across six benefit classifications for private insurance and four classifications for Medicaid. Insurers must use the same standards for placing medical/surgical and MH/SUD benefits in the respective classification.¹⁵

The six classifications for private insurance are:¹⁶

- Inpatient In-network
- Inpatient Out-of-network
- Outpatient In-network
- Outpatient Out-of-network
- Emergency Care
- Prescription Drugs

Medicaid and CHIP have four benefit classifications because there is no in-network and out-of-network distinction:¹⁷

- Inpatient
- Outpatient
- Emergency
- Prescription Drugs

In the outpatient benefit classification, plans can use sub-classifications for (1) office visits and (2) all other outpatient items and services.¹⁸ A plan may also use sub-classifications to create multiple tiers for in-network providers (e.g., in-network preferred and in-network participating), as long as “the tiering is based on reasonable factors” and “without regard” to whether the provider renders medical/surgical benefits or MH/SUD benefits.¹⁹ If a plan uses sub-classifications, it must compare MH/SUD and medical/surgical benefits across the sub-classification instead of the broader benefit classification.²⁰

¹⁵ 26 C.F.R. § 54.9812-1(c)(2)(ii) (2016); 29 C.F.R. § 2590.712(c)(2)(ii) (2013); 45 C.F.R. § 146.136(c)(2)(ii) (2013).

¹⁶ *Id.*

¹⁷ 42 C.F.R. § 438.910(b)(2) (2016); 42 C.F.R. § 440.395(b)(2)(ii) (2016); 42 C.F.R. § 457.496(d)(2)(ii) (2016).

¹⁸ 26 C.F.R. § 54.9812-1(c)(3)(iii)(C) (2016); 29 C.F.R. § 2590.712(c)(3)(iii)(C) (2013); 45 C.F.R. § 146.136(c)(3)(iii)(C) (2013).

¹⁹ 26 C.F.R. § 54.9812-1(c)(3)(iii)(B) (2016); 29 C.F.R. § 2590.712(c)(3)(iii)(B) (2013); 45 C.F.R. § 146.136(c)(3)(iii)(B) (2013).

²⁰ 26 C.F.R. § 54.9812-1(c)(3)(iii)(B)-(C) (2016); 29 C.F.R. § 2590.712(c)(3)(iii)(B)-(C) (2013); 45 C.F.R. § 146.136(c)(3)(iii)(B)-(C) (2013).
42 C.F.R. § 438.910(c)(2)(ii) (2016); 42 C.F.R. § 457.496(d)(3)(ii)(B) (2016); 42 C.F.R. § 440.395(b)(3)(ii)(B) (2016).

Mental health and substance use disorder benefits are often defined by the level of care in which services are rendered. MH/SUD services are typically provided in one of the following levels of care, depending on the severity of the patient’s condition:

- Outpatient treatment
- Intensive outpatient treatment
- Day/partial hospitalization
- Inpatient hospitalization
- A range of non-hospital residential treatment environments

Health services for medical, mental health and substance use disorder conditions are identified as intermediate levels of care if the service is more intensive than outpatient treatment but less intensive than inpatient hospitalization. For MH/SUD, intermediate benefits include intensive outpatient treatment, day/partial hospitalization and non-hospital residential treatment. For medical/surgical care, such benefits include home health care and skilled nursing facility care. While the Parity Act benefit classifications for outpatient treatment and inpatient hospitalization are self-evident, intermediate benefits, which must also be placed in one of these classifications, may not fit neatly into either. Plans that cover intermediate MH/SUD services must use a “comparable methodology” to place such services in the same category (e.g., outpatient/inpatient) as comparable intermediate medical services (e.g., skilled nursing facility and home health care).²¹ For example, if a plan covers residential treatment, partial hospitalization and intensive outpatient treatment for MH/SUD and covers skilled nursing facilities and home health care as medical services, it must place residential treatment and skilled nursing facilities in the same benefit classification (e.g., inpatient) and partial hospitalization/intensive outpatient and home health care in the same benefit classification (e.g., outpatient).²²

Benefit Standards

The Parity Act addresses discriminatory benefit coverage in a range of plan features, including:

- Coverage in all Benefit Classifications
- Lifetime and Annual Dollar Limits
- Financial Requirements
- Treatment Limitations
 - Quantitative
 - Non-quantitative

Coverage in all Benefit Classifications Requirement

Under the Parity Act, a plan that offers mental health and/or substance use disorder benefits must cover such benefits in all classifications in which medical/surgical benefits are covered. Thus, if a plan provides MH/SUD benefits in at least one benefit classification, such as an emergency service or a prescription drug, it

²¹ 26 C.F.R. § 54.9812-1(c)(2)(ii) (2016); 29 C.F.R. § 2590.712(c)(2)(ii) (2013); 45 C.F.R. § 146.136(c)(2)(ii) (2013).
78 Fed. Reg. 68,240, 68,246–47 (2013).

United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

²² 78 Fed. Reg. 68,240, 68,247 (2013).

must offer MH/SUD benefits in every benefit classification where medical/surgical benefits are offered.²³ For example, if a plan covers medical/surgical benefits in all benefit classifications, it cannot offer only outpatient MH/SUD treatment; it must offer inpatient, prescription drug and emergency services. Further, the plan cannot offer in-network and out-of-network medical/surgical benefits while excluding out-of-network MH/SUD benefits.²⁴ This standard ensures that a full range of MH/SUD benefits are offered and additional standards (see non-quantitative treatment limitations discussion below) limit the exclusion of specific services.

Lifetime and Annual Dollar Limits

Plans are barred from imposing more restrictive lifetime or annual dollar limits on MH/SUD benefits than on medical/surgical benefits. Annual or lifetime dollar limits on MH/SUD services are not permitted if the plan does not impose annual or lifetime dollar limits on medical/surgical benefits or if the plan imposes a lifetime or annual dollar limit on less than one-third of all medical/surgical benefits. In all other cases, the amount of the lifetime or annual dollar limit for MH/SUD benefits may be no less than the lifetime/annual dollar limit on medical/surgical benefits.²⁵

The Affordable Care Act (ACA) imposes additional requirements by prohibiting the use of lifetime or annual dollar limits for Essential Health Benefits (EHB).²⁶ Therefore, individual and small group plans subject to the EHB requirement are not permitted to impose annual or lifetime dollar limits on MH/SUD benefits that are covered in the state's benchmark plan.

Financial Requirements and Treatment Limitations

The Parity Act prohibits the use of financial requirements (FRs) or treatment limitations for MH/SUD benefits that are separate from or more restrictive than those imposed on medical/surgical benefits in the respective classification.²⁷ The Parity Act regulates treatment limitations that are expressed numerically (Quantitative Treatment Limitations or QTLs) as well as limitations on care that cannot be expressed numerically (Non-quantitative Treatment Limitations or NQTLs).

- QTLs limit the duration of care and include numerical caps on the number of days or visits for SUD treatment per year or episodes of care.
- FRs are out-of-pocket costs, such as deductibles, copayments, coinsurance, and maximum out-of-pocket costs.
- NQTLs include the full range of plan design features that regulate and limit access to care, including medical necessity criteria, utilization management standards, network adequacy and benefit exclusions.

A non-exhaustive list of FRs, QTLs and NQTLs regulated by the Parity Act is provided in [Exhibit 3, Financial Requirements and Treatment Limitations](#).

²³ 26 C.F.R. § 54.9812-1(c)(2)(ii)(A) (2016); 29 C.F.R. § 2590.712(c)(2)(ii)(A) (2013); 45 C.F.R. § 146.136(c)(2)(ii)(A) (2013).

²⁴ 26 C.F.R. § 54.9812-1(c)(2)(ii)(B) (2016); 29 C.F.R. § 2590.712(c)(2)(ii)(B) (2013); 45 C.F.R. § 146.136(c)(2)(ii)(B) (2013).

²⁵ 26 C.F.R. § 54.9812-1(b)(2)-(5) (2016); 29 C.F.R. § 2590.712(b)(2)-(5) (2013); 45 C.F.R. § 146.136(b)(2)-(5) (2013).

²⁶ 42 U.S.C. § 300gg-11(a) (2010).

²⁷ 26 C.F.R. § 54.9812-1(c)(2)(i) (2016); 29 C.F.R. § 2590.712(c)(2)(i) (2013); 45 C.F.R. § 146.136(c)(2)(i) (2013).

Discrimination Test: Financial Requirements (FRs) and Quantitative Treatment Limitations (QTLs)

Regulators can generally identify FRs and QTLs from insurance plan documents and some state insurance departments have adopted reporting mechanisms to ensure compliance.²⁸ The Parity Act applies a mathematical test to define discrimination for any plan feature that is expressed quantitatively. A FR or QTL imposed on a MH/SUD benefit cannot be “more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.”²⁹ The test must be applied separately to each type of FR or QTL within each classification.³⁰ Plan information regarding expected plan payments for medical/surgical benefits is required to conduct the mathematical analysis.

The Parity Act test bars the imposition of any type of FR or QTL (e.g., copay, visit limit) that is not imposed on two-thirds (substantially all) of medical/surgical benefits in the classification. If the “type” of FR or QTL meets the “substantially all” test, then the “level” (or value) of the FR or QTL for MH/SUD benefits can be no more restrictive than the level/value placed on more than half (51%, or the “predominant” level/value) of the FR or QTL for medical/surgical benefits.³¹ The “level” refers to the copay amount, coinsurance percentage or the number of days in the visit limit. For example, if the financial requirement in question is a \$30 copay for outpatient MH/SUD services, the test must determine whether the plan imposes a copay on two-thirds of the medical/surgical benefits in the in-network outpatient benefit classification, using the expected dollar amount to be paid for in-network outpatient medical/surgical benefits. If it does, the plan must next determine whether the plan expects that more than one-half of the in-network outpatient medical/surgical services (according to the expected annual dollar amount) will be subject to a \$30 copayment. If both parts of the test are met, the copay on outpatient MH/SUD services cannot be more than \$30.³²

Cumulative financial requirements (e.g., deductibles, out-of-pocket maximums) and QTLs (e.g., annual visit limits) for MH/SUD benefits cannot accumulate separately from the same cumulative requirement for medical/surgical benefits in the same classification.³³ For example, a plan that imposes an annual \$250 deductible on medical/surgical benefits cannot impose a separate annual \$250 deductible on MH/SUD benefits.³⁴

²⁸ Maryland Insurance Administration. (2018, January 26). *Bulletin 18-03: 2019 Affordable Care Act (“ACA”) Individual and Small Employer Form and Rate Filing Instructions*. Retrieved from <https://insurance.maryland.gov/Insurer/Documents/bulletins/18-03-2019-Affordable-Care-Act-Rate-and-Form-Filing.pdf>.

Washington State Office of the Insurance Commissioner. (2018). *Mental Health and Substance Use Disorder Financial Requirement Checklist*. Retrieved from <https://www.insurance.wa.gov/checklists-health-coverage-analysts>.

²⁹ 26 C.F.R. § 54.9812-1(c)(2)(i) (2016); 29 C.F.R. § 2590.712(c)(2)(i) (2013); 45 C.F.R. § 146.136(c)(2)(i) (2013).

³⁰ *Id.*

³¹ 26 C.F.R. § 9812-1(c)(3) (2016); 29 C.F.R. § 2590.712(c)(3) (2013); 45 C.F.R. § 146.136(c)(3) (2013).

³² United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

³³ 26 C.F.R. § 54.9812(c)(3)(v) (2016); 29 C.F.R. § 2590.712(c)(3)(v) (2013); 45 C.F.R. § 146.136(c)(3)(v) (2013).

³⁴ *Id.*

Discrimination Test: Non-Quantitative Treatment Limitations (NQTLs)

NQTLs are broadly defined as “non-numerical limits on the scope or duration” of treatment benefits.³⁵ NQTLs affect patient access to MH/SUD care through plan standards, such as medical necessity criteria, utilization management, provider networks and the scope of covered benefits. Possible Parity Act violations exist where a member is unable to find a MH/SUD provider in the plan’s network or where the plan excludes a MH/SUD service, such as methadone treatment for opioid use disorder in an Opioid Treatment Program. Plan documents, such as insurance policies and web portal materials, often do not identify NQTLs, leaving consumers in the dark about key plan requirements that affect access to care and making it difficult for consumers and regulators to identify NQTL violations.

The Parity Act regulates these plan features both *as written* in the policy and *in operation* (as implemented) by the plan or by a MH/SUD benefits manager, and the Act applies a comparative standard for discrimination. The standard requires that, as written and in operation, “any processes, strategies, evidentiary standards, or other factors” used to create NQTLs for MH/SUD benefits must be comparable to, and applied no more stringently than the “processes, strategies, evidentiary standards or other factors” used to impose and apply NQTLs for medical/surgical benefits in the benefit classification.³⁶ NQTLs are generally described in documents not typically available to consumers or regulators, including internal medical necessity and utilization management guidelines, provider contracts, and plan operating practices.³⁷ For plans that delegate the management of MH/SUD benefits to a third-party entity (i.e., behavioral health organization or BHO), the plan is required to ensure that the BHO’s standards “as written and in operation” are comparable to and no more stringently applied than the standards for medical benefits. The NQTL discrimination test is akin to other civil rights standards for “class-based” discrimination: the plan must use the same rules to regulate insurance access for MH/SUD benefits as it does for medical/surgical services, and it cannot apply those rules more stringently to MH/SUD benefits.

Assessing compliance for NQTLs requires specific information from plans including:

- A list of NQTLs that apply to mental health, substance use disorder and medical/surgical benefits in each benefit classification.
- Documentation regarding the factors, processes and strategies used to impose and apply NQTLs for both medical/surgical and MH and SUD benefits to demonstrate comparable standards.³⁸
- Data that tracks the implementation of the NQTLs (or, the NQTLs *in operation*) for medical/surgical, mental health and substance use disorder benefits to demonstrate no more stringent application of standards, such as rates of denials, frequency of prior authorization and continuing review, reimbursement rates, out-of-network utilization, and provider inclusion in networks.
- The plan’s comparative analysis for any NQTL that is imposed on MH/SUD benefits.

³⁵ United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*.

³⁶ 26 C.F.R. § 54.9812-1(c)(4)(i) (2016); 29 C.F.R. § 2590.712(c)(4)(i) (2013); 45 C.F.R. § 146.136(c)(4)(i) (2013).

³⁷ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

³⁸ *Id.*

The U.S. Department of Labor’s Self-Compliance Tool sets out a four-step process for carriers to utilize to confirm NQTL compliance, and it defines and gives examples of key elements and sources of evidence for the analysis. The Department of Labor (DOL) guidance is a roadmap for the types of plan information a State Attorney General should obtain from a plan to assess compliance with NQTL standards. Insurers have a legal obligation to offer only those plans that comply with the Parity Act, and an investigation of an alleged NQTL violation should start with a review of the plan’s compliance report, pursuant to the DOL guidance.³⁹

For a summary of the Parity Act’s compliance tests, see [Exhibit 4, Summary of Parity Act Tests](#).

Prescription Drugs

The Parity Act requires plans to provide equal coverage for medications that are prescribed for MH, SUD and medical/surgical conditions and allows plans to have a single, multi-tiered formulary that applies different financial requirements to different tiers. The plan must use reasonable factors to establish the tiers, which must meet NQTL requirements and cannot take into consideration whether a drug is generally prescribed for medical/surgical or MH/SUD conditions.⁴⁰ “Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.”⁴¹ In addition to cost requirements, all formulary features that limit access to medications are NQTLs and must satisfy those standards.

DOL has issued sub-regulatory guidance on the coverage of prescription medications for the treatment of opioid use disorders (methadone, buprenorphine and naltrexone/Vivitrol) that clarifies that the plan design features for such medications, including prior authorization, fail first requirements, dosage limits and exclusions, must comply with the Parity Act’s requirements.⁴² Recently, DOL issued an important clarification regarding the applicability of the Parity Act to the coverage of methadone, a medication approved by the Food and Drug Administration (FDA) for the treatment of pain management and opioid use disorder (OUD), but frequently omitted from plan coverage for OUD.⁴³ When prescribed for pain management, methadone is covered under the plan’s prescription drug benefit and dispensed under a prescription in a pharmacy like any other type of controlled substance. However, when used for OUD treatment, methadone is covered under the plan’s medical benefit because it is subject to unique federal dispensing requirements and can

³⁹ *Id.*

⁴⁰ 26 C.F.R. § 54.9812-1(c)(3)(iii)(A) (2016); 29 C.F.R. § 2590.712(c)(3)(iii)(A) (2013); 45 C.F.R. § 136(c)(3)(iii)(A) (2013).

⁴¹ *Id.*

⁴² United States Department of Labor, United States Department of Health and Human Services, & United States Department of the Treasury. (2016). *FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women’s Health and Cancer Rights Act Implementation*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>.

United States Department of Labor, United States Department of Health and Human Services, & United States Department of the Treasury. (2016). *FAQs About Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf>.

United States Department of Labor, United States Department of Health and Human Services, & United States Department of the Treasury. (2018). [Proposed] *FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-proposed.pdf>.

⁴³ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. The National Center on Addiction and Substance Abuse. (2016). *Uncovering Coverage Gaps: A Review of Addiction Benefits in ACA Plans*. Retrieved from <https://www.centeronaddiction.org/addiction-research/reports/uncovering-coverage-gaps-review-of-addiction-benefits-in-aca-plans>.

Weber, E., Woodworth, A., Vuolo, L., Feinstein, E., & Tabit, M. (2017). *Parity Tracking Project: Making Parity a Reality*. Retrieved from Legal Action Center’s website: https://lac.org/wp-content/uploads/2017/06/ES_ParityTrackingReport_ASC.pdf.

only be dispensed by specially-licensed Opioid Treatment Programs (OTPs).⁴⁴ The federal government clarified that if a plan covers methadone for pain but excludes coverage of methadone for OUD, it must “demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for [OUD] are comparable to and applied no more stringently than those used for medical/surgical conditions.”⁴⁵

Disclosure Requirements

As previously described, determining a parity violation requires information typically not contained in plan documents available to consumers or regulators and often requires the plan to disclose information from both the entity that manages the medical benefits and a separate behavioral health organization that manages the MH/SUD benefits.⁴⁶ Enforcement of the Parity Act relies upon the disclosure of plan information related to the development and application of financial requirements (FRs), quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs). Yet, health plans frequently seek to protect their information as confidential or proprietary and resist disclosure to consumers, providers and even regulators. In order to compel plans to provide the information necessary to determine violations and enforce the Parity Act, regulators have established specific disclosure requirements and clarified that plans cannot refuse to disclose specific information on the basis that it is proprietary.⁴⁷

Group and individual plans are required to provide the following information:

- Criteria for medical necessity determinations for MH/SUD benefits, upon request from a current or potential participant, beneficiary, or contracting provider.⁴⁸
- Reason for denial of request for reimbursement or payment for services for any MH/SUD benefit to any participant or beneficiary.⁴⁹
- In appeals of adverse benefit determinations, access to all documents relevant to the claim for benefits including documents with information about the processes, strategies, evidentiary standards, and other factors used to apply an NQTL for both MH/SUD benefits and medical/surgical benefits.⁵⁰

Employer-sponsored plans that are subject to the Employee Retirement Income Security Act (ERISA) must also disclose “instruments under which the plan is established or operated,” under ERISA’s general disclosure standards.⁵¹ This includes documents with information on medical necessity for both medical/surgical and mental health/substance use disorder benefits and documents that set out the plan’s standards for imposing and applying NQTLs to both medical/surgical and MH/SUD benefits. Under ERISA,

⁴⁴ 21 U.S.C. 823(g)(1) (2011); 42 C.F.R. §§ 8.1-8.15 (2018).

⁴⁵ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁴⁶ Weber, E., Woodworth, A., Vuolo, L., Feinstein, E., & Tabit, M. (2017). *Parity Tracking Project: Making Parity a Reality*.

⁴⁷ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁴⁸ 26 C.F.R. § 54.9812-1(d)(1) (2016); 29 C.F.R. § 2590.712(d)(1) (2013); 45 C.F.R. § 146.136(d)(1) (2013).

⁴⁹ 26 C.F.R. § 54.9812-1(d)(2) (2016); 29 C.F.R. § 2560.503-1 (2016); 29 C.F.R. § 2590.712(d)(2) (2013); 29 C.F.R. § 2590.715-2719 (2015); 45 C.F.R. § 146.136(d)(2) (2013); 45 C.F.R. § 147.136 (2010).

⁵⁰ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁵¹ 29 C.F.R. § 2590.712(d)(3); 78 Fed. Reg. 68,240, 68,247 (Nov. 13, 2013).

these items must be made available within 30 days of a participant's request and are not limited to disclosure in the context of an adverse benefit determination.

Plans routinely refuse to disclose information related to the development and application of NQTLs to members and even regulators. DOL has developed a model disclosure form to facilitate requests for disclosures.⁵² Monetary penalties can be assessed for failure to provide the documentation within the specified timeframe.⁵³

State Parity Laws

The federal Parity Act sets the floor for parity requirements, and states frequently enact laws to supplement federal standards.⁵⁴ State legislation and regulatory efforts often establish important requirements for parity compliance monitoring and enforcement.⁵⁵ For example, state law can establish minimum criteria for insurance department market conduct examinations or reports on enforcement efforts.⁵⁶ State laws may also establish carrier reporting requirements to demonstrate parity compliance. Such requirements are important to improve accountability and transparency in enforcement efforts.⁵⁷

Benefit Mandates

Federal Law

The Affordable Care Act (ACA) requires most individual and small group plans to cover mental health and substance use disorder benefits as an Essential Health Benefit.⁵⁸ The ACA does not define the specific services that must be covered but defers to the states to establish the minimum level of services under a benchmark plan.⁵⁹

⁵² United States Department of Labor. *Form to Request Documentation from an Employer-Sponsored Health Plan or an Insurer Concerning Treatment Limitations*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template-draft-revised.pdf>.

⁵³ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. United States Department of Labor. (2016). *FAQs about Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women's Health and Cancer Rights Act Implementation*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>.

⁵⁴ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁵⁵ Douglas, M., Wrenn, G., Bent-Weber, S., Tonti, L., Carneal, G., Keeton, T., Grillo, J. Rachel, S., Lloyd, D., Byrd, E., Miller, B., Lang, A., Manderscheid, R., & Parks, J. (2018). *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*. Retrieved from the ParityTrack website: https://chp-wp-uploads.s3.amazonaws.com/www.paritytrack.org/uploads/2018/09/KF-Evaluating-State-Mental-Health-Report-0918_web.pdf.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ 42 U.S.C. § 300gg-6(a) (2010); 42 U.S.C. § 18022 (2010).

⁵⁹ 45 C.F.R. § 156.100 (2018).

Centers for Medicare & Medicaid Services. (2011). *Essential Health Benefits Bulletin*. Retrieved from https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

State Law

Many states enact benefit mandates requiring state-regulated health plans to cover specific mental health and substance use disorder benefits.⁶⁰ States also enact laws regarding the administration of MH/SUD benefits by restricting prior authorization, concurrent and retrospective review requirements for services and prescription drugs and by requiring the use of certain approved patient placement tools for medical necessity determinations.⁶¹ To improve parity enforcement and protect consumer rights, states establish compliance reporting standards and require an ombudsman program to manage consumer-related complaints.⁶²

⁶⁰ Maryland requires individual and state-regulated group plans to cover specific services for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder, including inpatient treatment, residential treatment, partial hospitalization, intensive outpatient treatment and outpatient services (office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes), as well as residential crisis services for mental health. Md. Code Ann., Ins. § 15-802(b)–(c) (2018); Md. Code Ann., Ins. § 15-840 (2018).

⁶¹ New Jersey prohibits prior authorization for FDA-approved medications to treat SUD and for the first 180 days of medically necessary inpatient and outpatient SUD treatment at in-network facilities and prohibits concurrent and retrospective review for outpatient visits and for the first 28 days of inpatient, intensive outpatient, and partial hospitalization treatment.

N.J. STAT. ANN. § 17B:26-2.1hh (2018); N.J. STAT. ANN. § 17B:27-46.1nn (2018); N.J. STAT. ANN. § 17B:26-2.1hh (2018); N.J. STAT. ANN. § 17B:27-46.1nn (2018).

New Jersey and New York also require insurers to use tools designated by the state for medical necessity determinations and utilization reviews.

N.J. STAT. ANN. § 17B:26-2.1hh(h) (2018); N.J. STAT. ANN. § 17B:27-46.1nn(h) (2018); N.Y. Ins. Law § 4902(a)(9) (2018); N.Y. Pub. Health Law § 4902(1)(i) (2018).

The New Jersey Department of Health designated ASAM LOCI (American Society of Addiction Medicine Level of Care Index) and OASAS (New York State Office of Alcoholism and Substance Abuse Services) designated LOCADTR 3.0 (Level of Care for Alcohol and Drug Treatment Referral). N.J. Admin. Code § 10:163-2.1 (2018); New York State Office of Alcoholism and Substance Abuse Services. (2017). *Memorandum – Guidance for the Implementation of Coverage and Utilization Review Changes Pursuant to Chapters 69 and 71 of the Laws of 2016*. Retrieved from <https://www.oasas.ny.gov/manicare/documents/InsurancelawguidanceFINAL.pdf>.

⁶² Illinois and Delaware have annual parity compliance reporting processes for health plans.

Illinois General Assembly. (2018). House Amendment 3 to SB 1707. Retrieved from

<http://www.ilga.gov/legislation/100/SB/PDF/10000SB1707ham003.pdf>.

Delaware State Senate Assembly. (2018). Senate Bill No. 230. Retrieved from <https://legis.delaware.gov/BillDetail/26758>.

New York established a behavioral health ombudsman program to improve and centralize the consumer complaints system. N.Y. Mental Hyg. Law § 33.27 (2018).

Part 2: Recommendations for Attorneys General to Improve Parity Enforcement

Part 2 of this Toolkit offers recommendations to help State Attorneys General (State AGs) establish a parity enforcement program. These recommendations seek to help State AG offices raise the profile of the Parity Act and awareness about parity protections among consumers; help consumers file complaints related to insurance barriers for MH/SUD care; investigate violations; and improve coordination among the various federal and state agencies responsible for enforcing parity.

1. Determine the Attorney General's enforcement authority regarding health insurance and seek expanded authority, if necessary.
2. Declare the Attorney General's intent to enforce parity protections and investigate complaints.
3. Launch and advertise a consumer hotline to report problems related to consumer access to MH/SUD care.
4. Examine the legal authority for parity enforcement in the state, identify enforcement gaps that are appropriate for Attorney General engagement and create referral processes with the state's insurance regulator and Medicaid office.
5. Establish a cooperation agreement with the Department of Labor Employee Benefits Security Administration (EBSA) regional office for referrals of self-insured plan violations.
6. Educate legislators about the Attorney General's role in enforcing parity and the consumer hotline.

Enforcement Authority

The type of insurance product determines whether a federal or state regulator is responsible for enforcing the Parity Act. While the Parity Act is a federal law, the federal government delegated primary enforcement authority to the states.⁶³ The state insurance department is responsible for state-regulated plans, including individual, fully-insured small and large group plans, and fully-insured state or local government employer plans (if subject to the state insurance department’s regulation). The state’s Medicaid office is responsible for enforcing parity in Medicaid Managed Care, Children’s Health Insurance Program (CHIP) plans and Medicaid Expansion plans. The U.S. Department of Health and Human Services (HHS) enforces the Parity Act in states that notify HHS that they will not enforce or are not “substantially enforcing” the Parity Act and self-insured state or local government employer plans.⁶⁴ The U.S. Department of Labor (DOL) is responsible for parity enforcement for self-insured large group plans. See [Exhibit 5, Enforcement Authority](#) for additional information on insurance regulator enforcement authority.

Some State AGs can enforce parity through their general authority to investigate fraudulent or illegal conduct in consumer products, including health insurance, or through specific authorizing legislation.⁶⁵ For example, the New York Attorney General (NYAG) investigates carriers doing business in the state under its general authority to investigate repeat or persistent fraud and illegal conduct in consumer products and under the state’s consumer protection law.⁶⁶ These laws provide the NYAG with the authority to issue subpoenas and seek relief, including enjoining future business activity and/or fraudulent or illegal acts, obtaining restitution and imposing damages.⁶⁷ The NYAG can also assess civil penalties for violations of the consumer protection law.⁶⁸ The Massachusetts Attorney General (MAOAG) investigates carriers doing business in the state under its general authority to investigate “unfair or deceptive acts or practices in the conduct of any trade or commerce” under the state’s consumer protection law.⁶⁹

In some states, the attorney general is not granted authority to investigate health insurance as a consumer product or service.⁷⁰ In such states, an expansion of statutory authority should be considered.

Declare Intent to Enforce State and Federal Parity Protections

Consumers are often unaware of the Parity Act, the right it affords, or how to exercise their rights. A State AG can help raise public awareness and the law’s profile by publicly declaring her intent to enforce parity and investigate consumer complaints related to MH/SUD treatment barriers. In announcing this initiative, the AG can frame parity enforcement as a consumer protection issue or as a tool to address the state’s opioid and/or suicide epidemic.

⁶³ 42 U.S.C. § 300gg-22(a)(1) (2010).

⁶⁴ 42 U.S.C. § 300gg-22(a)(2), (b) (2010); 78 Fed. Reg. 68,240, 68,252 (Nov. 13, 2013).

⁶⁵ Douglas, M., et al. (2018). *Evaluating State Mental Health and Addiction Parity Statutes: A Technical Report*.

⁶⁶ N.Y. EXEC. LAW § 63(12); N.Y. GEN. BUS. §§ 349.

⁶⁷ N.Y. EXEC. LAW § 63(12); N.Y. GEN. BUS. § 349(b) and (f).

⁶⁸ N.Y. GEN. BUS. § 350-d.

⁶⁹ Mass. Gen. Laws ch. 93A, § 2 (2019).

⁷⁰ For example, in Ohio, the definition provision of the state’s consumer protection law defines consumer transactions to exclude those transactions defined in Ohio Rev. Code 5725.01, which includes insurance companies and health insuring corporations under 5725.01 (C). Ohio Rev. Code § 1345.01 et seq.

Consumer Hotline

Despite the ubiquity of problems faced by consumers when accessing MH/SUD care, consumers do not frequently complain to regulators because – in addition to being unaware of the Parity Act – the process to challenge an adverse decision is complex and confusing. To help consumers, a State AG should establish a hotline for consumers to report problems they face in accessing MH/SUD benefits through their health insurance. AG offices that have an existing hotline should advertise and encourage the public to use it for problem notification related to barriers to MH/SUD treatment. Hotlines provide important education and support for consumers attempting to navigate a confusing and complex process, and complaints are necessary to establish a basis for a parity investigation.

While state insurance regulators may have a consumer health complaint hotline, a hotline established by a State AG is an important supplement and, in some cases, may be advantageous for identifying systemic insurance problems. First, consumers frequently contact the AG with complaints related to consumer protection, and complaints related to health insurance should be incorporated into existing consumer complaints processes. Second, a single complaint line can serve as a clearinghouse regardless of the consumer’s type of insurance product. As explained in the Enforcement Authority section above, enforcement authority rests with different entities. Consumers are often unaware of the type of insurance they have and do not know which federal or state regulator can help them. Identifying the correct resource can be time consuming and causes many consumers to give up. Finally, consumers may not have the ability or desire to pursue an individual complaint through the insurance department but could make a single call to the AG to report a significant problem in accessing care.

Consumer hotlines should be well advertised and accompanied by efforts to educate consumers about parity. Events such as declaring the attorney general’s intent to enforce parity or the enactment of a new state parity law or benefit mandate may provide optimal opportunities to launch or advertise a consumer hotline. Enactment of a new law provides the opportunity to educate the public about the law’s protections and alert members of the public to contact the attorney general if they are denied coverage despite the law’s protections.

In addition, the complaint process should require minimal effort from consumers. Hotline staff should be well trained in identifying potential violations of parity or other insurance requirements, and the consumer should not be obligated to perform an analysis to identify a parity violation. The staff should be trained to identify potential parity violations from consumer narratives and should collect only the minimal amount of information needed from consumers, given the sensitive nature of MH/SUD treatment.

The New York Attorney General has a Health Care Bureau Helpline.⁷¹ Trained intake specialists and advocates staff the helpline to provide information, education and assistance to health care consumers, including resolving complaints and mediating disputes related to health care coverage.⁷² Complaints

⁷¹ New York State Office of the Attorney General. (2018). *Health Care Bureau*. Retrieved from <https://ag.ny.gov/bureau/health-care-bureau>.

⁷² New York State Office of the Attorney General. (2018). *Health Care Bureau*.

captured through this hotline helped the NYAG identify systemic coverage issues and were used to launch the office's parity investigations of seven carriers.⁷³

Other states, including Illinois,⁷⁴ Maryland⁷⁵ and Massachusetts,⁷⁶ have dedicated attorney general hotlines for consumer complaints related to health insurance. The Delaware attorney general has a dedicated hotline for individuals who are denied SUD treatment.⁷⁷

Create Referral Processes and Cooperation Agreements

A centralized State AG hotline for consumer complaints can help to mitigate the fragmented approach to parity enforcement and ensure that complaints reach the correct entity with enforcement authority. The AG should establish a cooperation agreement with the DOL Employee Benefits Services Administration (EBSA) Regional Office so that a consumer complaint related to a self-insured plan can be easily directed to the appropriate agency without additional consumer involvement.⁷⁸ The AG should also work closely with the state's insurance regulator and Medicaid office to share information about parity-related complaints to inform and coordinate regulatory oversight. State AGs should work with state insurance and Medicaid regulators to identify relevant state laws and assess gaps in enforcement. The State AG should create an additional avenue for parity enforcement by supplementing enforcement strategies carried out by the state's insurance regulators (e.g., pre-market compliance review, complaint investigations, market conduct examinations and Medicaid compliance reviews).

Educate Legislators

Individuals often complain to their elected officials about issues accessing MH/SUD care. A State AG should educate legislators about her role in parity enforcement so that legislators can inform their constituents about the AG's resources.

New York State Office of the Attorney General. (2018). *Mental Health Parity: Enforcement by the New York State Office of the Attorney General*. Retrieved from https://ag.ny.gov/sites/default/files/hcb_mental_health_parity_report.pdf.

⁷³ New York State Office of the Attorney General. (2018). *Mental Health Parity: Enforcement by the New York State Office of the Attorney General*.

⁷⁴ State of Illinois Office of the Attorney General. (2018). *Protecting Consumers – Health Care Bureau*. Retrieved from <http://www.illinoisattorneygeneral.gov/consumers/healthcare.html>.

⁷⁵ Maryland Office of the Attorney General. *Health Education and Advocacy Unit*. Retrieved from <http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx>.

⁷⁶ Massachusetts Office of the Attorney General. (2018). *File a Health Care Complaint*. Retrieved from <http://www.mass.gov/ago/consumer-resources/consumer-assistance/health-care-complaint.html>.

⁷⁷ Delaware Office of the Attorney General. *Substance Abuse Treatment Insurance Coverage Assistance Program*. Retrieved from <https://attorneygeneral.delaware.gov/dojtreatmentassistance/>.

⁷⁸ The NYAG entered into a Memorandum of Understanding with the Department of Labor, Employee Benefit Services Administration to work cooperatively by referring cases, conducting joint investigations and providing enforcement assistance regarding violations of federal and state health insurance laws.

New York State Office of the Attorney General & United States Department of Labor. (2015). *Memorandum of Understanding Between The United States Department of Labor, Employee Benefits Security Administration and The New York State Office of the Attorney General, Health Care Bureau*. Retrieved from https://ag.ny.gov/pdfs/MOU_bt看 USDOL EBSA_and_NYSOAG.PDF.

Basic Investigatory Approach

State attorneys general are experts in protecting consumers from fraudulent and deceptive practices, and each State AG office has its own process for launching an investigation. This section of the Toolkit provides an overview of the investigatory approach taken by at least one State AG to enforce parity protections. These steps have been generalized from the settlement agreements reached by the New York Attorney General (NYAG), and many of the examples are taken from the NYAG's findings. Recently, the Massachusetts Attorney General (MAOAG) also reached a settlement with one carrier related to the disclosure of utilization management standards for MH/SUD services and the accuracy of provider directories. Findings from the MAOAG's settlement are also referenced below.

1. Identify potential parity violations.

Most plans have eliminated disparate cost sharing requirements and visit limits on MH/SUD services and are now facially compliant with these Parity Act requirements. Currently, parity violations most frequently occur with non-quantitative treatment limitations (NQTLs), which are not evident from plan documents. These violations occur in the way MH/SUD benefits are covered and administered and, like many forms of discrimination, are initially identified through plan data that highlights disparities in outcomes for MH/SUD benefits. While disparate outcomes standing alone do not establish a parity violation, they signal areas in which to target an investigation.⁷⁹ For example, disparate levels of out-of-network utilization of MH/SUD services compared with medical services often derives from non-comparable network admission and credentialing, reimbursement or contracting practices.⁸⁰

The following list identifies examples of common MH/SUD treatment barriers that consumers face and can help guide the State AG in subpoenaing plan records and/or data to determine a potential parity violation.

- Was the consumer denied a service or medication for MH/SUD that is covered for a medical condition?
 - *nutritional counseling is denied for an eating disorder diagnosis but covered for diabetes treatments;*⁸¹
 - *methadone is covered for treatment of pain but not for opioid use disorder;*⁸²
 - *the plan excludes residential treatment for MH/SUD treatment and includes skilled nursing facility services for medical care.*⁸³

⁷⁹ 78 Fed. Reg. 68,240, 68,245 (Nov. 13, 2013).

⁸⁰ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁸¹ New York State Office of the Attorney General. (2014). *In the Matter of Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Assurance No.: 13-474, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: <https://lac.org/wp-content/uploads/2014/07/Cigna-AOD-Executed-1-7-14.pdf> (hereinafter, the "Cigna Settlement").

New York State Office of the Attorney General. (2016). *In the Matter of HealthNow New York Inc., Assurance No.: 16-105, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from https://ag.ny.gov/sites/default/files/healthnow_aod_fully_executed_8-19-16.pdf (hereinafter, the "HealthNow Settlement").

⁸² United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

⁸³ New York State Office of the Attorney General. (2014). *In the Matter of MVP Health Care, Inc., Assurance No.: 14-006, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: https://lac.org/wp-content/uploads/2014/12/Assur_of_Discon_-_NYS_AG_v_MVP_3-19-14.pdf (hereinafter, the "MVP Settlement").

- Does the plan impose more rigorous utilization review standards on MH/SUD than on medical/surgical services?
 - *higher number of utilization reviews for behavioral health services than for medical/surgical services;*⁸⁴
 - *concurrent review requirement applies to all inpatient SUD services, but most inpatient medical services are exempt from the requirement;*⁸⁵
 - *MH/SUD services are approved for a few days/visits at a time;*⁸⁶
 - *use of criteria to trigger an intensive utilization review for MH/SUD services that are more restrictive than those for medical/surgical services;*⁸⁷
 - *plan imposes utilization review standard after a certain threshold for outpatient MH/SUD visits, but no such standard applies for medical/surgical benefits;*⁸⁸
 - *the plan imposes prior authorization requirements for all Food and Drug Administration (FDA)-approved SUD medications.*⁸⁹
 - *higher percentages of adverse determinations for MH/SUD services;*⁹⁰
 - *higher number of claim denials for MH/SUD services or for specific MH/SUD services than for comparable medical/surgical services (e.g., inpatient care);*⁹¹
 - *spending on behavioral health services is not aligned with other trends in health spending;*⁹²
 - *incorrect application of medical necessity criteria;*⁹³
 - *fail-first or fail-twice requirements imposed on MH/SUD services;*⁹⁴
 - *requirement for treatment and discharge planning for MH/SUD services but not for medical/surgical services;*⁹⁵
 - *denials for behavioral health services are overturned on external review/appeal at higher rates than denials for medical services;*⁹⁶

New York State Office of the Attorney General. (2014). *In the Matter of EmblemHealth, Inc., Assurance No.: 14-031, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: https://lac.org/wp-content/uploads/2014/12/Emblem_Parity_AOD.pdf (hereinafter, the "EmblemHealth Settlement").

New York State Office of the Attorney General. (2015). *In the Matter of ValueOptions, Inc., Assurance No.: 14-176, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: <https://lac.org/wp-content/uploads/2014/07/ValueOptions-AOD-Fully-Executed.pdf> (hereinafter, the "ValueOptions Settlement").

New York State Office of the Attorney General. (2015). *In the Matter of Excellus Health Plan, Inc., Assurance No.: 14-201, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15*. Retrieved from Legal Action Center's website: <https://lac.org/wp-content/uploads/2014/07/Excellus-Parity-AOD-Executed.pdf> (hereinafter, the "Excellus Settlement").

⁸⁴ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

⁸⁵ Excellus Settlement.

⁸⁶ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement.

⁸⁷ *Id.*

⁸⁸ HealthNow Settlement.

⁸⁹ New York State Office of the Attorney General. (2016). *Cigna – Prior Authorization for Medication-Assisted Treatment Medications for Opioid Use Disorder* [letter from the New York State Assistant Attorneys General of the Health Care Bureau to the Vice President and Chief Counsel of Cigna]. Retrieved from https://ag.ny.gov/sites/default/files/ny_oag-cigna_mat_letter_agreement_101916.pdf.

New York State Office of the Attorney General. (2016). *Anthem – Prior Authorization for Medication-Assisted Treatment Medications for Opioid Use Disorder* [letter from the New York State Assistant Attorneys General of the Health Care Bureau to Anthem, Inc. and Empire BlueCross BlueShield]. Retrieved from https://ag.ny.gov/sites/default/files/final_letter_agreement_anthem-empire_mat_010117.pdf.

⁹⁰ MVP Settlement; ValueOptions Settlement.

⁹¹ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

⁹² EmblemHealth Settlement; ValueOptions Settlement.

⁹³ *Id.*

⁹⁴ EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

⁹⁵ EmblemHealth Settlement; ValueOptions Settlement.

⁹⁶ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement.

- *plan has a disproportionate amount of estimated cost savings from denials of behavioral health treatment (based on plan’s spending on behavioral health services).*⁹⁷
 - Does the plan have an adequate provider network/meet network adequacy standards?
 - *the plan does not contain a certain type of provider even though the service is covered by the plan;*⁹⁸
 - *the plan does not have a sufficient number of medication-assisted treatment (MAT)-authorized (buprenorphine-waivered) providers;*⁹⁹
 - *the plan does not maintain a network that is adequate in both the number and type of behavioral health providers to assure members are able to receive timely services;*¹⁰⁰
 - *members use out-of-network providers for MH/SUD services at a greater rate than for medical services.*¹⁰¹
 - Is the plan’s reimbursement for MH/SUD services similar to reimbursement for medical/surgical services?
 - *plan provides lower reimbursement for out-of-network MH/SUD services resulting in higher out-of-pocket costs;*¹⁰²
 - *reimbursement rates for network psychiatrists are lower than reimbursement rates for medical providers for the same procedure codes;*¹⁰³
 - *the plan does not reimburse for standard MH/SUD services;*¹⁰⁴
 - *reimbursement rates for psychiatric services are lower than in prior years.*¹⁰⁵
 - Does the carrier comply with disclosure requirements?
 - *adverse determination letters contain insufficient information regarding the reason for the denial or fail to identify the medical necessity criteria used for medical necessity determinations.*¹⁰⁶
2. Review evidence-based medical guidelines for SUD (e.g., American Society of Addiction Medicine Placement Criteria) and MH treatment to determine whether a plan excludes services or medications that are part of the medically accepted continuum of care.

⁹⁷ Excellus Settlement.

⁹⁸ ValueOptions Settlement.

⁹⁹ New York State Office of the Attorney General. (2016). *Anthem – Prior Authorization for Medication-Assisted Treatment Medications for Opioid Use Disorder* [letter from the New York State Assistant Attorneys General of the Health Care Bureau to Anthem, Inc. and Empire BlueCross BlueShield].

¹⁰⁰ Commonwealth of Massachusetts (2018). *Commonwealth of Massachusetts v. Aetna Health, Inc., Aetna Life Insurance Company, and Aetna Health Insurance Company, Assurance of Discontinuance Pursuant to G.L. Chapter 93A, § 5*. On file. (hereinafter, the “Aetna Settlement”).

¹⁰¹ Melek, S.P., Perlman, D., & Davenport, S. (2017). Addition and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates. *Milliman*. Retrieved from <http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>.

Claxton, G., Rae, M., Cox, C., & Levitt, L. (2018). An analysis of out-of-network claims in large employer health plans. *Kaiser Family Foundation*. Retrieved from Peterson-Kaiser Health System Tracker’s website: https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/?post_types=brief#item-start.

¹⁰² EmblemHealth Settlement; ValueOptions Settlement.

¹⁰³ ValueOptions Settlement.

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

3. Gather information from the consumer's health care provider to demonstrate that the service is medically necessary for the specific patient.
4. Subpoena records from the carrier regarding its policies/procedures for determining exclusions or coverage limitations, as well as claim payments and denials for the requested service for both MH/SUD and medical/surgical diagnoses, to determine whether there is a violation of the Parity Act or state law.
5. If the health plan carves out the management of MH/SUD benefits to a behavioral health organization, ensure the carrier has a process for comparing claims payments and benefit denials across MH/SUD and medical/surgical benefits to identify disparities and assess all plan standards.

Remedies

The following list summarizes remedies obtained by the NYAG in settlement agreements with seven carriers and by the MAOAG in a settlement agreement with one carrier. This list provides a range of options, but is not exhaustive, and the remedy must be tailored to the case and pattern of violations.

1. Require the carrier to change the benefit standard or practice,¹⁰⁷ including updating plan language (if necessary),¹⁰⁸ providing training to staff on changes to benefits and practices¹⁰⁹ and informing plan members of the change in standards.¹¹⁰
2. Require the carrier to reprocess and pay all inappropriately denied claims to affected plan members,¹¹¹ and notify members of their right to file claims for services previously denied and for which members paid for out-of-pocket and reimburse for services eligible for coverage under corrected standards.¹¹²
3. Assess monetary penalties¹¹³ to serve as a deterrent and recoup costs associated with the investigation.¹¹⁴
4. Require the carrier to submit to ongoing monitoring to verify compliance with the settlement agreement.¹¹⁵

¹⁰⁷ Cigna Settlement; MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement; HealthNow Settlement.

¹⁰⁸ Cigna Settlement.

¹⁰⁹ Cigna Settlement; MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

¹¹⁰ MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement.

¹¹¹ Cigna Settlement; HealthNow Settlement.

¹¹² MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement; HealthNow Settlement.

¹¹³ Cigna Settlement; MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; HealthNow Settlement; Aetna Settlement.

¹¹⁴ Cigna Settlement; Excellus Settlement; Aetna Settlement.

¹¹⁵ Cigna Settlement; MVP Settlement; EmblemHealth Settlement; ValueOptions Settlement; Excellus Settlement; HealthNow Settlement; Aetna Settlement.

Conclusion

State attorneys general can help improve access to MH/SUD treatment by actively enforcing federal and state parity requirements. In some states, enforcement authority falls under the State AG's existing authority to investigate fraudulent or illegal conduct in consumer products, including health insurance, or through specific statutory authority. In other states, legislation will be required to provide the State AG with authority to address health insurance as a consumer product or service. State AGs can improve consumer protection in health insurance by raising awareness of the Parity Act among the public and creating a mechanism for consumers to file informal complaints through a consumer hotline. State AG enforcement can help supplement existing enforcement efforts by state insurance departments and Medicaid offices as well as federal regulators, and all responsible regulatory agencies should coordinate enforcement efforts. While State AGs are keenly knowledgeable about investigatory approaches and the enforcement strategy that will be most effective in their respective states, this Toolkit is meant to provide broad recommendations and generalized approaches, borrowing from successful enforcement efforts in New York and Massachusetts. The goal is to help State AGs expand access to mental health and substance use disorder treatment through robust enforcement of the Parity Act.

Acknowledgements

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Suggested Citation:

Parity at 10 Campaign (2019). *State Attorney General Parity Act Enforcement Toolkit*. Available at <https://parityat10.org/>.

Exhibit 1

RESOURCE LIST

Below are a list of resources prepared by the Departments of Labor and Health and Human Services and parity experts from several non-governmental organizations:

- United States Department of Labor. *Mental Health and Substance Use Disorder Parity*. Retrieved from <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity>.
- United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>.
- United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2017). *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*. Retrieved from <https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.
- United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtl-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf>.
- American Psychiatric Association. (2018). *Mental Health Parity*. Retrieved from <https://www.psychiatry.org/psychiatrists/practice/parity>.
- The Kennedy Forum & Scattergood Foundation. *ParityTrack*. Retrieved from the ParityTrack website: <https://www.paritytrack.org/>.
- Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*. Retrieved from <https://lac.org/wp-content/uploads/2016/06/LAC-Parity-Guide-2016.pdf>.
- Parity at 10. (2018). *Parity at 10*. Retrieved from <http://parityat10.org>.

Exhibit 2

PARITY ACT APPLICABILITY		
Insurance Product	Definition	Notes
Large group plans ¹¹⁶	Plans offered by employers with 51 or more employees	Only applies to large employer plans that cover MH/SUD benefits. ¹¹⁷ Applies to both fully-insured (state-regulated) and self-insured/ERISA (federally-regulated) large employer plans.
Small group plans ¹¹⁸	Plans offered by employers with 50 or fewer employees	Requires plans to cover MH/SUD benefits in compliance with Parity Act (ACA EHB requirement). Only applies to small group plans subject to the ACA and does not apply to “grandfathered” or self-funded plans.
Individual plans ¹¹⁹	Plans purchased by individuals on federal and state marketplaces	Requires plans to cover MH/SUD benefits in compliance with Parity Act (ACA EHB requirement).
Medicaid Managed Care plans ¹²⁰	Managed care plans that contract with states to deliver Medicaid benefits and additional services ¹²¹	Parity applies regardless of whether the behavioral health benefits are provided through managed care or fee-for-service. ¹²²
Medicaid Alternative Benefit Plans ¹²³	Medicaid plans for the expansion population	Requires coverage of MH/SUD benefits in compliance with Parity Act (ACA EHB requirement).

¹¹⁶ 26 C.F.R. § 54.9812-1(e) and (f) (2016); 29 C.F.R. § 2590.712(e) and (f) (2013); 45 C.F.R. § 146.136(e) and (f) (2013).

¹¹⁷ 26 C.F.R. § 54.9812-1(e)(1) (2016); 29 C.F.R. § 2590.712(e)(1) (2013); 45 C.F.R. § 146.136(e)(1) (2013).

¹¹⁸ 45 C.F.R. § 147.150(a) (2014); 45 C.F.R. § 156.115(a)(3) (2016).

¹¹⁹ 45 C.F.R. § 147.160(a) (2013).

¹²⁰ 81 Fed. Reg. 18389 (March 30, 2016) (codified at 42 C.F.R. pts. 438, 440, 456, et al.)

¹²¹ Centers for Medicare and Medicaid Services. *Managed Care*. Retrieved from <https://www.medicare.gov/medicaid/managed-care/index.html>.

¹²² 42 C.F.R. § 438.920 (2016).

¹²³ 81 Fed. Reg. 18389 (Mar. 30, 2016) (codified at 42 C.F.R. § 440.395).

Children’s Health Insurance Program plans (CHIP) ¹²⁴	Plans for children under age 19 in families that earn too much money to qualify for Medicaid but not enough to buy private insurance	If the state’s CHIP plan covers Early and Periodic Screening, Diagnostic and Treatment in compliance with the Parity Act, the CHIP plan is presumed to be parity compliant. ¹²⁵
State and local government plans	Plans for state and local government employees	Self-insured state and local government plans can opt-out of Parity Act compliance. ¹²⁶
Church-sponsored plans	Plans for church employees or employees of church-affiliated entities	Can opt-out of Parity Act compliance. ¹²⁷
Federal Employee Health Benefits (FEHB) Program plans	Plans for federal government employees	Not covered by statute but under a letter from the U.S. Office of Personnel Management. ¹²⁸

¹²⁴ 81 Fed. Reg. 18389 (2016) (codified at 42 C.F.R. pts. 438, 440, 456, et al.).

¹²⁵ 42 C.F.R. § 457.496(b) (2016).

¹²⁶ 42 U.S.C. § 300gg-21(a)(2) (2010).

¹²⁷ *Id.*

¹²⁸ United States Office of Personnel Management. (2008). *Letter No. 2008-17, Subject: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 – Federal Employees Health Benefits Program Carrier Guidance*. Retrieved from <https://www.opm.gov/healthcare-insurance/healthcare/carriers/2008/2008-17.pdf>.

Exhibit 3

FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS	
Standard	Example
Financial Requirements ¹²⁹	<ul style="list-style-type: none"> • Deductibles (cumulative) • Co-payments • Coinsurance • Out-of-pocket maximums (cumulative)
Quantitative treatment limitations ¹³⁰	<ul style="list-style-type: none"> • Annual day/visit limits (cumulative) • Episode day/visit limits • Lifetime day/visit limits (cumulative) • Limits on number of treatments • Limits on days of coverage
Non-quantitative treatment limitations ¹³¹	<ul style="list-style-type: none"> • Medical necessity determinations • Exclusions or limitations based on whether treatment is experimental/investigative • Prior authorization • Concurrent authorization • Retrospective review • Outlier model for utilization management • Formulary design and tier placement • Network tier design • Provider network standards • Reimbursement rates • Network adequacy • Methods for determining usual, reasonable and customary charges • Fail-first policies/step therapy protocols • Exclusions of treatment for certain conditions • Exclusions based on failure to complete a course of treatment • Restrictions on provider/service billing codes • Access to out-of-network provider standards • Geographic location/facility type/provider specialty restrictions • Written treatment plan requirement • Probability/likelihood of improvement requirements

¹²⁹ 26 C.F.R. § 54.9812-1(c)(1)(ii) (2016); 29 C.F.R. § 2590.712(c)(1)(ii) (2013); 45 C.F.R. § 146.136(c)(1)(ii) (2013).

¹³⁰ 26 C.F.R. § 54.9812-1(c)(1)(ii) (2016); 29 C.F.R. § 2590.712(c)(1)(ii) (2013); 45 C.F.R. § 146.136(c)(1)(ii) (2013).

See also: United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

¹³¹ 26 C.F.R. § 54.9812-1(c)(4)(ii) (2016); 29 C.F.R. § 2590.712(c)(4)(ii) (2013); 45 C.F.R. § 146.136(c)(4)(ii) (2013).

See also: United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*.

United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*. 78 Fed. Reg. 68,240, 68246 (Nov. 13, 2013).

	<ul style="list-style-type: none">● Scope of services● Limitations on inpatient services where the patient is a threat to self or others● Exclusions for court-ordered services and involuntary holds● Exclusions for services provided by clinical social workers
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Exhibit 4

SUMMARY OF PARITY ACT TESTS		
Standard	Test	Examples/Red Flags
Coverage in all Benefit Classifications	<ul style="list-style-type: none"> If a plan offers MH/SUD benefits in at least one benefit classification, it must offer MH/SUD benefits in every benefit classification in which medical/surgical benefits are offered (including out-of-network). 	<ul style="list-style-type: none"> Plan covers the full range of medical/surgical services (inpatient, outpatient, emergency care, prescription drugs) and only covers MH/SUD treatment in an outpatient clinic. Plan covers out-of-network outpatient treatment for medical/surgical and excludes out-of-network outpatient MH/SUD treatment.¹³² No coverage for residential SUD treatment.¹³³ No coverage for medications approved by the FDA for the treatment of opioid addiction.¹³⁴
Financial requirements (FRs)/Quantitative treatment limitations (QTLs)	<ul style="list-style-type: none"> FRs and QTLs for MH/SUD benefits cannot be more restrictive than the predominant FR/QTL that applies to substantially all medical/surgical benefits in the same classification. The type of FR or QTL (e.g., copay, coinsurance, deductible, visit limit) must apply to at least two-thirds of the medical/surgical benefits in the same benefit classification (based on the dollar amount of plan payments 	<ul style="list-style-type: none"> More restrictive limits on the number of days of MH/SUD treatment or on the number of visits to MH/SUD providers.¹³⁵ Higher co-payments for outpatient MH/SUD visits than for outpatient medical/surgical benefits.¹³⁶ For private insurance plans, a separate deductible for MH/SUD services.¹³⁷

¹³² United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

¹³³ Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*.

26 C.F.R. § 54.9812-1 (c)(4)(iii) (2016); 29 C.F.R. § 2590.712(c)(4)(iii) (2013); 45 C.F.R. § 146.136(c)(4)(iii) (2013).

United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*.

¹³⁴ United States Department of Labor, United States Department of Health and Human Services, & United States Department of the Treasury. (2016). *FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, and Women’s Health and Cancer Rights Act Implementation*. Retrieved from <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>.

Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*.

¹³⁵ 26 C.F.R. § 54.9812-1(c)(2)(i) (2016); 29 C.F.R. § 2590.712(c)(2)(i) (2013); 45 C.F.R. § 146.136(c)(2)(i) (2013).

United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*.

¹³⁶ *Id.*

¹³⁷ 26 C.F.R. § 54.9812-1(c)(3)(v) (2016); 29 C.F.R. § 2590.712(c)(3)(v) (2013); 45 C.F.R. § 146.136(c)(3)(v) (2013).

	<p>expected to be paid for the plan year in the benefit classification).</p> <ul style="list-style-type: none"> ● If not, that type of FR or QTL cannot be imposed on the MH/SUD benefit. ● If yes, what is the predominant level of the FR/QTL (e.g., amount of the copay, number of days in visit limit)? This is the value that applies to at least 51% of the medical/surgical benefits in the benefit classification subject to that type of FR/QTL (based on expected plan payments). ● If the MH/SUD FR/QTL is more restrictive than the predominant level, it cannot be imposed. ● Cumulative FRs and QTLs for MH/SUD benefits cannot accumulate separately from those for medical/surgical benefits when such benefits are in the same benefit classification. 	
<p>Non-quantitative treatment limitations (NQTLs)</p>	<ul style="list-style-type: none"> ● NQTLs placed on MH/SUD benefits must be “comparable to” and “applied no more stringently than” NQTLs placed on medical/surgical benefits in any benefit classification. ● Identify all services to which the NQTL applies in each benefit classification.¹³⁸ ● Identify the factors used to design the NQTL. ● Identify the sources used to define the factors. Are the sources comparable for medical/surgical and MH/SUD?¹³⁹ ● Are the factors comparable to and applied no more stringently for MH/SUD benefits as written and in operation?¹⁴⁰ 	<p>For examples of NQTL violations, see:</p> <ul style="list-style-type: none"> ● Regulations¹⁴¹ ● MHPAEA Enforcement Fact Sheets¹⁴² ● Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance¹⁴³ ● Legal Action Center Parity Guide¹⁴⁴

¹³⁸ United States Department of Labor. (2018). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ 26 C.F.R. § 54.9812-1(c)(4)(iii) (2016); 29 C.F.R. § 2590.712(c)(4)(iii) (2013); 45 C.F.R. § 146.136(c)(4)(iii) (2013).

¹⁴² United States Department of Labor, Employee Benefits Security Administration. *MHPAEA Enforcement Fact Sheets*. Retrieved from <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement>.

¹⁴³ United States Department of Labor & United States Department of Health and Human Services. *Warning Signs – Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance*.

¹⁴⁴ Legal Action Center. (2016). *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law*.

Exhibit 5

ENFORCEMENT AUTHORITY	
Regulator	Plan Type
Department of Labor (DOL)	<ul style="list-style-type: none"> • Self-insured large employer (ERISA) plans
Department of Health and Human Services (HHS)	<ul style="list-style-type: none"> • Non-federal governmental plans (state and local government employee plans) • States that notify the Centers for Medicare and Medicaid Services (CMS) that they do not have authority to enforce/are not enforcing the Parity Act
Office of Personnel Management	<ul style="list-style-type: none"> • Federal Employees Health Benefit Program plans
State Insurance Commissioners	<ul style="list-style-type: none"> • Individual plans • Fully-insured small group plans • Fully-insured large group plans
State Medicaid Departments	<ul style="list-style-type: none"> • Medicaid Managed Care plans • Medicaid expansion plans • Children’s Health Insurance Program plans